THE RIVERWALK GROUP LLC
The Phillips Mansion
666 Glenbrook Road, 1st Floor
Stamford, CT 06906
T: 203.329.3759
www.TheRiverwalkGroup.com

Adolescent/Young Adult (16-21 yrs)

Date form completed: _____

Please provide the following information and answer the questions below. Information you provide here is *protected as confidential information*. If you rather discuss a question at the first visit, please note that.

Name: _____
Last First MI

Birth Date: _____/_____/_____ **Age**: _____ **Gender** ☐ Male ☐ Female ☐ _____

Name of Parent/Guardian #1 _____
Last First MI

Name of Parent/Guardian #2 _____
Last First MI

Other Parent(s)/Guardian(s) involved with Adolescent/Young Adult: (Step-parent, Live-In Partner etc.)

Name/Relationship to Child: _____
Last First MI

Name/Relationship to Child: _____
Last First MI

Primary Address for Child:

_____
Number/Street

_____
City State Zip

Contact info for Parent/Guardian: *

Home Phone: (_____) _____ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: (_____) _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we email you? ☐ Yes ☐ No

Contact info for Adolescent/Young Adult:

Cell/Other Phone: (_____) _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we email you? ☐ Yes ☐ No

**if you would like to add other contact information for additional parents/guardians please add on back of page in same format.*

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Current Family Situation:

Who currently resides in the home with you? _____

_____

Where have you lived through out your life and with whom? _____

_____

Marital history of your biological parents: ☐ Married ☐ Separated ☐ Deceased ☐ Divorced ☐ Never Married

Do you have Step-Mother? ☐ Yes ☐ No Describe the relationship: _____

_____

Do you have Step-Father? ☐ Yes ☐ No Describe the relationship: _____

_____

If you do not live with both parents or have a unique living arrangement, please describe: (ei: who has primary custody, visiting schedules etc.) _____

_____

Have you ever been placed, boarded or lived away from the family? ☐ Yes ☐ No If Yes, explain circumstances: _____

_____

Are there currently any major family stressors? ☐ Yes ☐ No Explain: _____

_____

_____

Are there any other family members living in the home: ☐ Yes ☐ No

Name of Family Member Living in Home	**Relation to Child**	**If Sibling Full/Half/Step/Other**	**Relationship with Family Member? Good/Fair/Discord**
			☐ Good ☐ Fair ☐ Discord
			☐ Good ☐ Fair ☐ Discord
			☐ Good ☐ Fair ☐ Discord
			☐ Good ☐ Fair ☐ Discord
			☐ Good ☐ Fair ☐ Discord
			☐ Good ☐ Fair ☐ Discord
			☐ Good ☐ Fair ☐ Discord

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If you are adopted:

Age when came into the home: _____ Date of Legal adoption: _____

Reason and circumstance for adoption: _____

_____

What have you been told about the adoption and when? _____

_____

Health of the Family Members:

List all the family members and how related to the client who have a history of any of the following psychological problems or other health problems.

Issue	Yes	No	List Family Member/How related
Alcohol/Substance Abuse			
Anxiety			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide Attempts			
ADHD			
Mood Disorders (“Bipolar”)			
Behavior Problems			
Other psychological problems			
Other health issues			

Additional information about family you wish to share? _____

_____

_____

_____

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Current Concerns:

Why are you (or your family) seeking counseling? _____

_____

How long have these problems been occurring? _____

Has there been any life changes/stressful events in your life or family recently? ☐ Yes ☐ No _____

_____

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression?
☐ Yes ☐ No If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
☐ Yes ☐ No If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain?
☐ Yes ☐ No If yes, please describe: _____

_____

Where you referred to counseling by anyone? ☐ Yes ☐ No If yes, who? _____

General and Mental Health Information

How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing: _____

_____

_____

_____

Have you previously received any type of mental health services? (psychotherapy, psychiatric services, etc.)

☐ Yes ☐ No Previous therapist/practitioner(s): _____

_____

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Have you ever been admitted to a psychiatric hospital? ☐ Yes ☐ No If yes, List below:

Age admitted	Facility	How Long	Reason/diagnosis	Recommendations/Medications

*Please list additional information on the back of sheet if needed.

How would you rate your current sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing: _____

_____

_____

How many times per week do you generally exercise:

☐ None ☐ 1-2 ☐ 3-5 ☐ Everyday

What types of exercise to you participate in: _____

_____

_____

_____

Please list any difficulties you experience with your appetite or eating patterns: _____

_____

Do you drink alcohol or engage in recreational drug use? (circle drugs/alcohol or both) ☐ Yes ☐ No

Is yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Are you currently in a romantic relationship? ☐ Yes ☐ No If yes, for how long? _____

On a scale of 1-10 how would you rate your relationship? (1=poor)_____

What significant life changes or stressful events have you experienced recently? _____

_____

_____

_____

Do you currently take any prescription medications? ☐Yes ☐ No If yes, please list and reason for taking:

Medication	Reason

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Have you ever been prescribed psychiatric medications? ☐ Yes ☐ No If yes, please list and proved dates:

Medication	Approximate dates

Have you ever seen a medical specialist for any medical problem? (endocrinologist, neurologist, genetics etc.)
☐ Yes ☐ No **If yes, please list:**

Age	Doctor Name/Specialty	How Long	Reason/diagnosis	Recommendations/Medications

*Please list additional information on the back of sheet if needed.

