Visionary Psychiatry
535 SE Washington Street, Hillsboro, Oregon 97123
Phone: (503) 755-6703
Fax: (503) 755-6704
Website: www.VisionaryPsych.com
Email: Visionary@VPTeam.hush.com

PEDIATRIC INTAKE QUESTIONNAIRE

Please fill out this form as completely as possible.
This information will help us to better assess your child before any consultation.

Date (mm/dd/yyyy):		**Preferred language:**	
Person completing form:		**Relationship to the Patient:**	
PATIENT INFORMATION			
First name:		Last Name:	
Date of birth (mm/dd/yyyy):	Age:	☐ Male ☐ Female	
Permanent address:			
City:	State:	Country:	Zip code:
Home phone:	Cell phone:	Work phone:	Email:

PARENT(S) INFORMATION			
Mother's first name:		Mother's last name:	
Father's first name:		Father's last name:	
Other guardian first name:		Other guardian last name:	
Who is the patient's primary caretaker?	☐ Mother	☐ Father	☐ Other *(please specify):*

Note: If parents are separated or divorced, or if someone other than the biological parent is the primary caretaker, custody or power of attorney paperwork must be on file prior to receiving care.

REFERRING PHYSICIAN INFORMATION			
First name:	Last name:	Specialty:	
Office address:			
City:	State:	Country:	Zip code:
Office phone no.:	Office fax no:	Email:	

INSURANCE INFORMATION		
☐ *Check here if patient is uninsured*		
Name of Insurance Provider:		Subscriber's name:
Policy no. (ID):		Group no.:
Insurance address:		
City:	State:	Zip code:
Phone no.:		Fax no:

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SUMMARY OF PRESENT ILLNESS/PRIMARY CONCERN			
What is your child's primary medical concern?			
Please list any additional medical diagnoses:			
1.	5.		
2.	6.		
3.	7.		
4.	8.		
At what age did you first note something wrong in your child?			
Over time, the clinical course of my child's illness has been:	☐ Stable	☐ Progressive	☐ Improving
Please describe:			

PREGNANCY HISTORY				
Were there any problems in the pregnancy? *Please check all that apply.*			☐ Yes	☐ No ☐ Unknown
☐ Bleeding	☐ Hospitalization	☐ Surgery		
☐ Diabetes	☐ Premature Labor	☐ Toxemia		
☐ High blood pressure	☐ Pre-eclampsia	☐ Other:		
☐ Infection(s), please specify:				
Were any medications or drugs used in the pregnancy? Please check all that apply.			☐ Yes	☐ No ☐ Unknown
☐ Alcohol (amount):	☐ Smoking (amount):			
☐ Prescription medication (please specify):	☐ Other drugs(please specify):			
☐ Prenatal Vitamins	☐ Folic Acid			
☐ Other:				
Were any tests or procedures done in the pregnancy? *Please check all that apply.*			☐ Yes	☐ No ☐ Unknown
☐ Amniocentesis, results:	☐ Maternal serum screening, results:			
☐ Carrier screening (please specify):	☐ Noninvasive Prenatal Testing (NIPT), results:			
☐ Chorionic villi sampling (CVS), results:	☐ Ultrasound, results:			
☐ Fetal MRI, results:	☐ Other:			
Delivery:				
Mother's age at delivery:	Length of pregnancy (weeks):			
Labor: ☐ Spontaneous ☐ Induced, reason:	Delivery: ☐ Vaginal ☐ C-section			
Were there any problems during the delivery?			☐ Yes	☐ No ☐ Unknown
Please describe:				

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BIRTH HISTORY			
Weight:	Length:	Head circumference:	
Apgars scores if known:	Days spent in the hospital:		
Did your child spend time in the NICU (Neonatal intensive care unit)?		☐ Yes	☐ No
Please explain:			
Were there any medical concerns when the child was a newborn? *Please check all that apply.*		☐ Yes	☐ No
☐ Breathing problems	☐ Jaundice		
☐ Birth defect *(please specify)*:	☐ Low muscle tone		
☐ Feeding problems	☐ Other:		

