CGR BEACON CLINIC P.A.
P.O. BOX 496080
PORT CHARLOTTE, FL. 33952
941-629-7855/ 941-629-9589 FAX

NAME____PREFER TO BE CALLED__________________

DATE OF BIRTH______________________ AGE________ MALE_______ FEMALE__________

SOCIAL SECURITY NO:_____________________________ MARRIED? YES OR NO

ADDRESS____

HOME PHONE________________________ BUSINESS PHONE___________________ CELL___________________

BIRTH MOTHER'S NAME__________________________ BIRTH FATHER'S NAME __________________________

STEP MOTHER'S NAME ____________________________STEP FATHER'S NAME____________________________

PRIMARY CONTACT NAME ____

PERSON TO NOTIFY IN CASE OF EMERGENCY____

RELATIONSHIP___________________ BEST WAY TO CONTACT THEM__________________________________

BEST WAY TO CONTACT YOU_______________________________ MAY WE LEAVE A MESSAGE? YES OR NO

SCHOOL ____

PRIMARY INSURANCE_________________________________ PRIMARY ID NUMBER________________________

SECONDARY INSURANCE ______________________________ SECONDARY ID NUMBER_____________________

PRIMARY SUBSCRIBER'S NAME____

SUBSCRIBER'S BIRTH DATE______________________ SOCIAL SECURITY______________________________

RELEASE: I AUTHORIZE THE RELEASE OF ANY OR ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

ASSIGNMENT OF BENEFITS: I AUTHORIZE THE PAYMENTS OF MEDICAL BENEFITS DIRECTLY TO BEACON CLIINC, INC., FOR SERVICES RENDERED. I ALSO REQUEST THE PAYMENT OF GOVERNMENT BENEFITS (MEDICARE AND FEDERAL BCBS) DIRECTLY TO BEACON CLINIC, INC.
INSURANCE: YOUR INSURANCE MAY OR MAY NOT PAY ALL OR PART OF OUR FEES. ANY BALANCE REMAINING WILL BE THE RESPONSIBILITY OF THE PATIENT OR GUARDIAN IN ACCORDANCE WITH THE LAW. FAILURE TO DO SO COULD RESULT IN YOU OR THE GUARDIAN BEING RESPONSIBLE FOR ALL OR PART OF THE COST INCURRED.

CLIENT SIGNATURE ____DATE___________________

I AM THE PARENT OR LEGAL GUARDIAN OF ____
CLIENT'S NAME

I HAVE FULL, PARTIAL, OR ROTATING CUSTODY OF THE ABOVE MINOR CHILD. I HEREBY GIVE MY PERMISSION TO THE PROFESSIONAL STAFF OF THE BEACON CLINIC TO ENGAGE IN MENTAL HEALTH TREATMENT INCLUDING MEDICATION MANAGEMENT, COUNSELING/PSYCHOTHERAPY AND RELATED PROFESSIONAL SERVICES WITH MY DAUGHTER/SON. I ACKNOWLEDGE THAT ALL PARENTS WITH PARENTAL RIGHTS HAVE THE RIGHT TO VIEW THE MEDICAL RECORDS AND BE INVOLVED IN TREATMENT DECISIONS UNTIL THE CHILD IS 18 YEARS OF AGE. I CONTEST THAT ALL PERSONS WITH LEGAL AUTHORITY FOR THIS CHILD CONSENT FOR TREATMENT.

____ ________________________________
CHILD'S NAME (PRINT) CHILD'S DATE OF BIRTH

____ ____ ___________
NAME OF PARENT/GUARDIAN (PRINT) SIGNATURE OF PARENT/ LEGAL GUARDIAN DATE

Rights and Responsibilities
-CHILD-

You have the right:
- To courteous, kind, competent care.
- To collaborative care with your child's primary physician, or any of your child's specialists.
- To ask questions (Questions are good!)
- To an explanation of your child's treatment plan.
- To learn about your child's diagnosis and treatment options.
- To be seen within 30 minutes of your child's appointment (every effort will be made to see you in a timely fashion).
- To have your phone calls returned in a timely manner (We will make every effort to return those calls within one business day).
- To obtain a second opinion.
- To seek treatment elsewhere.
- To know my credentialing, my scope of practice, my training and education.
- To know if I feel I cannot help you.
- To utilize alternative and or adjunctive treatment options (just please let us know).
- To emergency treatment and crisis intervention 24 hours a day (during non office hours please call Crisis Stabilization Unit 941-575-0222, Riverside Behavioral Center 941-627-2474, any Emergency Department or 911.) If you need to be admitted to RBC or CSU, the physician on call will be able to take care of you). (Please take a list of your Medications and allergies with you).

