VALENA & ASSOCIATES
CHILD, ADOLESCENT & ADULT PSYCHIATRY

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Welcome to our practice. We are pleased to have the opportunity to work with you and hope that this handout will provide information helpful in making an informed decision concerning our services and your treatment. Please feel free to ask questions you may have at any time.

Appointments:

While our services are available by appointment only, we make every effort to address emergencies as quickly as possible. Appointments for psychotherapy are scheduled for 50 minutes while appointments for medication checks and psychological testing will vary upon needs. Please be aware that testing fees include face to face contact as well as test scoring, interpretation, and report generation. Because this time is reserved for you, it is necessary to charge for appointments which are not cancelled 24 hours in advance. However, we will credit your account for the first missed appointment if your next one is kept. All other missed appointments will be billed ($40.00 for 30 minute appointments and $75.00 for 50 minute appointments) unless we agree that an emergency has occurred to create the need for the late cancellation. If three appointments are missed with no cancellation notice, our professional relationship will be terminated and a referral may be made to another mental health provider as needed.

Treatment:

We encourage you to become an informed consumer of the procedures, goals, rationale, and possible side effects of medications and psychotherapy used in your treatment. Both methods of treatment can be highly beneficial, although they are not completely free from risk. Potential side effects from medications vary greatly and will be discussed in detail with you prior to their prescription. For psychotherapy, the risks may include the experience of intense and unwanted feelings (e.g., anger, fear, guilt, or anxiety), recalling of unpleasant life events, or facing unpleasant thoughts and beliefs. It is important to remember that these feelings are often natural and normal and are an important part of the therapy process and should be discussed in your sessions.

Therapy is essentially a relationship between the patient and the therapist. The initial focus of therapy is to understand the thoughts, feelings, and life situations that concern you. Therapy can offer support, the development of specific skills such as communication, parenting, problem solving, and self-control, and guidance to facilitate your desired goals. However, as the patient you have the responsibility to decide your ultimate course of action. Formal and informal assessments, readings, journal writing, and other “homework” are often suggested to enhance your therapy experience.

Patient's Rights:

At any time, our patients may question and/or refuse therapeutic, medication, or diagnostic procedures, or gain whatever information they wish to know about the process and course of treatment. You also have the right to seek a second opinion from another clinician. Patients are assured of confidentiality, which is protected by professional ethical standards and by Indiana State Law. This law also applies to adolescents. While the parent/guardian is entitled to information regarding their child's progress, we have found that it is most helpful if the teenager is not pushed to disclose everything they discuss with their clinician. There are some exceptions to confidentiality that are legally mandated. These include: 1) if in our best professional judgment a patient has an intention to harm him/herself, someone else, or is gravely disabled to the point of being unable to take care of his/her basic needs; 2) if there is any reason for us to suspect child abuse, neglect, or molestation; 3) if there is any reason for us to suspect elder abuse; 4) if there is a legal action in which we or our records are subpoenaed or if we are ordered by a judge to release our records. In the above cases, we will make an effort to discuss the release of this information with you before it is sent, but we are under no obligation to do so. If there is a need to release information from your records for other circumstances (e.g., to talk with a child's teacher, primary care physician, etc.), it will be discussed with you and you must sign a "Release of Information" form, even if the release is at your request. Finally, in cases of divorce, Indiana law allows non-custodial parents to have equal access to the custodial parent with respect to all medical (including mental health) and school records.

Termination:

Termination from treatment may occur at any time and may be initiated by either the patient or our staff. If a decision is made to terminate, there may be a minimum of one session notice so that the reason(s) for termination can be explored. If any referral is warranted, it will be made at that time.

Charges:

The charges for our services are based on the usual, reasonable, and customary fee profiles of this area. Our charges vary by clinical service and will be discussed with you in advance. The fee includes our time in session as well as our time on your behalf that involves record keeping, session preparation, and telephone calls for the purpose of scheduling, clarifying billing information, or consultation with other professionals who may be involved with you (e.g., primary care physician). Our patients are expected to pay for services when they are provided, which includes co-pays, deductibles, and balances. Any balance not paid after 60 days could result in collection agency fees being added to your account balance and indefinite termination from our practice for all family members.

Insurance:

If you have a health insurance plan, a portion of the cost of your treatment may be reimbursed. While we will be happy to file your claims, you are responsible for knowing the terms of your policy and the extent of your coverage. Insurance balances that remain after 60 days may become patient responsibility. If we do not participate in your plan, payment is expected in full at the time of service before a claim will be filed on your behalf. Often insurance companies require diagnostic and treatment information before reimbursing us. We will release this information to them as needed so your claims can be paid promptly. While this is sensitive information and is generally treated as such by insurance companies, we cannot guarantee how any particular insurance company respects this information. If you prefer that we do not release this information to your insurance company for reimbursement purposes, you will be responsible for the entire fee for your services.

CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned, agree and consent to participate in the mental health services provided by Valena and Associates as defined in Indiana State law. This consent applies to my child or ward if they are the identified patient.

I understand that I am consenting and agreeing only to those mental health services that my provider is qualified to provide within the scope of his/her license and training.