DEVELOPMENTAL HISTORY				
Were you ever concerned about your child's development? If yes, at what age?			☐ Yes	☐ No
How old (in months) was your child when he/she began to:				
Smile:	Roll over:	Sit:	Crawl:	
Pull to stand:	Walk:	Use single words:	Make sentences:	
Is your child's speech delayed now?			☐ Yes	☐No
Has your child lost any of the above skills?			☐ Yes	☐ No
Is your child in a special education program right now?			☐ Yes	☐No
☐ Early Intervention	☐ Inclusion Program	☐ Special education classroom		
☐ Other:				
Does your child currently receive any special therapy? Please check all that apply.			☐ Yes	☐ No
☐ Speech (times per week):	☐ Occupational therapy (times per week):			
☐ Physical therapy (times per week):	☐ Other:			
Has your child ever had IQ testing? If yes, please specify numerical results below.			☐ Yes	☐ No
☐ Full scale IQ:	☐ Verbal IQ:	☐ Non-Verbal IQ:		
Do you have any concerns about your child's behavior? Please check all that apply.			☐ Yes	☐ No
☐ ADHD (Attention Deficit Hyperactivity Disorder)	☐ Autism Spectrum Disorder	☐ Obsessive Compulsive Disorder (OCD)		
☐ ADD (Attention Deficit Disorder)	☐ Bipolar Disorder	☐ PTSD		
☐ Anxiety	☐ Depression	☐ Self-stimulation		
☐ Aggressive	☐ Frequent tantrums	☐ Self-injury		
☐ Atypical sleeping pattern	☐ Hyperactive	☐ Schizophrenia		
☐ Atypical eating habits	☐ Other:			

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FAMILY HISTORY					
Is the child adopted? *If yes, please answer the family history information to the best of your knowledge.*				☐ Yes	☐ No
Is the child's mother alive?				☐ Yes	☐ No
If No,	Age of death:	Cause of death:			
Please list any health problems in the mother:					
What is the mother's ancestry? Please check all that apply					
☐ Caucasian	☐ African American	☐ Asian	☐ Native American	☐ Hispanic	
☐ Jewish	☐ Unknown	☐ Other:			
Has the child's mother had any pregnancy losses (miscarriage)?				☐ Yes	☐ No
If yes, please list the number and reason(s):					
Is the child's father alive?				☐ Yes	☐ No
If No,	Age of death:	Cause of death:			
Please list any health problems in the father:					
What is the father's ancestry? *Please check all that apply.*					
☐ Caucasian	☐ African American	☐ Asian	☐ Native American	☐ Hispanic	
☐ Jewish	☐ Unknown	☐ Other:			
Are the child's parents related to each other?				☐ Yes	☐ No
If yes, please indicate relationship (first cousins, second cousins, etc.):					
Does the child have any FULL brothers and sisters? (i.e. same mother and father) *If sibling is deceased, please write age of death as "d. 14yr" and record cause of death in health problems section*				☐ Yes	☐ No
Name		**Age**	**Healthy?**	**Health problems**	
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
Does the child have any HALF brothers and sisters from his/her mother? *If sibling is deceased, please write age of death as "d. 14yr" and record cause of death in health problems section*				☐ Yes	☐ No
Name		**Age**	**Healthy?**	**Health problems**	
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
	☐ Male ☐ Female		☐ Yes ☐ No		
Does the child have any HALF brothers and sisters from his/her father? *If sibling is deceased, please write age of death as "d. 14yr" and record cause of death in health problems section*				☐ Yes	☐ No
Name		**Age**	**Healthy?**	**Health problems**	
	☐ Male ☐ Female		☐ Yes ☐ No		

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	☐ Male ☐ Female		☐ Yes ☐ No	
	☐ Male ☐ Female		☐ Yes ☐ No	
	☐ Male ☐ Female		☐ Yes ☐ No	

MEDICATIONS *(Current and Past)*		
Name	**Reason for taking**	**Currently taking?**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

VACCINES		
Are your child's vaccines up to date?	☐ Yes	☐ No
Please specify any vaccines that are not up to date:		

ALLERGIES *(Please list)*
1.
2.
3.
4.
5.

