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CREEKWOOD ASSOCIATES

Dear Prospective Client:

In this Intake Packet, you will find several forms and questionnaires that will need to be completed prior to your initial appointment. Included are the following:

- Practice Guidelines
- Client Information Form
- Consent for Treatment
- Release of Information
- Parent Questionnaire

Please complete these forms to the best of your ability. In addition, the following items will be helpful to have if available:

- A copy of any previous psychiatric records
- A copy of any previous neuropsychological or psychological evaluations
- A copy of physician records outside of routine medical care
- If applicable, a copy of the most recent IEP

This information will be important to fully understand your child's past and current functioning, and will help to guide the ongoing assessment and treatment of your child. Please contact our office with any questions or concerns.

Sincerely,

Eric Nolan, M.D.

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Practice Guidelines

The following guidelines have been developed to help you access treatment and care in the simplest and clinically-appropriate manner. It is important that all patients and their families understand these guidelines for continuation of treatment provided by Dr. Nolan and Creekwood Associates. Dr. Nolan wants to give each of his patients his full attention, and the following guidelines will allow him to provide the best care possible.

Appointments

All appointments are made in advance by phone or in person at the time of visit. Dr. Nolan runs his practice on time, and only on rare occasions will he be running behind schedule. Please expect your appointment to start and end at the scheduled time.

- **Late Arrivals:** If you arrive late to your appointment, you will be seen for the remainder of the time. However, lost time cannot be made up at that visit. If you expect to be late, please let Dr. Nolan know as soon as possible by leaving an urgent phone message.
- **Cancellations/Missed Visits:** Each appointment time is reserved exclusively for a specific patient. If you are unable to make an appointment, please call to cancel the appointment at least 24 hours in advance. Otherwise, a full fee will be charged to you directly. Insurance plans do not cover missed appointment fees. This policy applies regardless of reason for the missed or canceled appointment.
- **Frequent Cancellations/Missed Visits:** Close monitoring of progress is an essential part of optimal care. In order to maintain an active patient status and receive medication refills, patients are expected to keep appointments as medically necessary determined by the practice. If you missed three consecutive visits or have not been seen for more than six months, your patient status may be inactivated.
- **Appointments are required when the following occur:**
  - Phone calls, faxes or letters sent with communications/updates on how you or your child is doing, with callbacks or medication refills requested as a result
  - Medication change requests or discussions
  - Discussions/updates regarding the treatment plan or care of a patient

Availability

Dr. Nolan is highly responsive to important clinical issues that need to be addressed outside of scheduled appointment times. Routine questions and medication adjustments are best made during regularly scheduled sessions when your concerns can be fully explored. Patients who require frequent or extended phone consultations may be billed for the additional time and effort.

- **Routine Phone Calls:** If Dr. Nolan is not reached directly, please leave a message on his voice mail with your name, a call back number, and a brief message. Phone messages are checked once a day and are returned within 48 hours.
- **Urgent Phone Calls:** Dr. Nolan is available via an answering service after office hours and on weekends for urgent clinical issues. He may be reached at 847-717-7902. Please provide the information requested, and Dr. Nolan will get back to you as soon as possible. A charge may apply for frequent after-hours phone calls.
- **Emergency Phone Calls:** In the case of life-threatening emergencies, please directly call 911 or go to the nearest emergency room.

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Prescriptions

Only established patients will receive medication refills from Dr. Nolan. Please contact your pharmacy directly for refills, and they will fax your refill authorization request to the practice at 630-377-1415. Once the fax is received, please allow Dr. Nolan 48 to 72 business hours to process your refill.

The following medications are considered Controlled Substances, and cannot be called into your pharmacy. Each will require a written prescription.

Ritalin	**Dexedrine**	**Methylin**	**Concerta**
Vyvanse	**Focalin**	**Adderall**	**Daytrana**

The above prescriptions are only good for 30 days from the date written on the prescription. Therefore, it is important that you plan to obtain a prescription in a timely manner and not wait until you have one or none of your medication left. We require at minimum 48 hours, but prefer 72 hours for written prescriptions. Other prescriptions (non-controlled substances) will be called into your requested pharmacy within 48 hours. If a prescription expires or is lost, there will be a $20 rewrite prescription fee that must be paid prior to having your rewritten prescription mailed or picked up.

Letters, Forms and School Medication Consents

Please Note: Any letters, forms and consents will not be completed unless Creekwood Associates has a signed release from the patient (12 yrs and older). Blank releases can be obtained at the front desk.

To better meet your needs and to ensure a timely response as well as continuity of care for you or your child, please allow at least 72 hour notice to complete any required letter, forms or medication consents. Please complete all sections of any forms that have demographic information on them, as Dr. Nolan will complete the medication and clinical portion only. Please ensure we have the correct name, address and/or fax numbers of the intended recipient, so we can forward the required documentation to the necessary party in a timely fashion. Failure to give proper notice for completion of the form may result in a delay in meeting your request, or a fee charged if immediate service is required.

