Policies of the DNA Comprehensive Therapy Services

If you have any questions not covered by this statement, please feel free to ask for clarification.

The Practice
Dr. Metheny is a board certified and highly trained psychiatrist who works with children, adolescents and their families. She welcomes the opportunity to meet with you and your family and is very motivated to help!

One of the many benefits of treatment at our office is that we offer numerous services in addition to psychiatry including psychology, occupational therapy, speech therapy, behavioral therapy and educational tutoring. This ensures that you and your child will have all the resources they need under one roof!

Confidentiality and Release of Information
All information disclosed within sessions is confidential and may not be revealed to anyone outside of the DNA Comprehensive Therapy Services without your written permission, except for disclosures as required by law. The law does require clinicians to report to the authorities any reasonable suspicions of child or elder abuse, or danger of harm to self and/or to others unless protective measures are taken.

To the extent necessary to determine insurance benefits or liability for payment and to obtain reimbursement, DNA Comprehensive Therapy Services may disclose portions of the patient's medical record and account file to any person or corporation that may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers.

Financial Agreement
It is a patient's responsibility to know his/her insurance coverage for mental health, as your mental health benefits and general medical coverage may be provided by two separate plans. Our office staff is happy to help answer questions and help with this process. If your plan does not cover the services rendered, you may be billed and held responsible for all non-covered services.

Patients in poor credit standing with DNA Comprehensive Therapy Services will make their co-payments or payment in full at the time of their visit. We reserve the right to assign unpaid bills to a collection agency.

Fees for Psychiatry Services
Dr. Metheny is currently scheduling new patients for comprehensive assessments for diagnostic and treatment purposes. The doctor is in the process of enrolling to various insurance panels and at this time is seeing patients for a fee for service.

The initial intake is a comprehensive diagnostic assessment where the doctor will gather important information regarding the developmental, behavioral and psychiatric history of the child. This visit will consist of face to face time with the doctor for the parents and the child (either together or separately depending on what is deemed most appropriate). This initial visit is 60 minutes and the doctor may order lab or imaging tests. She will also utilize assessment tools and gather information from other providers involved in the case.

This initial thorough assessment is $300. Follow up appointments thereafter will be based on the complexity of the situation. The doctor may recommend and prescribe medications, engage in therapy or perform exams in order to best understand and treat your child. The appointment times for follow ups can be 60, 45 or 30 minutes depending on the individual needs.

You will be asked to pay for the service fee up-front. We will then provide you the necessary information for you to submit the bill to your insurance carrier for reimbursement. We would expect that you would get between 50-80% of the payment back.

DNA Comprehensive
THERAPY SERVICES

You may be billed for telephone calls, written reports or other services that specifically require the doctors time outside of the scheduled appointment.

Cancelled Appointments
A patient who fails to appear at or cancels within 24 business hours of an appointment will be charged for that appointment.

Repeated “no-shows” may jeopardize your ability to receive treatment.

General Medical Consent
The patient or the patient’s legal representative hereby consents to general and medical care, including but not limited to medical services, X-ray and laboratory examinations rendered to the patient by or under the general or special instructions of the physician practicing within the DNA Comprehensive Therapy Services.

Emergency Services
The on-call services are for emergencies only. Please call: 239-209-3142. After hours, on-call emergency services may be charged at a higher fee.

The undersigned certifies that he or she has read, understands, and accepts the terms and conditions of this form. The undersigned is either the patient or is duly authorized to sign this form and receive a copy.

____
Printed name of Patient

____
Printed Name of Parent/Guardian

____ ____________________
Signature of Parent/Guardian Date

Rachel Metheny, M.D.
DNA Comprehensive Therapy Services 14180 Metropolis Ave Suite 2 Fort Myers, FL 33912

DNA Comprehensive
THERAPY SERVICES

Pediatric Information Form

Patient Information Section

Patient Name: ____ Date of Birth: ____________ M F

Current Diagnosis (if any): ____

Home Address: ____

____

Primary Phone: ___________________________________

School Attended: ____ Grade: ___________

School Phone: ___________________________________

Child's Primary Physician: ____

Address/Phone: ____

____

Child's Referring Physician: ____

Address/Phone: ____

____

Guardian Information Section

First Guardian Name: ____

Relationship to Patient:_______________________________ Marital Status: ________________________

Occupation: _________________________

Primary Phone: _______________________________ (circle one) Cell Home Work

Secondary Phone: _____________________________ (circle one) Cell Home Work

E-mail Address: _________________________________

Preferred form of Contacted (circle one): E-mail Phone

Second Guardian Name: ____

Relationship to Patient:_______________________________ Marital Status: ________________________

Occupation: _________________________

Primary Phone: _______________________________ (circle one) Cell Home Work

Secondary Phone: _____________________________ (circle one) Cell Home Work

E-mail Address: _________________________________

Preferred form of Contacted (circle one): E-mail Phone

Emergency Contact: ____

Relationship: ____ Phone: __________________________

Insurance Information Section

Insurance Type: ____

Member ID Number: _________________________________ Group Number: _____________________________