We are not a non-hospital, non- emergency out-patient facility. We do not offer 24 hour care.
- To a reasonable fee for my service.
- To your own thoughts, feelings and behavior. (No physical or verbal abuse will be tolerated, though).
- To not to be judged or shamed if you relapse.
- **To confidentiality and privacy of your diagnosis and care.**

Beacon Clinic reserves the right to refuse treatment for legal or ethical purposes.
__________ (initial)

You are responsible for:
- Notifying us if you cannot make your appointment due to cancellation or no show in a 24 hour period, therefore, a fee will be charged accordingly.
- **Giving us three days notice for any medication refill.**
- Giving us 2 weeks notice for any medication refill of a controlled substance (Xanax, Ativan, Klonopin, Ambien, Sonata, Ritalin, etc). The prescribing of those medications is done only in collaboration with physician.
- Being honest. (ie, If you are not taking your medications as directed, please let us know).
- To let us know if you have concerns regarding your child's treatment.
- Letting us know all the medications you are taking. (name, dose, time, etc). including over the counter, or herbal supplements. Seeking additional information on your diagnosis, medication an treatment options.
- Help if you feel suicidal (by calling here, CSU: 941-575-0222 or RBC 941-637-2474 9or 911).
- For not giving up (repetitive suicide attempts will not be tolerated)
- Respect the thoughts feelings and behavior of others you encounter in this office, (including maintaining their privacy, and right to confidentiality.)
- Notifying us if you feel you are relapsing, so I can reevaluate and redirect your care.
- Keeping your bill current.
- Providing us with a current accurate address, and way of getting in touch with you.
- For treatment to be effective, we require full disclosure.

By signing I agree to have read all of the above statements.

PRINTNAME:____ DATE:_______________________

PATIENT SIGNATURE:____

COPY GIVEN TO PATIENT: _______________

PSYCHIATRIC HISTORY

In the past or currently, has the child been diagnosed or treated, or felt you had any of these:

____ Depression
____ Bipolar disorder
____ Posttraumatic Stress
____ Eating disorder
____ Suicide attempts
____ Anxiety
____ Schizophrenia
____ Nightmares
____ Substance problems
____ ECT
____ Panic attacks
____ Hallucinations
____ Flashbacks
____ Alcohol problems
____ Inpatient therapy
____ADHD
____Autistic Spectrum Disorder
____Sensory Integration Issues
____ Outpatient therapy

Past or current psychiatrist (s): ____

Past or current therapist (s):____

MEDICATION HISTORY: **Check any medication you have taken before or are taking now.**

____ Ativan
____ Klonopin
____ Librium
____ Valium
____ Xanax
____ Lexapro
____ Buspar
____ Celexa
____ Effexor
____ Luvox
____ Paxil
____ Prozac
____ Serzone
____ Wellbutrin
____ Zoloft
____ Lamictal
____ Depakote
____ Trileptal
____ Lithium
____ Neurontin
____ Tegretol
____ Topamax
____ Remeron
____ Haldol
____ Prolixin
____ Risperdal
___ Seroquel
____ Zyprexa
____ Geodon
____ Clozaril
____ Abilify
____ Aricept
____ Namenda
____ Concerta
____ Strattera
____ Adderall
____ Dexadrine
____ Vyvanse
____ Ambien
____ Sonata
____ Lunesta
____ Rozerem

Other(s): ____

SUBSTANCE ABUSE HISTORY:

Ever used tobacco? [ ] Yes [ ] No How often?____________________ Attempts to quit?_________
Ever used caffeine? [ ] Yes [ ] No How often?____________________ Attempts to quit?_________
Ever used alcohol? [ ] Yes [ ] No How often?____________________ Attempts to quit?_________
Ever used street drugs? [ ] Yes [ ] No How often?____________________ Attempts to quit?_________
Ever used IV drugs? [ ] Yes [ ] No How often?____________________ Attempts to quit?_________
Ever abused prescription drugs?
[ ] Yes [ ] No How often?____________________ Attempts to quit?__________

FAMILY HISTORY: (Please indicate who, if anyone, in your family has the following)

Mentally impaired _________________________________
Alzheimer's disease _________________________________
Neurological disorders ______________________________
Attention deficit/hyperactivity ________________________
Learning disabilities ________________________________
Alcoholism _______________________________________
Drug abuse _______________________________________
ADHD____
Depression___________________________
Anxiety ______________________________
Obsessive/compulsive disorder ____________
Schizophrenia _________________________
Bipolar disorder ________________________
Eating disorders _______________________
Suicide attempts ______________________