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Client Information Form

Today's Date ___/___/___ (Date of Appointment)

Patient Name: _____ Sex: ____ Age: ____
Last First Middle
Address: _____ Apt# ____

City: _____ State: _____ Zip Code: _____

Patient's SS#: _ _ _-_ _-_ _ _ _ Birthdate: ___/___/___ Marital Status: _____Race: _____
All statements and correspondences will be sent to the above address unless otherwise indicates. Please include the numbers where we may contact you and/or leave a message:

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____

Emergency Contact: _____ Phone: ( ) _____ Relationship:_____

Pharmacy name:_____ Pharmacy Phone: _____

IF MINOR: Parent #1 Name: _____ Parent #2 Name: _____

Other Legal Guardians, if any: _____

Custody Arrangements, if any: _____

Financially Responsible Party: _____ Relationship to Patient: _____

Insured Person's Information (**for Blue Cross/Blue Shield PPO Patients ONLY**)

Name: _____

Address: _____Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Ext. _____

Insured ID# _____ Insured SS#: _ _ _-_ _-_ _ _ _

Group/Plan #: _____ Insurance Co. Phone: ( ) _____

Employer of Policy Holder: _____ Insurance Effective Date: ____ / ____ / ____

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Treatment/Policy Consents

1. I have the legal right to authorize and I hereby consent for services for myself and/or my dependent at Creekwood Associates, which may include initial evaluation, psychotherapy, medication management, or group therapy.
2. I authorize communication within the Creekwood Associates treatment team, which includes my psychiatrist and therapist, covering clinicians, and office personnel in order to provide appropriate treatment.
3. I understand that appointments not canceled at least 24 hours in advance will be billed to the patient at the session rate, and cannot be billed to, nor reimbursed by, my insurance company.
4. I understand that follow up treatment is required on an ongoing basis to provide quality care. Creekwood Associate's psychiatrists require follow up every 2 months. Failure to follow up on the recommended schedule may result in prescription refill requests being denied.
5. I understand that clinicians at Creekwood Associates may refer me and/or my dependent to clinicians or services outside of the practice if they feel that cannot provide the necessary treatment.
6. I understand that Creekwood Associates does not utilize email as a method to communicate clinical and/or urgent information. I understand that I must call Creekwood Associates for all clinical, urgent and/or emergent concerns.

Financial Consents/Authorizations

1. I have completed the demographic and insurance information on the Intake Packet to the best of my knowledge, and authorize Creekwood Associates to release any medical information (including dates of service, types of service, diagnosis/treatment plans, treatment progress, progress notes) to process my insurance claim.
2. I understand that I am responsible for contacting my insurance company to obtain benefit information prior to my initial appointment at Creekwood Associates.
3. I hereby assign all medical benefits, private insurance, and any other insurance programs to Creekwood Associates. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether paid by my insurance company or not, and I will be responsible for any amounts uncollected by Creekwood Associates.
4. I understand that failure to keep current with payments may cause and interruption in treatment services until a payment plan is arranged or balance is paid. In addition, I understand that I must inform Creekwood Associates of any change in my insurance coverage. Failure to do so may result in claims not being filed in a timely fashion, and may result in my being liable for any amounts unpaid by my insurance company.
5. If we have a contract with your insurance company, we will bill your insurance company for the provider portion. Any deductibles, co-pays, and/or applicable fees are due at the time of my office visit. Creekwood Associates accepts cash, checks and credit cards. The office charges a $35 returned check fee for any checks returned to our office by our bank.
6. If you are a parent and are unable to accompany your child to an appointment, please send payment with them or maintain your credit card on file. Creekwood Associates is not responsible for upholding financial agreements between legal guardians.
7. If fees are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. Creekwood Associates will charge a 25% collection fee should your account be turned over to a collection agency. I authorize Creekwood Associates to release the demographic information necessary to the collection agency in order to collect payment for services rendered.

I have read, understood and agree to the above statements regarding my responsibilities as a patient receiving services from clinicians at Creekwood Associates.

_____	_____	_____	_____
Signature of Patient (age 12 and older)	Date	Signature of Responsible Party	Date
_____		_____	_____
Print Patient's Name		Witness	Date

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AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ _____ _____
Name SSN DOB
authorize Creekwood Associates to ( ) disclose to ( ) obtain from ( ) disclose to and obtain from:

Name of facility/person:_____
Address:_____
Tel/Fax/Email:_____

( ) Psychiatric Evaluation/Assessment including Diagnosis
( ) Mental Health/Crisis Assessment
( ) Mental Status Exam
( ) Psychological Evaluation/Test Results
( ) Most Recent Contact/Progress
( ) Recommendations
( ) Financial
( ) Recent Physical Exam Records
( ) Psychiatric or Progress Notes
( ) Medical/Medication Information
( ) Discharge Summary
( ) Treatment Plan/Summary
( ) Attendance
( ) Insurance

Please initial the following items, if these information below will be used and/or disclosed:
_____ Mental Health/Developmental Disabilities information and/or records
_____ HIV/AIDS related information and/or records
_____ Drug/Alcohol diagnosis, treatment and/or referral information
For the following purpose(s):
( ) Continuity of care and treatment planning
( ) Determination of Eligibility for Services
( ) Family Involvement
( ) Other

Information may be disclosed/obtained through Phone, Mail, Fax, In-person, E-Mail.
Restrictions if any: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information regarding mental health and developmental disabilities, substance use/abuse or AIDS under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Federal Substance Abuse Confidentiality Requirements, and the Illinois AIDS Confidentiality Act. I understand that the authorized entity above that receives the information has the right to inspect and copy the information disclosed.