Name of Pediatrician/Internist: (If more than one, please list all)

Name	City, State	Dates Patient there
Name	City, State	Dates Patient there
Name	City, State	Dates Patient there

If you wish to have your primary care doctor contacted please let us know so that appropriate forms can be filled out. Do you want information to be shared with your primary care doctor? ☐ Yes ☐ No

Developmental History:

Normal Pregnancy? ☐ Yes ☐ No **Length of Pregnancy:** _____**weeks**

If complications with pregnancy, explain: _____

Birth Weight: _____ **Birth Length:** _____ **Delivery Type:** ☐ Vaginal ☐ Cesarean ☐ Induced ☐ Breech

Any complications with delivery and/or after birth (NICU stay?) ☐ Yes ☐ No Explain: _____

Did mother take any prescribed or drugs of abuse during pregnancy? ☐ Yes ☐ No Explain: _____

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How would you describe your interactions with sibling and peers? _____

_____

_____

Do you have any special habits, fears or idiosyncrasies? _____

_____

_____

Educational History:

Name of School	City/State	Dates Attended	Grades Attended

*if you need additional space please you back of form

Are you or have you ever been enrolled in any special education or specially modified classes? ☐ Yes ☐ No

If yes, explain: _____

_____

Have you ever been retained or skipped a grade? ☐ Yes ☐ No If yes, explain: _____

_____

Do you attend school on a regular basis? ☐ Yes ☐ No If no, explain: _____

_____

If you are currently in school, are you motivated to attend school? ☐ Yes ☐ No

What is your favorite class? _____

What is your least favorite class? _____

Have you ever been suspended or expelled? ☐ Yes ☐ No If yes, explain: _____

_____

Do you (or did you) participate in extracurricular activities? ☐ Yes ☐ No If yes, explain: _____

_____

_____

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Additional Information:

Are you currently employed? ☐ Yes ☐ No If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

Do you consider yourself and/or your family to be spiritual or religious? ☐ Yes ☐ No If yes, describe your faith or belief? _____

What do you consider to be some of your strengths? _____

What do you consider to be some of your weakness? _____

What would you like to accomplish out of your time in therapy? _____

IF A PARENT OR GUARDIAN WOULD LIKE TO ADD ADDITIONAL INFORMATION PLEASE SEE NEXT PAGE.

Name of person filling in form: _____

Signature of person filling in form: _____ Date: _____

Therapist Signature: _____ Date: _____

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Additional Information from Parent/Guardian:

Name of Person Filling out page and relationship to patient: _____

_____

Date: _____

What are some of this adolescent's/young adult's strengths and talents? _____

_____

_____

_____

_____

_____

What would you like to accomplish out of therapy? _____

_____

_____

_____

_____

Anything else you would like to share or let the clinician know about your child/situation? _____

_____

_____

_____

_____

_____

Signature of person filling in form: _____ Date: _____

Therapist Signature: _____ Date: _____

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Practice Policies and Procedures

We offer comprehensive services for children, adolescents, adults, and families. Our practice is composed of specialists trained in different modalities who can effectively manage the diverse aspects of psychiatric needs. We offer a wide range of services and in-depth evaluations. Please refer to our website for a complete listing of our services and modalities currently offered. Your practitioner will work closely with you to develop a treatment plan that meets your specific needs.

Appointments

All appointments must be scheduled directly with the Clinician. Some Clinicians use an online scheduling system and you will be setup with an user name and password if this is available to you at the first session. The session length will vary depending on the services required.

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. Thank you for your consideration regarding this important matter.

Confidentiality

The medical records of our clients are highly confidential. Information contained in the records will not be released without proper written consent. When treating a child or adolescent, parents are kept informed of the general progress of treatment but specific and personal information is kept confidential. In the case of a divorce situation where medical custody is shared, consent and authorization regarding disclosure of any information is required from both parents.

Contacting Our Office

Phone Calls

If you have an emergency, please reach out to your clinician, if you do not hear from them immediately, go to your nearest emergency room. Our office number is 203-329-3759 and each clinician has a voicemail box through that number. All phone messages are responded to as quickly as possible. Be sure to leave your name, phone number, and convenient times when you can be reached. Do not leave sensitive medical information on voicemail.

