9263 Medical Plaza Dr, Ste A
North Charleston, SC 29406
843-377-1600 (phone)
843-377-1601 (fax)
www.tricountybehavioral.com

FREQUENTLY ASKED QUESTIONS

What should I bring to my first appointment?

1) COMPLETED paperwork (pages 2-6)
2) Copy of guardianship or custody paperwork (if applicable)
3) Pill bottles of all current medications (prescribed and over-the-counter)
4) Health insurance card
5) Driver's license
6) Payment (due at time of service). We accept cash, check, & major credit cards.

Why do you need my credit card information and will you charge my credit card?
Credit card information is necessary prior to scheduling an initial appointment in order to reserve your appointment time. *Your credit card will be charged $65 only if you "no show" or call to cancel your appointment within 24 hours of the scheduled appointment time. Otherwise, your credit card will not be charged.*

How early should I arrive to my first appointment?
If you have already completed the required paperwork listed above, please plan to arrive at least 10 minutes early so that we can make copies of necessary identification cards. If you have not completed the required paperwork, please plan to arrive 30 minutes prior to your scheduled appointment time.

How much will my appointment cost?
Please call you insurance company if you have any questions about how much your appointments will cost. Cost for an appointment with a psychiatrist depends on several factors, such as the complexity and length of the appointment, copay amount, and deductible.

Have questions that are not answered here?
Please visit our website at www.tricountybehavioral.com or call us at 843-377-1600

******MINORS MUST BE ACCOMPANIED BY THEIR LEGAL GUARDIAN. STEPPARENTS ARE NOT LEGAL GUARDIANS UNLESS THEY HAVE LEGALLY ADOPTED THE CHILD******

******PLEASE REMEMBER TO BRING COMPLETED PAPERWORK TO YOUR FIRST APPOINTMENT******

CHILD/ADOLESCENT INTAKE

Full Name ________________________________ Today's Date ________________________________

Date of Birth ______________________________ Age _________Sex ____________________________

Form completed by __________________________ Marital status of parents _____________________

Primary Care Physician ______________________ Who has legal custody of child? ________________

Mother's Name______________________________ Father's Name _______________________________

Address __________________________________ Address ____________________________________

____ ____

Phone ___________________________________ Phone ______________________________________

Occupation _______________________________ Occupation __________________________________

Please describe the reason(s) for seeking treatment at this time ______________________________________

____

Current Symptoms/Behaviors (check all that apply)

____ Depression
____ Crying spells
____ Energy increase
____ Appetite increase
____ Trouble sitting still
____ Spends more time alone
____ Loss of interest
____ Feelings of guilt
____ Feelings of grief
____ Compulsions/rituals
____ Difficulty falling asleep
____ Excessive sleeping
____ Afraid of new situations
____ Increased irritability
____ Lack of motivation
____ Energy decrease
____ Appetite decrease
____ Trouble concentrating
____ Verbally abusive
____ Complains of aches/pains
____ Hallucinations
____ Anxiety/worry
____ Family problems
____ Middle night awakenings
____ Suicidal ideas/attempts
____ Absent from school
____ Seems to be having less fun
____ Mood swings
____ Binge eating
____ Weight change (↑/↓amount____)
____ Personality change
____ Physically abusive
____ Purging after meals
____ Delusions
____ Panic attacks
____ Is down on himself/herself
____ Early morning awakenings
____ Homicidal ideas/attempts
____ Phobias/fears

____ Other ____

Former psychiatric care (psychiatrist, psychologist, counselor, psychological testing)

For what reason	When	By whom	Type of treatment

All current medications, including over-the counter, sleep medications, birth control, vitamins, & herbal supplements. If unsure of dosage please check the pill bottle or call your pharmacy.

Name of medication	Dosage	For what reason	How long	Side effects (if any)

Previous psychiatric medications (e.g, for ADHD, depression, anxiety, sleep, etc.)

