

Grant A. Killian, Ph.D., P.A.

Licensed Psychologist FL # PY 3298

web page address: www.killianphd.com

Mailing Address

2871 N.E. 30 Street

Lighthouse Point, FL 33064-8524

954-786-9000 (office) 954-782-9000 (fax)

The Preserve

7700 Congress Avenue, Ste. 2110

Boca Raton, FL 33487

954-786-9000 (office) 954-782-9000 (fax)

Please complete all information for the identified patient. If you are the parent filling out the form for your child make sure the information is about the child and not you. Some items will not apply to a child you can write in N/A for not applicable.

Name First: _____ Last: _____

Street Address: _____

City : _____ State: _____ Zip: _____ - _____

Additional Address: _____

City, St, Zip: _____

If Patient is a child please list the parent or guardian's numbers.

Phone Numbers: What number do you prefer the office use to contact you? Please check.

Home _____ Cell _____ Work _____

Email Address: _____

Social Security Number for child: _____ Race: _____

Date of Birth for child: _____ Male Female

Name & Relationship and phone number of who to contact in emergency for Assistance: _____

I am giving permission to Dr. Killian to speak with the above person in an emergency.

Name of Insurance and ID# (From Ins. card): _____

Authorization # from insurance company if needed: _____

Name of school if patient is a student: _____

Place of employment of primary insured: _____

Primary Care Physician or Family Doctor: _____

Phone Number of Primary or Family Doctor: _____

I authorize the release of my treatment reports to my PCP or behavioral health practitioners. Agree Decline

How do you prefer the office confirm appointments? Phone Text Email

Who referred you: _____

Please state why patient/child is attending therapy: _____

Who is child living with at home: please list names, ages, & relationships:

Previous therapy for child Yes No If yes, when/how long _____

Are you under Psychiatric care: Yes No Psychiatrist: _____

Describe alcohol use: Yes No _____ wkly average

Describe nicotine use: Yes No _____ wkly average

Describe other substances used Yes No _____ wkly average

Parents: Married Separated Divorced Deceased

Mother's age, health condition, if living, or age of death _____

Father's age, health condition, if living, or age of death _____

Brothers: names and age _____

Sisters: names and age _____

Describe the relationship child has/had with grandmother

Describe the relationship child has/had with grandfather

Please complete all information for the identified patient. If you are the parent filling out the form for your child make sure the information is about the child and not you. Some items will not apply to a child you can write in N/A for not applicable.

Check any history of abuse for the patient of-- Physical Verbal Emotional Sexual
Any family members diagnosed with the following:

- Schizophrenia Who _____
- Depression Who _____
- Mania Who _____
- Bipolar Who _____
- Committed Suicide Who _____
- Alcohol or substance abuse Who _____

Describe any health problems child have _____

List any allergies for child if any _____

List all major events and/or traumas with dates, if more room is needed attach a list.

List any pets, type and names _____

Education:	Year completed	Location
<input type="checkbox"/> Completed H.S.	_____	_____
<input type="checkbox"/> College	_____	_____
<input type="checkbox"/> Post Graduate	_____	_____
<input type="checkbox"/> Doctoral	_____	_____

Please read all pages and sign all designated places

CONSENT and CONFIDENTIALITY

I agree to seek treatment &/or evaluation for myself, child, spouse, or family, participate actively in treatment planning, provide information to Dr. Killian, which will enable delivery of appropriate care and give permission for my signature be on file. Laws protect confidentiality of communications between client and psychologist, information can only be released with a prior written authorization. Exceptions are: (a) in certain legal proceedings Dr. Killian may be required to testify and/or release records. (b) Dr. Killian is legally required to take action to protect patients and others from harm even though that requires revealing information about treatment and diagnosis. If there is evidence of a child, elderly person, or a disabled person being abused, Dr. Killian must file a report with the appropriate state agency and/or police. (c) If Dr. Killian believes a client is threatening serious bodily harm to another Dr. Killian is required to take protective actions, which may include notifying the potential victim, notifying the police and/or seeking appropriate hospitalization. If a client threatens to harm him/herself, Dr. Killian may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection. Dr. Killian may occasionally consult about a case with other professionals or may be required by your insurance company to consult. In these cases, every effort is made to avoid revealing the identity of the client. Consultants and insurance company are bound to keep the information confidential. As a parent you have the right to general information about treatment, but not necessarily the complete record or specific test scores and/or answers. This written summary of exceptions to confidentiality should prove helpful in, but you may discuss any questions or concerns you may have, these governing laws are complex, but since I am not an attorney, if you need specific advice, you should consult an attorney.