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Email

You can also reach your individual clinician by email. You can find their email address on our website on their individual pages. Email addresses are all standardized to be the first letter of the clinician's first name plus their last name then @theriverwalkgroup.com. Due to privacy considerations, we do not discuss clinical matters via the internet or email. We will occasionally send follow-up emails that pertain to scheduling, billing, or other administrative matters that do not include any sensitive medical information. If you have a clinical matter that needs to be discussed between sessions, please contact your clinician to arrange a means to discuss further.

Fees/Payment Information

For further information on fees please speak directly to your clinician. Attached to this packet is a "Form of Payment" sheet to be completed to alert us how you will be settling your invoices. The Riverwalk Group accepts multiple forms of payment. We accept health savings accounts, cash, checks, bank to bank deposits and credit cards.

Insurance

The Riverwalk Group is an out of network provider, which means that you pay The Riverwalk Group directly after each session. This also means that we do not participate with any insurance companies. The Riverwalk Group will provide you with a paid invoice after each session that includes all necessary coding, dates and confirmation of payment so that you can submit to your insurance company. It is very important to us that our clients receive the maximum reimbursement from their insurance companies and we will help in any way possible to ensure this process is efficient and straightforward for our clients. We recommend that you begin exploring this process as early as before the first therapy session or consultation.

Questions to ask your insurance company when inquiring about Out-of- Network Benefits:

- Does my plan cover out-of-network behavioral/mental health?
- What are my out-of-network mental health benefits?
- Do I have a deductible? If so, what is it?
- What is the coverage amount per therapy session?
- Is the amount paid to me based on the actual fee or based on what is considered reasonable and customary?
- How many therapy sessions does my plan cover?
- Is there a limit to my coverage?
- Is a referral required from my primary care physician?
- What information does The Riverwalk Group need to provide to receive reimbursement?

Tips to help with getting insurance reimbursement:

We recommend that you create a paper file for all your claims. Each time an invoice comes to you from The Riverwalk Group, you should print it, make a copy and attach it to a claim form from your insurance company. Keep a copy of the claim form and invoice and mark the date you sent it. We recommend that you fill out the necessary items in the health form and make multiple copies so that it is easily accessible and is simple to attach our invoice to it. Mail, scan or fax to your insurance company. If you have not heard from them in two weeks, call to confirm that they have received the claim. Additionally, make a copy of your insurance card to have in the file. Make sure you copy both the front and back of card.

Visiting Our Offices & Parking

All the Riverwalk Group Clinicians see patients at our location in Stamford Connecticut at the Phillips Mansion at 666 Glenbrook Road. The mansion sits in a complex called "Riverwalk" and is surrounded by townhouses. When you enter the parking lot, **please park in a space that says APG, Mansion or ES.** APG spaces are in front of the mansion, if you are facing the mansion, the spaces are to the right. There are additional spaces located in the back of the mansion as well. If you park in the back, you can walk up the steps to the front door or ask your clinician about using our back entrance.

Please **do not** park in spaces with numbers. These are for the residents that live in the townhouses. Additionally, please **do not** park in spaces that say M. Sank or any other name, as these belong to our neighbors and are for their staff and clients.

When you enter the front door of the mansion, head straight back through the foyer to the door on the right next to "The Riverwalk Group" sign. Once in our offices, head down hallway to the waiting room. Your clinician will come to get you at the time of our scheduled appointment. Feel free to help yourself to complimentary coffee, tea or water while you wait. As there are several consultation rooms next to the waiting area, we respectfully request that you keep conversations to a minimum and allow the waiting area to be a quiet space.

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Payment Policies for The Riverwalk Group

The Riverwalk Group provides psychotherapy, yoga therapy, group therapy, workshops and programming. Payment is expected at the end of each session, unless other arrangements have been previously made.

The following options are available for payment (please check one you chose):

- ☐ Cash or Check at time of visit
- ☐ Credit card payment. Note: A service fee of 3.5% will be added for credit card transactions

I, _____(First and Last Name) have read the above policy and understand that payment is due at the end of each session by check, cash or credit card.

If payment is not received as mentioned above, then you have my permission to charge my credit card as written below and/or on file.

Signature: _____

Today's Date: _____

Name on Card: _____

Billing Address Credit Card: _____

_____

Type of Credit Card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

**Note: Information written here will be entered to a secure system that will store your credit card in a way that is encrypted and not accessible except under the appropriate circumstances to make a payment. This paper will be destroyed after this information is transferred. The credit card information is NOT stored anywhere in our offices.*

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Notice of Patient Privacy Practices and Rights

Limits of Confidentiality

The confidentiality of your personal health information is very important to us. Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. If you have any questions or concerns, please feel free to discuss with your clinician. It is important to us that you understand this privacy notice and its clinical implications.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18) **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received/reviewed and/or read the HIPAA Notice of Privacy Practices including the Limits of Confidentiality.

Signature of patient or Representative	Printed Name	Date

If personal representative's signature appears above, please describe Personal Representative's relationship to the patient.

Witness	Printed Name	Date