CURRENT SYMPTOMS

Please check any symptoms that the child is experiencing:

A.
[ ] Inattentive to details
[ ] Difficulty sustaining attention, tasks, or play
[ ] Disorganized
[ ] Does not seem to listen when spoken to directly
[ ] Does not follow instructions/ finish tasks
[ ] Avoids mentally challenging tasks
[ ] Often loses things
[ ] Forgetful
[ ] Easily distracted
[ ] Fidgets
[ ] Difficulty remaining seated
[ ] Runs/climbs excessively
[ ] Difficulty playing quietly
[ ] "On the go"
[ ] Talks excessively
[ ] Interrupts
[ ] Blurts answers to questions intrusively

B.
[ ] Often bullies/threatens
[ ] Often starts fights
[ ] Used a weapon
[ ] Cruelty to people
[ ] Stolen with victim present
[ ] Forced sexual activity
[ ] Lies/ cons
[ ] Serious fire setting
[ ] Deliberate destruction of property
[ ] Breaking and entering
[ ] Stolen without victim present
[ ] Often violates parental curfew
[ ] Runaway behavior
[ ] Frequent Truancy
[ ] Loses temper
[ ] Argues with adults
[ ] Defiant
[ ] Annoys others
[ ] Blames others
[ ] Touchy/easily annoyed
[ ] Angry/resentful
[ ] Spiteful/vindictive

C.
[ ] Upset when considering separation from home/caretaker
[ ] Separation nightmares
[ ] Worry about harm to caretaker
[ ] Worry about events causing separation
[ ] Fear of being alone without caretaker
[ ] Fear of sleep without caretaker near
[ ] Physical symptoms when separated from caretaker

D.
[ ] Self-mutilation
[ ] Urinary infections/chafing
[ ] Stomach pain
[ ] Wetting/soiling

E.
[ ] Sadness/loneliness
[ ] Trouble sleeping
[ ] Sleep too much
[ ] Nightmares
[ ] Withdrawal
[ ] Suicidal thougths
[ ] Suicidal attempts
[ ] Eating too much
[ ] Eating too little
[ ] Purging
[ ] Laxatives
[ ] Fatigue
[ ] Crying spells

F.
[ ] Value changes
[ ] Manipulative
[ ] Secretive
[ ] Moody
[ ] Alcohol use
[ ] Drug use
[ ] Tobacco use
[ ] Caffeine use
[ ] Underachievement
[ ] Poor motivation
[ ] Change in friends
[ ] Poor communication

G.
[ ] Fearful/ worrying
[ ] Restless/ edgy
[ ] Poor concentration
[ ] Tires easily

H.
[ ] Friendship problems
[ ] Out-of-home placement

PSYCHO/SOCIAL HISTORY

What state were you born in? _____
Were your biological mother and father together at that time?_______
Did they remain together during your childhood?_________
Are there step mothers?_______ or step fathers?______ Names________________________________
Overall how would you describe your childhood(in a word or a sentence)?_________________________
How would you describe your mother? (or step mother etc)_____________________________________
How would you describe your father? (or step father etc)____
How many siblings did you have?
Sisters____ Brothers_____ Stepsisters______ Stepbrothers_____ Half sisters______ Half brothers______
Where are you in the birth order? (oldest, youngest, etc.)? _________________
Was child or any other child in the family adopted? [ ] Yes [ ] No
Are they aware of the adoption? [ ] Yes [ ] No
Was it an open adoption (i.e., contact with the birth parents)? [ ] Yes [ ] No
Grade? _______________ School? ____
Have you ever been charged with a misdemeanor of felony?________________________________
Have you experienced any trauma or significant life changing event?______________________________
____
Experienced any Verbal Abuse? Yes or no By whom? ____
Physical Abuse ? Yes or no? By whom?____
Sexual Abuse? Yes or no? By whom?____
Did you press charges or report incident? Yes or no To whom?__________________________________
Have you ever witnessed domestic violence? Yes or No.
Have you ever hit someone, or broken something in a state of rage or anger? Yes or No
Are you a violent person? Yes or No, Is there anyone else who would say you are? Yes or No

Current living arrangements? (who all in your household)?_______________________________________
What are your hobbies and things you enjoy doing?____
Do you have a religious affiliation?____
What is the worst part of your life at this time?____
What is the best part of your life at this time?____
How would you describe your overall personality?____
What are your strengths? ____
What are your weaknesses?____

Is there anything else we need to know to provide you with the best treatment options?

What do you need from this appointment? (what is your expectation)?