Policy Holder's Name: ______________________________________ Policy Holder's DOB: _____________________

Additional Remarks: ____

____

____

____ ______________________

Signature of Guardian Date

____

Guardian Relationship to Patient

DNA Comprehensive
THERAPY SERVICES

HIPAA Release Form

Patient Name: ____________________ Date of Birth: ____________

Release of Information

[X] I authorize the release of information including diagnosis, records: examination rendered to me and claims information. This information may be released to and from the staff and clinicians of DNA Comprehensive Therapy Services along with the following people/places:

Name of Referring Doctor: ____________________

Specialty: ____________________

Phone #: ____________________ Fax #: ____________________

Name of Primary Doctor: ____________________

Specialty: ____________________

Phone #: ____________________ Fax #: ____________________

Name: ____________________

Specialty / Relationship: ____________________

Phone #: ____________________ Fax #: ____________________

Name: ____________________

Specialty / Relationship: ____________________

Phone #: ____________________ Fax #: ____________________

Name: ____________________

Specialty / Relationship: ____________________

Phone #: ____________________ Fax #: ____________________

Name: ____________________

Specialty / Relationship: ____________________

Phone #: ____________________ Fax #: ____________________

This release of information will remain in effect until terminated by patient or guardian in writing.

____________________ ____________________

Signature of Patient or Guardian Date

____

Relationship to Patient

____________________ ____________________

Witness Signature Date

Child/Adolescent Intake Form

Patient Information Section

Patient Name: ____ Date of Birth: ________________________

Gender: ___________ Ethnicity: ___________________________ Adopted: ______________________________________

Place of Birth: _____________________________ Parent's marital status:_______________________________________

If divorced, what are the custody arrangements? ____

Child's Primary Physician (with phone number):____

Address/Phone: ____

____

Family Members

____

____

Areas of Concern (Check all that apply)

Personal/Social Adjustment

[ ] Unduly sad
[ ] Overly anxious
[ ] Overly aggressive
[ ] Temper tantrums
[ ] Withdrawn or shy
[ ] Disturbing habits or mannerisms
[ ] Strange or bizarre behavior
[ ] Problems in peer relationships
[ ] Drug or alcohol problems
[ ] Problems with the law
[ ] Harms self or others (suicidal or homicidal)
[ ] Other: ___________________________

School Adjustment

[ ] Academic problems
[ ] Difficulty with peers
[ ] Difficulty with authority
[ ] Attendance problems or reluctance to go to school
[ ] Behavior problems
[ ] Learning disabilities
[ ] Attentional problems
[ ] Aches and pains related to school
[ ] Other: ___________________________

Family Adjustment

[ ] Parent-child problem
[ ] Marital conflict or co-parenting problems
[ ] Sibling conflict
[ ] Recent family changes
[ ] Neighborhood difficulties
[ ] Mother experiencing difficulties
[ ] Father experiencing difficulties
[ ] Sibling experiencing difficulties
[ ] Drug or alcohol problems in family
[ ] History of trauma or loss
[ ] Domestic violence
[ ] Abuse
[ ] Other: ___________________________

Physical/Developmental Factors

[ ] Eating
[ ] Sleeping
[ ] Toileting
[ ] Grooming
[ ] Language or speech
[ ] Perceptual/visual functions
[ ] Motor coordination problems
[ ] Other: ___________________________

History of Current Problem

Duration and primary concern (include changes in mood, behavior, sleep, eating, free-time activities, and school concerns). Please use backside of page for important history. ____

____

____

____

____

____

____

What have you already done to address this concern and how effective were these efforts?
____
____
____

Was there an event that caused you to seek treatment now? [ ] Yes [ ] No If yes, please describe.
____
____
____
____

School History

Current school: ______________________________ Teacher's name: ______________________________
Current grade level: ____________

Please issues with the following grade levels listed:
Preschool ____
____
Kindergarten ____
____
Grades 1-3 ____
____
Grades 4-5 ____
____
Grades 6-8 ____
____
Grades 9-12 ____
____

504 B/Individualized Educational Program (IEP) [ ] Yes [ ] No
What was the outcome of the evaluation/accommodations? ____
____
____
____

(Check all that apply)
[ ] Learning disabilities class ____________________
[ ] Behavioral/emotional disorders class ____________________
[ ] Resource room ____________________
[ ] Speech and language therapy ____________________
[ ] Suspended, expelled, retained ____________________
[ ] Other (please specify): ____________________

Please list all other evaluations your child has had (i.e. Psychological, Educational, Speech, Occupational Therapy) Please bring copies of these evaluation to the first appointment.