READ CAREFULLY this section SCHEDULING APPOINTMENTS Monday through Saturday.

Because time has been reserved exclusively for me and/or my family members, I AM REQUIRED TO PROVIDE AT LEAST TWENTY-FOUR (24) HOURS' ADVANCE NOTICE IF UNABLE TO KEEP THE SCHEDULED APPOINTMENT SCHEDULED MONDAY THROUGH SATURDAY. In the event I do not provide the required notice prior to canceling I will be charged rate of what my insurance company or the managed care company allows for the failed session or I will be discharged due to noncompliance. Payment must be received before another appointment will be scheduled. All future appointments already scheduled will automatically be canceled. If I am late for an appointment, no attempt is made to contact office, Dr. Killian will see the next patient scheduled if they arrive during my scheduled appointment.

BILLING and PAYMENTS

You are expected to pay for each session or co-payments at the time of the session or unless you have insurance coverage, which requires another arrangement. You are responsible for any co-payments required or deductibles that must be met by you at the time of service. Payment for professional services you may require such as report writing, telephone conversations, and preparation of records will be charged at my hourly rate at the time these services are requested. If you become involved in litigation which requires my participation, you will be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I will charge my hourly rate for the preparation, for attendance at any legal proceeding, and travel portal to portal which is different and cannot be billed to the insurance company.

INSURANCE and MANAGED CARE REQUIREMENTS

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have for your treatment. Many HMO's and PPO's require advance authorization and are oriented toward short-term treatment approach designed to resolve specific problems. Dr. Killian is required to complete some Managed Care Forms by the 1st or 2nd session pertaining to the therapy and will release such information necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes with representatives of my insurance or managed care company. Due to the specific nature of these forms, this information may be completed during the 1st session. Insurance and managed care companies may ask to review the entire record and file. By signing this form you are giving permission to send notes when they are requested,

managed care forms, and claims with dates of service, diagnosis & **procedure codes**. In addition, these companies require a **release of records to your PCP and other behavioral health practitioners**.

CONTACTING ME

The office telephone voice mail system is monitored frequently and we make every effort to return your call the same day. If you are difficult to reach, please leave times when you are available. If there is a **life threatening** emergency please call 911 immediately or go to the nearest hospital. If you wish to leave an emergency message for Dr. Killian press 0 and leave your name, number and a brief message as to the nature of the emergency and Dr. Killian will be paged. If Dr. Killian is out of town the doctor's name and number providing backup coverage will be on the voice mail. An emergency is when a "patient is suicidal and may harm themselves or may harm others." Please do not abuse the privilege of paging Dr. Killian for non-emergency situations. LEAVE YOUR MESSAGE ON THE OFFICE VOICE MAIL 954-786-9000.

PROFESSIONAL RECORDS

Both law and the standards of my profession require that I keep legible appropriate treatment records. Statute 456.057 states: "when a patient's...chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's records shall be provided directly to a subsequent treating professional upon receipt of a signed release of records, I will forward a copy or a summary (Statute 456.057) of your records to another appropriate professional. Clients will be charged an appropriate fee for any preparation time, which is required to comply with an information request and you will be informed by the office manager if there is any request for your information before any information is given out. **According to the Florida Psychological Association, "records could be deficit" if there is no attempt by the psychological provider to "obtain past mental health records". It is the obligation of you the patient, parent or guardian to obtain copies of all these health records and provide copies of these records or have these records sent to Dr. Grant A. Killian, Ph.D., P.A. at his mailing address in Lighthouse Point.** Based on Florida medical laws for records, I therefore would like as many past records as you might be able to acquire; thus, you must **sign** one of these lines.