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Fee Schedule and Appointments

As a patient of Visionary Psychiatry, it is essential for you, to provide us with the correct insurance policy information at the time services are rendered. Accurate insurance information ensures efficient claims processing and prevents billing issues. We kindly request that you bring your insurance card to every visit to help us verify your coverage and avoid delays in your care.

We are pleased to process and file your billings or claims with your insurance provider on your behalf. However, please be aware that you are responsible for any co-payments and any balance due that is not covered by your insurance, especially if it is not received within the timely filing guidelines set by your insurance provider.

Cancellation Policy

We understand that there may be instances where you are unable to keep an appointment. If you need to reschedule or cancel your appointment, please give us at least 24 hours' notice. This allows us to offer the appointment slot to another patient who may need it. Otherwise, a no-show fee may apply.

If a patient does not meet the specified condition, they must adhere to the following protocols:

a. *First violation:* Patient receives a reminder but incurs no charge.
b. *Second violation:* A $90 fee applies.
c. *Third violation:* A $195 fee is charged.

Ensuring clear communication of this policy will help streamline scheduling and demonstrate consideration for the patient's and the provider's time.

If there are **(3)** three instances of missed appointments (no-calls/no-shows) or late cancellations within (1) one year from your initial visit with your provider, it may result in discharge from the clinic.

Appointments

Our staff can schedule appointments from 9 am to 5 pm Monday through Friday. Our providers' office hours vary, but our staff can help you find a convenient time. Same-day appointments will be accommodated based on availability. You will receive an email reminder one week prior to your scheduled appointment, as well as a reminder on the day before. Our communication is facilitated through RXNT therefore the correspondence will originate from this platform.?????????

Medication and Refill Policy

To ensure the effective management of your medication, it is essential that you are fully aware of and adhere to the following guidelines:

1. To receive refills for your medication, it is important that you are seen regularly by your provider. The frequency of these appointments will be determined by your provider based on your individual needs.
2. Keep track of your medication supply and schedule refill appointments in advance to avoid running out of medications. Refills cannot be done on weekends or holidays.
3. Requests for refills may take up to 48 hours to be available at your pharmacy.
4. Be aware of potential side effects of the medications and report any unusual or severe reactions to your healthcare provider immediately.
5. If another provider has made adjustments to your medication or you have experienced any new health issues or changes, please inform our office as soon as possible. This information is crucial for us to manage your treatment effectively and to ensure your safety.

Limits of Confidentiality

Visionary Psychiatry ensures that all information shared during the patient consultation, including medical records, personal details, and any verbal and written discussions, is kept strictly confidential. We adhere to all legal and ethical guidelines to protect your privacy. We are committed to maintaining the highest standard of confidentiality. Any patient information cannot be shared without consent from the patient or the patient's legal guardian.

Duty to Warn and Protect
Visionary Psychiatry is required to warn the intended victim and provide information to authorities when there are grounds to suspect that an individual is threatening serious bodily harm to another person. In the event that someone reveals or indicates a suicide plot, Visionary Psychiatry is required to notify the relevant authorities and endeavor in good faith to notify the patient's emergency contact.

Abuse of Children and Vulnerable Adults
It is the responsibility of Visionary Psychiatry to notify the relevant social service and/or legal authorities if a patient reports or implies that they are abusing a child (or vulnerable adult), have recently abused a child (or vulnerable adult), or that a child (or vulnerable adult) is in danger of abuse.

Prenatal Exposure to Controlled Substances
Visionary Psychiatry must disclose any admitted prenatal exposure to possibly dangerous controlled substances.

Minor / Guardianship
Parents or legal guardians of non-emancipated minor patients have the right to access the patient's records.

Insurance Providers
Insurance companies and other third-party payers can request information about the services provided to patients. This information may include the types of services, dates and times of services, diagnosis, treatment plans, descriptions of impairments, progress of therapy, case notes, and summaries.