CHILD/ADOLESCENT MEDICAL HISTORY

ALLERGIES:______________________________**Height**________________**Weight**_______________________
Pediatrician;____

Were any of the following situations associated with the pregnancy or birth of child?

[ ] Mother had diabetes
[ ] Mother had high blood pressure
[ ] Mother had an illness
[ ] Mother was considered high risk
[ ] Bed rest during pregnancy
[ ] Drug use during pregnancy
[ ] Alcohol use during pregnancy
[ ] Prescription medication taken
(name) ____
[ ] Born before eight months' gestation
[ ] Born after ten months' gestation
[ ] Birth weight below 5 lbs.
[ ] Cesarean section delivery
[ ] Forceps delivery
[ ] Labor over 25 hours
[ ] Anesthesia given
[ ] Induced labor

Did your child:

[ ] First sit-up after 12 months
[ ] First walk after age 2
[ ] First speak sentences after age 3
[ ] Ever receive speech therapy
[ ] Toilet trained for bladder after age 4
[ ] Toilet trained for bowel after age 4
[ ] Ever receive occupational therapy
[ ] Ever receive physical therapy

As a baby, did child experience:

[ ] Colic
[ ] Irritability
[ ] Excessive crying
[ ] Sleep difficulties
[ ] Problems bonding
[ ] Feeding difficulties
[ ] High fever
[ ] Poisoning
[ ] No crying, or very little crying as infant

Please check those that apply:

[ ] Asthma
[ ] Seizure or Convulsion
[ ] Hydrocephalus
[ ] Meningitis
[ ] Unconsciousness
[ ] Encephalitis
[ ] Head injury- How often?________________ Open_______________________ Closed____________________
[ ] Hearing Problems
[ ] Speech problems
[ ] Vision problems
[ ] Immunizations up to date
[ ] Current/ previous birth control
[ ] Past pregnancy
[ ] Current pregnancy LMP________________________
[ ] Heart problems: ____
[ ] Lung problems: ____
[ ] Stomach problems: ____
[ ] Musculoskeletal problems: ____
[ ] Endocrine problems (i.e. diabetes, thyroid, etc.): ____

Surgery or Hospitalization	Dates	Reason	Length of Stay

Describe any significant injuries or accidents:____
____

Medication	Dose	Frequency

CGR BEACON CLINIC, P.A
.
<u>Consent and Authorization</u>

I, ________________________________ authorize Beacon Clinic, Inc. to obtain and/or release information regarding________________________________from/to:
(Patient Name)

- Physicians, clinicians, therapists: (only as identified below)

____
____
____
____

- Pharmacy

As designated on any refill request_________________________
____

- Attorney: (only as identified below)

____
____

- Other: (only as identified below)

____
____
____
____

- Specific information requested:

____
____
____
____

All efforts will be made to protect your privacy and maintain confidentiality as described in Florida statutes.

______________________________ ______________________
Signature: Patient/Parent/Guardian Date

Witness: ________________________

Charlene Rosenfield, A.R.N.P., B.C., Kathleen Kaloski, A.R.N.P, B.C.
Thomas Wilingham, M.D., Donna Chimato, M.S., L.M.H.C.
Gerald N. Ross, Ed.D., Christina Rooney, M.A., L.M.H.C.
Chantelle Grant, LC.S.W., Suzanne Morgenroth-Desio, L.M.H.C.
Charles Starks, Ed.D., L.M.H.C.

FEE AGREEMENT FOR TESTIMONY

The undersigned Client, or as parent or guardian of the Client, hereby agrees that in the event any clinician affiliated with CGR Beacon Clinic, P.A. d/b/a Beacon Clinic (hereafter the "Clinic") is subpoenaed to provide deposition or court testimony, that the client or guardian shall pay the clinician, in advance of the date of testimony, at the clinician's hourly rate then in effect, for all time to be expended in connection with deposition or court testimony, including all time expended in preparation for testimony and traveling to and from the location of testimony, as well as all costs of duplicating any records or documents when copies are require . Furthermore, in the event legal proceedings become necessary to compel payment in accordance with the terms of this agreement, the undersigned agrees to pay all reasonable attorney's fees incurred by the clinician or the Clinic in connection therewith.
The undersigned acknowledges and agrees that this Fee Agreement for Testimony is given as an inducement for the Clinic and its clinicians to provide professional services to the client.

____
Client signature

Print Name: _______________________________
Date: ____________________________________

____
Parent/guardian signature

Print Name: _______________________________
Date: ____________________________________

____
Parent/guardian signature
Print Name: _______________________________
Date: ____________________________________