- There are no past psychological or psychiatric records_____
- I refuse to release past psychological or psychiatric records_____
- I will have past psychological or psychiatric records forwarded_____

I have read the information in this document, agree to abide by its terms during our professional relationship, my signature authorizes payment of medical benefits to Dr. Killian for services rendered and authorizes Dr. Killian to take my photograph for identification purposes and/or medical documentation for electronic medical records (EMR). I am aware that the privacy rule gives the right to request restrictions on uses of my protected health information. I can request a copy of the Privacy Practices or obtain them on Dr. Killian's website, www.killianphd.com. I am giving permission for Dr. Killian's office to call me and leave a message to confirm an appointment and if necessary send a bill to my home address. If I do not agree I need to contact Janie Killian, Privacy Officer to request changes. By signing this form I am giving consent for my behavioral healthcare practitioner to release the information to my active Insurance or Managed Care Company until the period of time at which I am no longer an active. I understand that my records are protected under Federal and/or State Confidentiality Regulations. This authorization may be revoked at any time except to the extent that action has already occurred. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment with Dr. Killian. This consent is given of my own free will.

Client's, Patient, Parent, Guardian Signature

Date Signed

Print Name that was signed

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Name of Patient: _____

Date Completed: _____ Relationship to patient: _____

Completed by (FIRST & LAST Name): _____

CHECK ALL THAT APPLY TO YOU OR TO THE PATIENT.

1. Have had a loss of reputation?
2. Have had feelings of emptiness?
3. Are you having worsening depression?
4. Feeling rejection, hopeless &/or helpless?
5. Feeling guilty or want to punish someone?
6. Feeling isolated and withdrawal from the world?
7. Feelings detached from yourself, or unreality, feeling you are going crazy, losing control, or feeling paranoia?
8. Have had a loss of ability to meet obligations?
9. Have you been suffering from a chronic illness?
10. Have you been giving away important belongings?
11. Have had an unplanned pregnancy or recent abortion?
12. Have you made efforts to get help that has been unsuccessful?
13. Have had thoughts that you want to change what is happening in your life by leaving?
14. Do you tend to be extremely accident-prone?
15. Do you tend to avoid taking care of your health?
16. Do you tend to be reckless and do not think about risks?
17. Intense anger or controlling anger, temper problems, recurrent fighting with others and then feel guilty?
18. Tend to use drugs or alcohol to change bad feelings?
19. Tend to over use or over dose with either drugs or alcohol?
20. Has something stressful happened recently that has made you feel negative about life?
21. Are guns, throwing knives, knives as weapons, brass knuckles, swords, or other weapons in the home?
22. Do you tend to listen to music, movies, videos or books about death?
23. Do you dwell on issues of death or have an attraction or obsession to death?
24. Thinking you would like to go to sleep and not wake up?
25. Has anybody close to you died recently and you had thoughts of wishing it were you or joining him or her?
26. Know anyone that has committed suicide and you had thoughts of wishing it were you or joining him or her?
27. Have or had fantasies of jumping off a building?
28. Have or had thoughts that you might drown yourself?
29. Have or had fantasies of seeing you dead surrounded by others alive?
30. Have or had thoughts about hanging yourself or using a gun on yourself or others?
31. Have or had thoughts about using the car to harm yourself in an accident or by carbon monoxide?
32. Have or had any other suicidal behaviors, thoughts about killing, gestures, self-mutilation, plans, or threats?
33. Are here because you tried to hurt yourself?
34. Received treatment for self-harm in the past?

35. Is there a specific time you think you will die?

Name of Patient: _____

36. Feel you need to keep yourself safe from yourself to avoid doing self-harm?

37. Have you ever said in the past 6 months any of the following?

CHECK ALL THAT APPLY TO YOU OR TO THE PATIENT.