I understand that this agreement does not guarantee that we will attain my goals; however, I agree that I will pay for access to Valena and Associates' resources as mental health providers and their willingness to apply their skills and resources in good faith.

I stipulate that this agreement will become part of my medical record which is accessible to myself and Valena and Associates, but to no other person without my written consent, with the exceptions as stated above. My provider may discuss my progress with my physician(s) or physician group _____.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the release of any information regarding service rendered and allow a photocopy of my signature to be used to file insurance. I direct my insurance to issue payment for all medical/mental health benefits due me directly to my provider. This assignment and authorization will remain in effect until revoked by me in writing. I understand that I am responsible for the fees for all services rendered and that I may be charged for refilling lost prescriptions.

My signature indicates that I have read the above presented in this disclosure statement. I understand the information and agree with the conditions of treatment stated or implied here. I have received a copy of this office's policies and a notice of privacy practices.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Valena & Associates Staff Signature Date

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PATIENT REGISTRATION

DATE:_____ COMPLETED BY:_____

PATIENT INFORMATION:

NAME:_____
First *Middle* *Last*
MAIDEN NAME:_____ MARITAL STATUS:_____

AGE:_____ BIRTHDATE:_____ SEX:_____ SS#_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

COUNTY:_____ TOWNSHIP:_____

Please only list phone numbers that you grant us permission to contact.

HOME PHONE:_____ ALTERNATE PHONE:_____

EMPLOYMENT INFORMATION:

EMPLOYER:_____

ADDRESS:_____

WORK PHONE:_____ EXT._____ LENGTH OF EMPLOYMENT:_____

NEXT OF KIN INFORMATION:
Who to contact if the above party is not available.

FULL NAME:_____

RELATIONSHIP TO PATIENT:_____ PHONE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

WHO REFERRED YOU TO OUR PRACTICE?_____

SOCIAL/FAMILY HISTORY

PLEASE LIST PERSONS CURRENTLY LIVING IN YOUR HOUSEHOLD.

NAME	AGE	SEX	RELATIONSHIP	OCCUPATION

MEDICAL HISTORY

PAST PSYCHIATRIC TREATMENT:

HAVE YOU EVER RECEIVED HELP FOR EMOTIONAL PROBLEMS? ☐ YES ☐ NO

IF SO, PLEASE LIST WHEN, WHERE, NATURE AND OUTCOME OF TREATMENT.

WAS THE TREATMENT HELPFUL? WHY OR WHY NOT?

PAST MEDICAL HISTORY:

LIST ANY DISEASES, MAJOR ILLNESSES, HOSPITALIZATIONS, OR SURGERIES:

NAMES OF CURRENT PHYSICIANS, REASONS SEEN, AND APPROXIMATE DATES OF SERVICE:

MEDICAL HISTORY:

PLEASE LIST ANY ALLERGIES OR ADVERSE MEDICATION REACTIONS:

LIST CURRENT MEDICATIONS BEING TAKEN, BOTH PRESCRIPTION AND OVER-THE-COUNTER:

PLEASE CHECK BELOW FOR ANY PHYSICAL SYMPTOMS YOU MAY BE EXPERIENCING:

□ CHRONIC COUGH	□ JOINT PAINS	□ CHRONIC RASH
□ WEIGHT LOSS	□ EASILY FATIGUED	□ CHRONIC SORE THROAT
□ NIGHT SWEATS	□ FEVER/CHILLS	□ HEADACHES
□ WEIGHT GAIN	□ ABDOMINAL CRAMPS	□ BLUE/PURPLE SPOTS ON SKIN
□ PERSONALITY CHANGES	□ CLAY COLORED STOOLS	□ YELLOWING OF EYES OR SKIN
□ LOSS OF APPETITE	□ MEMORY PROBLEMS	□ DIFFICULTY CONCENTRATING
□ NAUSEA	□ MUSCLE PAINS	□ CHRONIC "UNHEALING" SORES
□ DARK/ORANGE URINE	□ DIARRHEA	□ RECURRENT "FEVER BLISTERS"
□ INCREASED HEART RATE WITH EXERTION		□ SWOLLEN LYMPH GLANDS
□ WHITE SPOTS ON THROAT OR MOUTH		□ VOMITING
□ FOUL APPEARING SPUTUM (SPITTING)		□ TENDER ABDOMEN

□ OTHER: _____

PLEASE LIST ANY MAJOR ILLNESSES AND EMOTIONAL DIFFICULTIES IN YOUR FAMILY HISTORY:

SYMPTOM CHECKLIST

NAME:_____ DATE:_____

FOR EACH QUESTION BELOW, PLEASE CIRCLE HOW YOU HAVE FELT DURING THE PAST WEEK.