Name of medication	Dosage	For what reason	How long	Side effects (if any)

Current or past medical problems (if none please indicate) ______________________________

Allergies or adverse reactions (if none please indicate) _________________________________

Surgeries or hospitalizations (include dates) ____

Date of last physical exam __________ **Are immunizations up to date?** ___________________

Has the child had a normal hearing and vision screen within the last year? _______________

Has the child ever had a seizure? ___ **Has the child ever had a concussion?** _______________

Date of last menstrual period (if applicable)____

Does the child seem to overreact to certain textures, smells, or noises?____________________

FAMILY HISTORY	Which family member?		Which family member?
Heart Disease	______	Psychosis/hallucinations	______
Abnormal heart rhythm	______	Schizophrenia	______
Sudden cardiac death	______	Panic disorder	______
Asthma	______	Anxiety/worry	______
Diabetes	______	Learning disability	______
Neurologic problems	______	ADHD	______
Seizures	______	Eating disorder	______
Cancer	______	Bipolar/manic depressive	______
Thyroid problems	______	Tics (involuntary movements)	______
Stroke	______	Genetic disorder	______
Alcohol problems	______	Depression	______
Drug problems	______	OCD	______

SUBSTANCE USE	Age at first use	How often (Last 6 months)	How much	Date last use
Caffeine	______	______	______	______
Cigarettes/tobacco	______	______	______	______
Huffing (glue/Whiteout, etc.)	______	______	______	______
Alcohol	______	______	______	______
Marijuana	______	______	______	______

Other (hallucinogen/mushrooms, amphetamine/speed, sedatives/sleeping pills, PCP, cocaine/crack, prescription pain pills, etc.) ______

EDUCATIONAL INFORMATION

Grade ______ School ______

Current educational problems ______

Special education classroom? Y/N Type of class and how much time daily? ______

Ever been held back a grade? Y/N If yes, what grade? ______

Special tutoring or therapy (OT/PT/ST) in school ______

DEVELOPMENTAL HISTORY

Mother's Pregnancy Length ______Cigarettes Y/N Alcohol Y/N Non-prescription drugs Y/N Medications Y/N

If yes to any of above please describe ______

Pregnancy, labor, or delivery complications ______

Age that child: Crawled______Walked______Put 2 words together______Potty trained______

Describe any concerns in child's development ______

OTHER INFORMATION

Names, ages, and relationships of everyone in household ______

______

Any significant changes in the past year? ______

Activities outside of school ______

Does the child have an easy or hard time making friends? ______

As far as you know has the child ever been abused (physically, sexually, or emotionally)? ______

Ever lived in a home with lead-based paint? Y/N Number of nights/wk your family eats dinner together? ______

How many total hours daily does the child watch TV, play video games or use the computer? ______

What kinds of guns are in the home? ______ Are guns locked up? ______

Religion ______ Has the child ever any problems with the law? ______

Has DSS ever been involved with your family? Y/N If yes, for what reason? ______

Who/what is your family's source of strength or support? ______

Child's assets or strengths______

*****COMPLETE THIS PAGE ONLY IF THE CHILD IS HAVING DIFFICULTY SLEEPING OR IS TIRED/FATIGUED DURING THE DAY*****

When answering these questions, think about the past week. If last week was unusual for any reason, choose the most recent typical week. Check always if something occurs every night, usually 5-6 times/week, sometimes 2-4 times/week, rarely once/week, and never less than once/week

What is the child's usual bedtime on school nights?__________ On weekends? ____________
What time does the child wake up on school days? __________ On weekends? ____________
Does the child nap?__________ If yes, how long do the naps usually last? _________________
Usual total amount of sleep each day (combining overnight sleep & naps) ________________

	Always	Usually	Sometimes	Rarely	Never
Goes to bed at the same time at night					
Falls asleep alone in own bed					
Exercises for at least 30 minutes during the day					
Falls asleep with rocking or rhythmic movements					
Needs a parent in the room to fall asleep					
Resists going to bed at bedtime					
Afraid of sleeping in the dark					
Moves to someone else's bed during the night					
Grinds teeth during sleep					
Snores loudly					
Awakens during the night and is sweating, screaming, and inconsolable					
Wakes up once during the night					
Wakes up more than once during the night					
Restless and moves a lot during sleep					
Seems tired during the daytime					
Falls asleep while involved in activities					
Drinks caffeinated beverages (soda, tea) in the afternoon or evening					

OFFICE POLICY STATEMENT

*****PLEASE INITIAL NEXT TO EACH SECTION*****

__________**APPOINTMENT CANCELLATION POLICY:** When you schedule an appointment with us, that time is specifically set aside for you. **IF YOU MISS AN APPOINTMENT WITHOUT CALLING TO CANCEL AT LEAST 24 HOURS IN ADVANCE YOU WILL BE CHARGED $65.** The only exception to this fee is if you can provide documentation you were hospitalized. You will be charged a no-show fee if you arrive late and have to be rescheduled for another day. If you come to your appointment without canceling ("no show") you will be required to provide a credit card number in order to schedule another appointment. On the second "no show" or less than 24 hour cancelation, the missed appointment fee will be collected. Please note that although we do offer courtesy email, text message, and phone call reminders, the patient is responsible for remembering his/her appointment. Insurance companies do not reimburse for these fees. After two no shows you may be no longer be able to be seen in our clinic.

