Woodview Psychology Group, LLC
70 East 91st Street, Suite 210 ▪ Indianapolis IN 46240
www.woodviewgroup.com
Tel: 317-573-0149
Fax: 317-573-0154

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	First Name:	M.I.:	Nickname:	
Birth Date:	Age:	☐Male ☐Female	Social Security #:	
Home Address:	City:	State	ZIP:	
Preferred Contact by: ☐ Home Phone _____ ☐Cell Phone _____ ☐ Work Phone_____				
Employer:	Occupation:	School:	Current Grade:	
Were you referred by your physician? ☐ Yes ☐No	May we contact your physician to let them know you were here? ☐ Yes ☐No			
Physician's Name:	If you were not referred by your physician, please tell us who referred you:			

IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)

Parent (1) Last Name:	First Name	M.I.:	Birth Date:	Social Security #:
Preferred Contact by: ☐ Home Phone _____ ☐Cell Phone _____ ☐ Work Phone_____				
Home Address (*if different from patient's*):	City:	State	ZIP:	
Employer:	Occupation:			

Parent (2) Last Name:	First Name	M.I.:	Birth Date:	Social Security #:
Preferred Contact by: ☐ Home Phone _____ ☐Cell Phone _____ ☐ Work Phone_____				
Home Address (*if different from patient's*):	City:	State	ZIP:	
Employer:	Occupation:			

EMERGENCY CONTACT

I give my consent to Woodview providers and/or staff to contact the following person in the event of an emergency:

Emergency Contact Name:	Relationship:	Phone Number:

INSURANCE

Company Name		Subscriber Name:
Subscriber ID Number:	Group Name:	Group Policy Number:

Your signature below indicates you have read and agree to the following:

CONSENT TO TREAT/AGREEMENT TO POLICIES

I have received a copy of and agree to "*Woodview Psychology Group's Policy Agreement*" and hereby request and authorize Woodview Psychology Group, LLC (hereafter referred to as "WPG") and its respective personnel to provide mental health services/treatment to me or my dependent (if patient is a minor). I understand that mental health services/treatment may include psychological assessment and/or psychotherapy. I am agreeing only to those services that WPG is qualified to provide within the scope of the provider'(s) license, certification, and training or the scope of those provider(s) directly supervising the services received by me. I also understand that, at any time, I can terminate this consent for treatment by putting such request in writing.

FINANCIAL AGREEMENT

I understand that I am responsible for all charges for services provided by WPG. I will pay in full, at the time of service, for all services rendered on my behalf or my dependent's behalf. WPG will provide a Billing Statement that I can file with my insurance provider for reimbursement.

If my mental health insurance coverage is through Sagamore Health Network, I will pay the co-pay at the time of service and WPG will submit a claim to Sagamore. I agree to provide accurate and updated healthcare/insurance information to WPG and hereby give consent to WPG to release any required information to my healthcare insurance to assist in the processing of claims, including protected healthcare information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). I also acknowledge and understand that I am responsible for any charges not covered by my health insurance.

NOTICE OF PRIVACY POLICIES

I hereby acknowledge that I have been offered a copy of the "Notice of Privacy Policies" and understand the information included in this document. I am aware that a copy of this notice will be given to me when I ask for a copy.

AUTHORIZATIONS FOR COMMUNICATION WITH WPG

For each of the following, please indicate your preference by initialing the appropriate statement:

Telephone Messages

I authorize that telephone messages regarding my appointment times may be left on my (please initial beside "*Yes*" or "*No*" for each item):

Home answering machine/voicemail	_____Yes	_____No
Work voicemail	_____Yes	_____No
Cell phone voicemail	_____Yes	_____No

Email Communications

___ *I do not consent to sending and/or receiving email communications to/from WPG.*

___ I consent to sending and/or receiving from email communications as part of treatment. I understand the risks of sending PHI through email, and with this agreement I am accepting these risks. I understand that I can terminate this agreement at any time by informing WPG in writing. Email address (*print*): _____

Text Messages

___ *I do not consent to sending and/or receiving text messages to/from WPG.*

___ I consent to receive text messages to the mobile telephone below from WPG. I will advise the practice if I change my mobile number and understand that a new consent form is required. I understand that I can terminate this agreement at any time by informing WPG in writing. By consenting to text messaging, I believe that the benefits for my healthcare outweigh the security risks. Mobile Number to receive text messages: (_____)_____

Teleconference/Skype

___ *I do not consent to the use of teleconferencing/video communications.*

___ I consent to the use of teleconferencing/video communications (telephone and/or Skype) as part of my treatment. I understand WPG's policies for using teleconference communications and agree to those policies. If using Skype, please provide your Skype address: _____

Signature: _____ Relationship to Patient: _____ Date: _____

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Child/Adolescent Background

Child's Name: _____ Preferred name: _____

Today's Date: _____ Person completing form: _____

What are your primary concerns regarding your child/specific questions you would like help with?

_____

_____

_____

_____

_____

When did you first become concerned about your child?