	NOT AT ALL				VERY MUCH
DO YOU HAVE PAINS IN YOUR LOWER BACK?	0	1	2	3	4
DO YOU FEEL BLOCKED IN GETTING THINGS DONE?	0	1	2	3	4
DO YOU FEEL SHY OR UNEASY WITH THE OPPOSITE SEX?	0	1	2	3	4
DO YOU FEEL LONELY?	0	1	2	3	4
DO YOU FEEL NERVOUS OR SHAKY INSIDE?	0	1	2	3	4
DO YOU HAVE TEMPER OUTBURSTS THAT YOU CANNOT CONTROL?	0	1	2	3	4
ARE YOU AFRAID IN OPEN SPACES OR ON THE STREET?	0	1	2	3	4
DO YOU FEEL THAT MOST PEOPLE CANNOT BE TRUSTED?	0	1	2	3	4
DO YOU FEEL THAT OTHERS CAN CONTROL YOUR THOUGHTS?	0	1	2	3	4
DO YOU EXPERIENCE SORENESS OF YOUR MUSCLES?	0	1	2	3	4
DO YOU HAVE TO CHECK AND RECHECK WHAT YOU DO?	0	1	2	3	4
ARE YOUR FEELINGS EASILY HURT?	0	1	2	3	4
DO YOU FEEL BLUE?	0	1	2	3	4
ARE YOU SUDDENLY SCARED FOR NO REASON?	0	1	2	3	4
DO YOU HAVE URGES TO BEAT OR HARM SOMEONE?	0	1	2	3	4
DO YOU FEEL THAT YOU ARE WATCHED OR TALKED ABOUT BY OTHERS?	0	1	2	3	4
DO YOU HEAR VOICES THAT OTHERS DO NOT HEAR?	0	1	2	3	4
DO YOU EXPERIENCE HOT OR COLD SPELLS?	0	1	2	3	4
DO YOU HAVE DIFFICULTY MAKING DECISIONS?	0	1	2	3	4
DO YOU FEEL INFERIOR TO OTHERS?	0	1	2	3	4
DO YOU WORRY TOO MUCH ABOUT THINGS?	0	1	2	3	4
DO YOU FEEL FEARFUL?	0	1	2	3	4
DO YOU HAVE URGES TO BREAK OR SMASH THINGS?	0	1	2	3	4
ARE YOU AFRAID TO TRAVEL ON BUSES, SUBWAYS, OR TRAINS?	0	1	2	3	4
DO OTHERS NOT GIVE YOU PROPER CREDIT FOR YOUR ACHIEVEMENTS?	0	1	2	3	4
DO YOU HAVE THOUGHTS THAT ARE NOT YOUR OWN?	0	1	2	3	4
DO YOU EXPERIENCE NUMBNESS OR TINGLING IN PARTS OF YOUR BODY?	0	1	2	3	4
DOES YOUR MIND GO BLANK?	0	1	2	3	4
DO YOU FEEL UNEASY WHEN PEOPLE WATCH OR TALK ABOUT YOU?	0	1	2	3	4
DO YOU FEEL NO INTEREST IN THINGS?	0	1	2	3	4
ARE YOU UNEASY IN CROWDS (EX: SHOPPING OR AT THE MOVIES)?	0	1	2	3	4
DO YOU FEEL TENSE OR KEYED UP?	0	1	2	3	4
DO YOU FEEL THAT PEOPLE WILL TAKE ADVANTAGE OF YOU?	0	1	2	3	4
DO YOU FEEL LONELY EVEN WHEN YOU ARE WITH PEOPLE?	0	1	2	3	4
DO YOU FEEL WEAK IN PARTS OF YOUR BODY?	0	1	2	3	4
DO YOU HAVE TROUBLE CONCENTRATING?	0	1	2	3	4
DO YOU FEEL VERY SELF-CONSCIOUS WHEN WITH OTHER PEOPLE?	0	1	2	3	4
DO YOU FEEL HOPELESS ABOUT THE FUTURE?	0	1	2	3	4
DO YOU HAVE SPELLS OF TERROR OR PANIC?	0	1	2	3	4
DO YOU FEEL THAT YOU ARE BEING PUNISHED FOR YOUR SINS?	0	1	2	3	4
DO YOU HAVE FEELINGS OF HEAVINESS IN YOUR ARMS OR LEGS?	0	1	2	3	4
DO YOU FEEL WORTHLESS?	0	1	2	3	4
DO YOU FEEL SO RESTLESS THAT YOU CAN'T SIT STILL?	0	1	2	3	4
DO YOU FEEL SOMETHING IS WRONG WITH YOUR MIND?	0	1	2	3	4

PLEASE BRIEFLY DESCRIBE THE PROBLEMS YOU HAVE BEEN EXPERIENCING WHICH PROMPTED YOU TO SEEK OUR HELP:

PLEASE WRITE ANY ADDITIONAL INFORMATION WHICH YOU FEEL IS IMPORTANT FOR US TO KNOW:

PERMISSION FOR TREATMENT:

Permission is hereby granted to the physician and/or providers and other persons acting under direction and supervision of Dr. Valena & Associates to administer examination, treatments, and procedures as are deemed necessary for myself and/or the patient named on this registration.

Date	Signature	Relationship	Witness

GUARANTOR'S STATEMENT:

In consideration of services rendered or to be rendered by Dr. Valena & Associates to the above patient, I agree to pay all accumulated charges not covered by verified and assigned insurance.

Date	Signature	Relationship	Witness