- a. "I am a loser"
- b. "I am a failure"
- c. "I hate my life"
- d. "I am worthless"
- e. "I have no future"
- f. "I wish I were dead"
- g. "I wish I did not exist"
- h. "I have nothing to lose"
- i. "I have nothing to live for"
- j. "I have nothing in my life"
- k. "I will be dead soon anyway"
- l. "I would be better off not alive"
- m. "I am going to have a heart attack"
- n. "I am worth more dead than alive"
- o. "I am going to blow my brains out"
- p. "I am to blame for all my troubles"
- q. "If I die so what"
- r. "I'll show them"
- s. "Life is not worth living"
- t. "My family would be better off without me"
- u. "Nobody needs me"
- v. "Nobody cares anyway"
- w. "There is no reason to keep living"

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Name of Patient: _____

Date Form Completed: _____

Completed by (First/Last name): _____ Relationship to patient: _____

Ex: Self, Parent, Grandparent, Teacher, etc.

Check any of these that occurs more than by most children & has been a problem for a while.

- 1. fails to pay attention to details--careless mistakes in work
- 2. poor attention span
- 3. acts like they are not listening when spoken to
- 4. incomplete work, does not complete schoolwork
- 5. poor organizational skills
- 6. avoids tasks that require attention
- 7. loses things
- 8. distracted by unimportant noises and events
- 9. forgetful

- 1. moves around and cannot sit still in seat
- 2. does not remain seated when required
- 3. inappropriate running and climbing (e.g., climbing on furniture)
- 4. cannot play quietly makes excessive noise
- 5. hyperactive with excess energy
- 6. constantly talks
- 7. answers questions without being called upon
- 8. unable to wait taking turns
- 9. interrupts conversations and never lets others complete questions or sentences

Name of Dr. Prescribing	Medication name Prescribed	Mg (Dosage) of the Medication	Frequency / Day	Date Medication was First Started

ADD inattention (6); ADD hyperactive (6); ADD combined 6 + 6

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Name of Patient: _____

Date Form Completed: _____

Form Completed by (First/Lastname): _____ Relationship to patient: _____

Check any item that meets the following: a behavior that is exhibited by the child to a greater degree than by most children his or her age and has been a continuous behavior for at least six months.

Opp. Def. Dis.

313.81 (4 for six months)

- 1. blows up and loses temper
- 2. argues excessively
- 3. defiant, oppositional, and refuses to comply with requests or norms
- 4. annoys people on purpose
- 5. blames others for own mistakes or misbehavior
- 6. quickly annoyed
- 7. hotheaded and resentful
- 8. vengeful

Name of Dr. Prescribing	Medication name Prescribed	Mg (Dosage) of the Medication	Frequency / Day	Date Medication was First Started

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Name of Patient: _____

Date Form Completed: _____

Completed by (First/Last name): _____ Relationship to patient: _____

Check any of these that occurs more than by most children & has been a problem for a while.

- 1. tends to be a bully and intimidating
- 2. physically fights excessively
- 3. uses weapons that cause serious harm (e.g., a bat, brick, knife, gun)
- 4. physically abusive to people
- 5. physically abusive to animals
- 6. victimizes others through theft (e.g., mugging, purse snatching, extortion, armed robbery)
- 7. sexual abusive
- 8. plays with matches and fire setting
- 9. destruction of personal property
- 10. breaking and entering
- 11. lies and does not tell the truth
- 12. shoplifting, forgery, steals and uses credit cards
- 13. does not abide the by parental curfew rules, before age 13
- 14. runs away overnight from home (at least twice) or one extended period
- 15. truancy, before age 13

Name of Dr. Prescribing	Medication name Prescribed	Mg (Dosage) of the Medication	Frequency / Day	Date Medication was First Started

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Name of Patient: _____

Date Form Completed: _____

Completed by (First/Last name): _____ Relationship [mother, teacher]: _____

Check any item that applies:

- 1. Depressed, irritable, angry or mood swings during the day.
- 2. Diminished interest in activities tending to be apathetic compared to others.
- 3. Apparent weight loss or weight gain in less than a few months.
- 4. Sleeping during the day, with head down as if not getting enough sleep.
- 5. Too Agitated or too slowdown most every day.
- 6. Seems fatigue or loss of energy most every day.
- 7. Apparent feelings of worthlessness or guilt during the week or day.
- 8. Less able to think, concentrate or tending to be indecisive compared to others.
- 9. Reports thinking or wishing for death, harming self, suicidal thoughts, or plans.

Name of Dr. Prescribing	Medication name Prescribed	Mg (Dosage) of the Medication	Frequency / Day	Date Medication was First Started