_____

_____

Early Developmental History:

Is this child your biological child or adopted? (circle) *biological* *adopted*

If adopted, at what age did you adopt this child? _____

If adopted, please list country of birth for this child: _____

Did the pregnancy have any complications? No Yes: (explain) _____

_____

How long was the pregnancy? _____ Baby's birth weight: _____

Were there any difficulties caring for this child during the first year? No Yes: _____

_____

Did you seek any services, such as First Steps, in the first 3 years? No Yes: _____

_____

_____

Please list the age your child reached the following milestones:

said first word: _____ used simple sentences: _____

sat up alone: _____ crawled: _____ walked alone: _____

toilet trained during day: _____ dry at night: _____

Medical History:

Please list current medications, including over-the-counter:

Name of medication	Dose/frequency	Length of time on medication	Name of Prescribing Physician

Please circle yes/no for a history of any of the following, and explain if yes:

Allergies No Yes: _____
Hearing problem No Yes: _____
Vision problem No Yes: _____
Hospitalization No Yes: _____
Serious accident No Yes: _____
Serious illness No Yes: _____
Chronic illness No Yes: _____
Seizure No Yes: _____
Tics No Yes: _____
Night terrors No Yes: _____

Please circle yes/no for the following <u>current</u> concerns, and explain if yes:

Eating problems No Yes: _____
Sleep problems No Yes: _____
Bedwetting No Yes: _____
Stomachaches No Yes: _____
Headaches No Yes: _____
Menstrual cycle No Yes: _____

Please circle yes/no for any of these services that your child is receiving, or did receive in the past:

Speech/language therapy No Yes: _____
Occupational therapy No Yes: _____
Physical therapy No Yes: _____
Counseling No Yes: _____
Educational tutoring No Yes: _____

Educational History:

Name of current school: _____ Grade: _____

Circle if your child has any of the following: *GEI 504 ICEP IEP*

If your child has an IEP, circle the classification: *LD ASD CD OHI ED Mi/MoMD*

If your child has an IEP, what services are provided: _____

_____

What grades, or GPA, does your child currently have? _____

Circle your child's most recent ISTEP: English: *passed failed* Math: *passed failed*

Did your child ever repeat a grade? No Yes (what grade): _____

Please list all schools your child attended; list for what grades if s/he attended more than one school. If you homeschooled your child for any of these years, please note this as well:

Preschool: _____

Elementary: _____

Middle school: _____

Intermediate/Junior High: _____

High School: _____

Has your child had any testing through the school? No Yes (when): _____

Have you sought testing for educational concerns anywhere? No Yes (when): _____

Is homework completion an area of concern? No Yes (explain): _____

_____

Has the school contacted you about behavior concerns? No Yes (explain): _____

_____

Social History:

List all extracurricular activities (sports, clubs, etc) that your child has been involved with over the last 6 months: _____

List the activities/toys your child enjoys in free time: _____

_____

Does your child entertain him/herself well? No Yes (explain): _____

Do you have any concerns about your child's social development? No Yes (explain): _____

_____

How is your child getting along with siblings and parents? _____

_____

How is your child getting along with other children his/her age? _____

_____

What do you think of your child's closest friends/peer group? _____

_____

Do you have any concerns about alcohol/drug use? No Yes (explain): _____

_____

Have there been any legal problems? No Yes (explain): _____

_____

Are you concerned about sexual activity? No Yes (explain): _____

_____

Family Information:

Please list who has legal guardianship of this child: _____

Please circle parents' marital status: *Never married* *Married* *Separated* *Divorced* *Widowed*

If parents are separated, divorced, or widowed, please explain when this occurred: _____

_____

If parents are separated or divorced, please describe the custody arrangements: _____

_____

_____

If one of the parents is NOT living in the child's primary home, please explain the frequency of contact: _____

_____

Please list all persons living in the child's primary home:

Name of person	Relationship to child	Age	Gender (M/F)	Highest grade/degree

If any immediate family member (e.g., parent, sibling) is living elsewhere, please list:

Name of person	Relationship to child	Age	Gender (M/F)	Highest grade/degree

Please circle yes/no for any of the following in the last year, and explain if yes:

Family move	No	Yes: _____
Marital problems	No	Yes: _____
Serious parent illness	No	Yes: _____
Serious sibling illness	No	Yes: _____
Serious accident to family member	No	Yes: _____
Parent job difficulties	No	Yes: _____
Death of close family member	No	Yes: _____

Please circle yes/no for a family history of the following. If yes, list <u>who</u> had these issues:

Learning difficulties	No	Yes (who): _____
ADHD/ADD	No	Yes (who): _____
Anxiety problems	No	Yes (who): _____
Autism	No	Yes (who): _____
Depression	No	Yes (who): _____
Bipolar disorder	No	Yes (who): _____
Suicide attempt	No	Yes (who): _____
Drug/alcohol problem	No	Yes (who): _____
"Nervous breakdown"	No	Yes (who): _____
Schizophrenia	No	Yes (who): _____
Any genetic syndrome	No	Yes (who): _____
Seizure disorder	No	Yes (who): _____
Thyroid problems	No	Yes (who): _____
Type I Diabetes	No	Yes (who): _____

If there is other information that you think will be helpful to us, please explain below:

_____

_____

_____

_____

_____

_____

_____