____
Type of Evaluation Name and Phone Number of Evaluator Date of Exam Outcome

____
Type of Evaluation Name and Phone Number of Evaluator Date of Exam Outcome

____
Type of Evaluation Name and Phone Number of Evaluator Date of Exam Outcome

Past Psychiatric History

Outpatient psychotherapy [ ] Yes [ ] No If yes, how long?
____

Family therapy [ ] Yes [ ] No If yes, how long?
____

Individual therapy [ ] Yes [ ] No If yes, how long?
____

Group therapy [ ] Yes [ ] No If yes, how long?
____

Inpatient (Hospital or Residential): [ ] Yes [ ] No If yes, where and when?
____
____

Past suicidal ideation? [ ] Yes [ ] No If yes, number of attempts, how when, and how?
____
____

Current suicidal ideation? [ ] Yes [ ] No If yes, number of attempts, how when, and how?
____
____

Previous diagnosis: ____
____
____

Medical History

Any significant or relevant medical problem (e.g. allergies, asthma, accidents and dates, surgery and dates, abuse and dates): ____
____
____

List all **current prescription medications**, over-the-counter medications, or supplements and how often you take them

____
Medication Name Total Daily Dosage Estimated Start Date

____
Medication Name Total Daily Dosage Estimated Start Date

____
Medication Name Total Daily Dosage Estimated Start Date

List all **past prescription medications**, over-the-counter medications, or supplements and how often you take them:
____
____
____
____

Has child had an **allergic reaction** or other problems with medications? [ ] Yes [ ] No If yes, which drugs, and briefly explain:____

Substance Use and Habits
Alcohol: [ ] Yes [ ] No If yes, how often? ____
Recreational Drugs: [ ] Yes [ ] No If yes, how often and what kinds? _________________________________
How often does your child sleep and for how long? ____
How are your child's eating habits? ____
List any other habits/interests:____

Family History
Please list below family member(s) who have (or had) emotional problems, depression, anxiety, psychiatric illness, drug or alcohol abuse, attentional difficulties, learning disabilities, autism, developmental delays or retardation, abuse, neglect, suicide attempts, etc.

____
Family Member (relationship to child) Problem

____
Family Member (relationship to child) Problem

____
Family Member (relationship to child) Problem

____
Family Member (relationship to child) Problem

Developmental Factors
Prenatal History

1. Mothers health during pregnancy was: _________________________
2. Age of mother at child's birth? ______________________________________
3. Did the mother have any exposure to drugs, alcohol, caffeine or tobacco during the pregnancy?____
____
4. Child born on schedule? [ ] Yes [ ] No If early, how premature? ______________________________________
5. Duration of labor? ____
6. Was delivery: [ ] Normal [ ] Breech [ ] Caesarian [ ] Forceps [ ] Suction [ ] Induced
7. Child's birth weight? ___________________ APGAR Score ________________
8. Were there complications following birth? [ ] Yes [ ] No
   If yes, what were they? ____
____
____
____
____

Postnatal Period / Infancy / Toddler

Feeding problems? [ ] Yes [ ] No
Sleep problems? [ ] Yes [ ] No
Problems with responsiveness (alertness)? [ ] Yes [ ] No
Were there health or congenital problems during infancy? [ ] Yes [ ] No
How was it to care for this child? [ ] Very easy [ ] Easy [ ] Average [ ] Difficult [ ] Very Difficult
How did the child behave with other people?
[ ] More Sociable than Average [ ] Average Sociability [ ] More Unsociable than Average
Rate the activity level of the child: [ ] Very Active [ ] Active [ ] Average [ ] Less Active [ ] Not Active

Developmental Milestones

Age child sat up: [ ] 3-6 months [ ] 7-12 months [ ] Over 12 months
Age child crawled: [ ] 6-12 months [ ] 13-18 months [ ] Over 18 months
Age child walked alone: [ ] Under 1 year [ ] 1-2 years [ ] 2-3 years
Age child spoke single words other that 'mama' or 'dada'?
[ ] 9-13 months [ ] 14-18 months [ ] 19-24 months [ ] 25-36 months [ ] 37-48 months
Age child strung two or words together:
[ ] 9-13 months [ ] 14-18 months [ ] 19-24 months [ ] 25-36 months [ ] 37-48 months
Age toilet trained?
Bladder controlled: [ ] Under 1 year [ ] 1-2 years [ ] 2-3 years [ ] 3-4 years
Bowel controlled: [ ] Under 1 year [ ] 1-2 years [ ] 2-3 years [ ] 3-4 years
How long did toilet training take from onset to completion?
[ ] Less than 1 month [ ] 1-2 month [ ] 2-3 months [ ] More than 3 months

Consent for Treatment of Minors:

This is to certify that the information on this form is accurate to the best of my knowledge. I give permission to Dr. Rachel Metheny to provide treatment for my child, ____. I verify that all legal guardians are aware of and give consent for this treatment as well.

____
Printed Name of Parent/Guardian

____ ______________________
Signature of Parent/Guardian Date