Other Limits of Confidentiality
In compliance with a court order or as mandated by law, information may be disclosed to the extent necessary for emergency medical care and for the purpose of making a claim on a delinquent account through a collection agency.

Notice of Privacy Acts
The following outlines the rights associated with this authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended from time to time.

Our Responsibilities

We recognize that your personal health information is private and sensitive. Safeguarding this information is our top priority. We are dedicated to ensuring the confidentiality and security of your health data. In addition, we will provide you with clear information about our privacy practices and adhere to the guidelines outlined in the notice.

Protected Health Information
Protected Health Information (PHI) comprises individually identifiable health information that definitively identifies the patient and pertains to the patient's past, present, or future physical and mental health or condition, along with related healthcare services.

Medical Information
At Visionary Psychiatry, patient records serve as a means of documenting health information, planning care and treatment, and facilitating health care operations. External parties, such as insurance companies, may require access to information such as procedure and diagnostic details to reimburse payments for services. It's important to emphasize that any information that may identify a patient will not be disclosed without their written authorization or that of their parent/legal guardian.

Medical information may be utilized to support patient care services such as laboratory tests and prescriptions. This information will also be used to create a treatment plan.

Additionally, the emergency contact information you have provided may be used to reach out to you if the address and phone number on file are no longer accurate. We may reach out to you via phone, text, or email to remind you of your upcoming appointment. We may also contact you to explore treatment alternatives or other health-related benefits that could be beneficial to you.

As per Virginia law, in the case of un-emancipated minors, there are circumstances that may necessitate the disclosure of health information to a parent or guardian in compliance with legal and ethical obligations.

Parents and guardians, in situations where you are the personal representative of an unemancipated minor, we are able to disclose health information about your child to you under specific circumstances.

Disclosure of Psychotherapy Notes

HIPAA, the Health Insurance Portability and Accountability Act, provides special protections for a category of medical records known as "Psychotherapy Notes." These notes are distinct from regular medical records and are defined as notes recorded by a mental health professional during a private counseling session or a group, joint, or family counseling session. These notes must be kept separately from the rest of the patient's medical records, regardless of the medium they are recorded on (e.g., paper or electronic), to ensure a higher level of protection.

It's important to note that certain information is not considered psychotherapy notes under HIPAA. This includes medication prescriptions and monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, and any summaries of diagnosis, functional status, treatment plans, symptoms, prognosis, and progress to date.

Under HIPAA regulations, written authorization from the patient is required to release psychotherapy notes to a third party. This additional layer of protection ensures that sensitive information shared during counseling sessions remains confidential unless explicitly authorized by the patient.

Patient Rights

As a patient at Visionary Psychiatry, you have the right to:

a) **Ask for limitations on specific uses of your protected health information.** We are not obligated by law to comply with your request.

b) **You have the right to request a paper copy of this Notice of Privacy Practices.** Additionally, you can ask us to limit the use or disclosure of your medical information for treatment, payment, or healthcare operations. While we are not obligated to agree to your request, we will notify you if we deny it. If we do agree to a restriction, we will not disclose your PHI (Protected Health Information) in violation of the restriction, unless it is necessary for emergency treatment or required by law.

c) **You have the right to inspect and obtain a copy of your protected health information for a nominal fee.** All medical and billing records, alongside other pertinent documentation utilized in the decision-making process regarding your healthcare, fall within the scope of this provision. It is important to note, however, that this provision does not extend to psychotherapy and

psychosocial notes, information prepared in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and certain PHI subject to legal constraints prohibiting access. Should you require further clarification on accessing your medical records, kindly direct your inquiries to our Practice Administrator.

d) **You have the right to request an amendment** if you believe that your health records contain inaccurate or incomplete information. Please be advised that we reserve the right to reject any request for an amendment that does not meet the following criteria:

- the request must be submitted in writing,
- lacks a substantiating reason to support the request,
- pertains to information not generated by our practice or included in our records,
- falls outside the scope of information accessible for review and duplication,
- or if the existing information in the records is accurate and comprehensive.