__________**PRESCRIPTION REFILLS:** Prescription refills consume a surprisingly large portion of staff time. There is a small fee (see Physician Ancillary Charges below) for refills given and refills may be denied due to missed or overdue appointments. Prescriptions will be given at each appointment with enough refills to last until the recommended time of your next appointment. To help ensure safety and well-being patients are expected to follow-up within the time frame recommended by their provider. If your refills are running low, it likely means it is time to schedule a follow-up appointment. **BEFORE CALLING OUR OFFICE TO REQUEST A REFILL, PLEASE CHECK YOUR BOTTLE OR CALL YOUR PHARMACY TO SEE IF YOU HAVE ANY REFILLS REMAINING. PLEASE ALLOW AT LEAST 48 HOURS FOR REFILL REQUESTS. NO REFILLS WILL BE CALLED IN ON FRIDAYS.**

__________**FEES:** There is a $25 charge for returned checks. Balances over 90 days may be sent to a collections agency. Medical record fees are $15 plus 65¢ per page.

__________**PHYSICIAN ANCILLARY CHARGES:** It is in the patient's best interest to have as much communication as possible in person as this increases the safety and efficacy of treatment. Insurance companies do not reimburse the fees listed below and therefore patients are responsible for all accrued charges. **WITH THE EXCEPTION OF SIGNIFICANT MEDICATION SIDE EFFECTS OR AN EMERGENCY, PLEASE DO NOT ASK YOUR DOCTOR TO CHANGE MEDICATION OVER THE PHONE.** If you think your medication isn't working or would like to discuss treatment options please schedule an appointment. This helps ensure optimal patient care.

• Telephone or e-mail consultation	$10 each 5 minutes
• Emergency calls after hours	$15 each 5 minutes
• Reports/letters/consultations	$10 per page
• Prescription refills due to overdue appointment or replacement of lost prescription	$10 per prescription

___________**DRUG SCREENING:** In accordance with prescribing guidelines any patient may be asked to submit a urine sample for drug screening at any time. Failure to comply with the test may result in the patient no longer being prescribed his/her medications. The purpose of dug screening is to confirm medication adherence, reduce diversion of medications, and to prevent accidental overdose due to overusing prescribed medications or drug-drug interactions.

___________**INSURANCE:** As a service to our patients, claims for visits are submitted to your insurance company by a contracted vendor. Our office will make every effort possible to obtain accurate information about your insurance benefits including limits of coverage, deductibles, and co-payments. You are responsible for all charges not covered by your insurance. **Payment is required in full at time of service**. Your physician's referral and verification of insurance benefits by our office are not a guarantee of insurance coverage. We recommend you contact your insurance company to ensure that you understand your coverage and to ensure you have coverage for mental health services. Do not assume that you will not owe anything if you have more than one insurance policy.

___________**PRIOR AUTHORIZATIONS:** if a prior authorization is required for a medication it is the responsibility of your pharmacy to notify our office. It is important we have your current insurance information on file. **After we submit the required paperwork, insurance companies can take up to one week to make a decision.** We cannot call insurance companies for approval during this waiting period. We appreciate your patience and will notify you as soon as a decision has been made.

CONFIDENTIALITY: Information regarding your treatment will not be released unless there is prior written consent, indication of clear and immediate danger to self or others, certain legal circumstances required by law, or disclosure of neglect or abuse of a child or members of vulnerable populations.

AUTHORIZATION TO RELEASE INFORMATION: By my signature below I authorize Tricounty Behavioral Health to release information about me to my insurance company and the referring provider. This information is protected under the Privacy Act, the Drug Abuse Office and Treatment Act, and the Comprehensive Alcohol Abuse & Alcoholism Prevention & Rehabilitation Act.

INFORMED CONSENT/ACKNOWLEDGEMENT OF UNDERSTANDING AND AGREEMENT: I consent to have Tricounty Behavioral Health perform or order clinical assessments, psychotherapy, provide consultations, recommendations, and/or related mental health treatment. I have read all of the information listed above regarding policies and procedures. My signature below indicates my understanding and agreement.

Signature:____ Date: ____________________________________

Printed Name:____