I also understand that the person I am authorizing to use the information may receive compensation for doing so. I understand that I may inspect and copy the information disclosed. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

_____ _____
Patient Signature (12 years old and older) Date

_____ _____
Guardian Signature for patient under 18 or patient with disability Date

_____ _____
Witness Date

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Parent Questionnaire

Child's Name: _____ Date of Birth: _____ Age: _____ Sex: _____

School: _____ Grade: _____ Birth Place: _____

Parent#1 Name: _____ Parent #2 Name: _____

Referral Source: _____

Would you like us to have contact with any outside professionals? If yes, who?

_____

Purpose of the Consultation:

_____

_____

Medical History

Current Medications: _____

Current Medical Problems: _____

Allergies: _____

Other Medical Providers: _____

History of Head Trauma: _____

History of Seizures/Seizure-like Activity: _____

History of Periods of Spaciness/Confusion: _____

History of Surgery: _____

History of Medical Hospitalizations (Place, cause, date, and outcome): _____

_____

History of Accidents Requiring Medical Care: _____

History of Abnormal Lab Tests, X-rays, EEG, CT/MRI, etc.: _____

_____

Present Height: _____ Present Weight: _____ Date of last physical exam: _____

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Family History

Family Development (Please list marriages, divorces, deaths, traumatic events, losses)

_____

_____

Siblings (names, ages, problems, strengths, relationship to the patient)

_____

_____

Maternal History:

Age____ Highest level of education: _____ Work: _____

Medical Problems: _____

Childhood Atmosphere (family position, history of abuse, illness) _____

_____

Has the mother ever sought psychiatric treatment? Yes _____ No_____

If yes, for what purpose? _____

_____

Please list any of the mother's blood relatives with learning problems or psychiatric problems, including but not limited to **depression, anxiety, suicide attempts, hospitalizations, alcohol/drugs, psychosis:**

_____

Paternal History:

Age____ Highest level of education: _____ Work: _____

Medical Problems: _____

Childhood Atmosphere (family position, history of abuse, illness) _____

_____

Has the father ever sought psychiatric treatment? Yes _____ No_____

If yes, for what purpose? _____

_____

Please list any of the father's blood relatives with learning problems or psychiatric problems, including but not limited to **depression, anxiety, suicide attempts, hospitalizations, alcohol/drugs, psychosis:** _____

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Child's Developmental History

Parent's attitude toward pregnancy: _____

Ease of conception: _____

Pregnancy complications: _____

Birth Weight _____ Length _____ Labor duration _____ Delivery: Vaginal ___ C-section___

APGARS: _____ History of Jaundice? Yes ___ No___ Time in hospital ____

Any other complications: _____

Mother's health after delivery: _____

Breastfed/Bottlefed ____ Food Allergies _____ Eating Difficulties? Yes ___ No___

Sleep Behavior (list sleep walking, nightmares, recurrent dreams, and current problems)

_____

_____

Separations from Parents: _____

School History

Current grade _____ Number of Schools Attended _____ Grades _____

Homework Problems _____

Concerns Regarding Learning _____

Strengths _____

Motivation _____

History of Special Education Services/IEP _____

Behavioral Problems _____

History of Suspensions/Expulsions/Retention _____

Overall Strengths

_____

_____

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Motor Development (Normal Range)

Rolled Over (3-5 months) _____ Sat Without Support (5-7 months) _____ Crawled (5-8 months) ____

Walked Well (11-15 months) _____ Ran Well (2 years) _____ Rode Tricycle (3 years) _____

Current activity level _____

Fine motor coordination (writing, drawing) _____

Gross motor coordination (running, jumping, balance) _____

Language Development (Normal Range)

Several words (1 year) _____ Three-word Sentences (2 years) _____

Vocabulary _____ Articulation _____ Comprehension _____

Compared to peers _____

Social Development (Normal Range)

Smiled (2-3months) ____ Stranger Anxiety (6-10 months) _____ Separated easily (2-3 years) _____

Cooperative Play (4 years) _____ Imaginative Play _____

Early peer relationships _____

Current peer relationships _____

Quality of attachment to Parent #1 _____

Quality of attachment to Parent #2_____

Hobbies/Interest _____

Emotional Development

Early temperament: _____

Current personality: _____

Mood: _____

Habits: _____

Fears/Phobias: _____