Please be advised that while we may accept your request, we are not obligated to delete any information from your health record. If we disagree with your request, you have the right to submit a statement of disagreement to be included with any future releases of the information in question.

e) **Obtain a documented record of the sharing or disclosure of your health information.** The record will only include information that has been shared for reasons other than treatment, payment, or healthcare operations, and will not contain information that was shared with valid authorization.

f) **Request for the transmission of your health information through alternative channels or to alternative destinations.** We are happy to accommodate reasonable requests provided that you furnish us with the alternative address/contact information and details regarding the payment arrangement.

g) **Revoke your Authorization.** You may revoke your authorization for the use or sharing of health information, except in cases where such actions have already been executed. To initiate the revocation or cancellation of this authorization, it is necessary to formally submit your request in writing to Visionary Psychiatry.

h) **It's important to understand your rights.** If you have any questions about this authorization, please feel free to reach out to our Practice Administrator. They will be more than happy to help clarify any concerns you may have.

i) **Refusal to sign Authorization.** As per our policy, your signature is required for authorization. Your decision to abstain from signing will not impact your eligibility to receive treatment. However, please note that should you choose not to provide your signature, Visionary Psychiatry reserves the right to decline treatment or refuse your admission as a patient in our practice.

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Acknowledgment

By signing this document, I acknowledge that I have the right to review the Visionary Psychiatry Notice of Privacy Practices before providing my consent.

The Notice of Privacy Act outlines the specific categories of uses and disclosures of my protected health information that will take place in my treatment, payment of my statements, or the execution of healthcare operations by Visionary Psychiatry. The Notice of Privacy Acts for Visionary Psychiatry can be accessed on the Visionary Psychiatry website at www.VisionaryPsych.com. This document outlines both my rights and the responsibilities of Visionary Psychiatry in relation to my protected health information.

Visionary Psychiatry reserves the right to make changes to the privacy practices outlined in the Notice of Privacy Act.

As a patient or legal guardian, a revised notice can be obtained by accessing the Visionary Psychiatry website, contacting the office by phone to request a revised copy to be sent via mail, or by requesting one during the next appointment. Additionally, a copy of the current notice will be displayed in the practice.

Patient's Name and Signature	Date
Parent or Legal Guardian Name and Signature (For patients under 18)	Relationship to the Patient

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Patient Consent

_____Confidentiality

I hereby confirm that I have reviewed and comprehended the privacy procedures of Visionary Psychiatry. I have been provided with a copy of the Health Insurance Portability and Accountability Act (HIPAA) information. Should any inquiries arise, I will promptly address them to the Visionary Psychiatry staff.

I have read and understand the privacy practices for Visionary Psychiatry. I have been offered a copy of the Health Insurance Portability Accountability Act (HIPAA) information. If I have any questions at any time, I will bring them to the attention of the Visionary Psychiatry Staff.

_____Limits of Confidentiality

I hereby confirm my acceptance of the confidentiality constraints, and I have a clear understanding of their meanings and potential consequences.

I agree to the limits of confidentiality and understand their meanings and ramifications.

_____Cancellation Agreement

I hereby acknowledge my responsibility to cover any costs arising from missed appointments or cancellations made with less than 24 hours' notice.

I agree to be financially responsible for missed appointments and/or appointments canceled with less than 24 hours notice.

_____Fee Schedule / Cost Share

I acknowledge and agree to the fee schedule, and I understand that I am responsible for paying all copays, cost shares, and deductibles at the time services are provided. I also agree to settle any outstanding balance that is not covered by my insurance within the specified timeframe

I agree and understand the fee schedule and that all copays, cost share and deductibles are payable by me at the time services are rendered. I agree to pay any balance not received by my insurance carrier in a timely manner.

_____Medication and Refill Policy

I hereby acknowledge and comprehend the medication and refill policy.

I agree to and understand the medication and refill policy.

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Consent to Treat

I, _____, have read the policies and procedures of Visionary Psychiatry and give consent for evaluation and treatment.

_____ _____
Patient's Name Date

_____
Name of Parent or Guardian of Minor Patient and Relationship

_____
Signature of Patient (Parent or Guardian if Patient is under 18