

Elaine F. Mateo, M.D.
Confidential Patient Information

Patient Name: _____
Date of Birth: _____ Age: _____
Home Address: (No PO box #s) _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Cell Phone: _____
Work Telephone: _____
At what number(s) may we leave a message? _____
Emergency Contact (Name and Phone): _____
Marital Status: _____ Occupation: _____
Employer: _____
Employer Address: _____
Referred by: _____

Billing Information

Person responsible for payment: _____
Address (include city/state/zip): _____
Home Telephone: _____ Work Telephone: _____
Cell Phone: _____

If a minor:

Parent's marital status: _____

Mother's Name: _____ Employer: _____
Home Address: _____
Home Telephone: _____ Work Phone: _____
Cell Phone: _____

Father's Name: _____ Employer: _____
Home Address: _____
Home Telephone: _____ Work Phone: _____
Cell Phone: _____

Minor's School: _____
Address: _____
Phone: _____

Consent for Treatment

I HEARBY AUTHORIZE AND VOLUNTARILY CONSENT FOR Dr. Elaine Mateo TO PROVIDE PSYCHIATRIC SERVICES CONSIDERED REASONABLY NECESSARY FOR MYSELF AND/OR MY MINOR CHILD.

I HAVE READ THE ABOVE AND PROVIDED THE INFORMATION TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

Signature Patient/Parent/Guardian

Date

Printed Name

Elaine F. Mateo, M.D.
Outpatient Services Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and make a note of any questions that you may have so that we can discuss them during our meeting.

Meetings

My normal practice is to conduct an evaluation which will last from 2 to 4 sessions. By the end of this evaluation I will be able to offer you some initial impressions of what our work will include and an initial treatment plan, if you decide to continue. During this time, we can both decide whether I am the best person to provide the services which you need in order to meet your treatment objectives. You should evaluate this information along with your own assessment about whether I am a person with whom you feel comfortable working with. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have any questions about my appropriateness, we should discuss them whenever they arise. If your doubt persists, I will be happy to help you secure an appropriate consultation with another mental health professional.

If psychotherapy is initiated, I will usually schedule one 50 minute session per week at a mutually agreed time. Once this appointment hour is scheduled, you will be expected to pay for it unless you provide **24 hours** in advance notice of cancellation (or unless we **both** agree that you were unable to attend due to circumstances which were beyond your control). If it is possible, I will try to find another time to reschedule the appointment.

Should our work involve medication monitoring, it is expected that you will continue psychotherapy until such time as we all agree it is no longer needed. Medication monitoring appointments last 30 or 50 minutes.

Professional Fees

Initial assessment (child) \$225 first hour, \$175 each subsequent hour

Initial assessment (adult, 90 minutes) \$285

Individual Psychotherapy with or without medication management

Adults(50 mins.) \$160

Children and Adolescents(60 mins.) \$175

Medication Management (20 -30 mins.) \$110

Family Therapy with or without patient present (60 mins.) \$210.00

Returned Check Fee \$30.00

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require such as letter writing, telephone conversations which last longer than 10 minutes, attendance to meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other service.

You will be expected to pay for each session at the time it is held, unless we agree otherwise.

Initials_____

Insurance Reimbursement

I do not file insurance claims from my office; you will have to file the claim directly with your insurance carrier. In order for us to set realistic goals and priorities, it is important to evaluate what resources are available to pay for your treatment. At each visit, I will provide you a statement of services that contains all the information you need to file the claim.

You, and not your insurance company, are responsible for full payment of the fee which we have agreed to. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers. If you have questions, you should call your insurance carrier to inquire about out-patient mental health services.

Contacting Me

I am often not immediately available by telephone. I am unable to take calls when I am with a patient. When I am unavailable, my telephone is answered by our office manager or by automatic voicemail which I monitor frequently. I will make every effort to return your call on the same day you make it with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available.

If you are having an emergency and feel you cannot wait for me to return your call, you should dial 911 or go to the nearest hospital and ask for the psychiatrist on call. As soon as you are able, you should contact me through the answering service to let me know what has taken place.

If you are calling after 5pm on weekdays or on the weekend **and** you absolutely need to speak to me before the next business day, you may contact me via the answering service. **The telephone number to the answering service is (770) 928-5044.**

If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact during my absence if necessary.

Prescriptions

You will receive prescriptions for an adequate supply of medication to last until your next appointment. As per government regulations, controlled substances such as Ritalin, Concerta, Focalin, Metadate, Dexedrine, and Adderall, Daytrana, and Vyvanse cannot be refilled and only a 30 day supply can be given at one time. This means that I am not able to give refills or call in prescriptions for these medications. **ALLOW 48 HOURS TO PROCESS PRESCRIPTION REQUESTS .**

Cancellation Policy

The scheduled appointment time is reserved exclusively for you. Therefore, if you must cancel your appointment, you have to give **24 hours** notice. Otherwise, you will incur a charge for the appointment as if it had taken place and for the amount of the scheduled appointment. **Monday appointments must be canceled by no later than 12pm on Friday in order to avoid a charge.**

Initials_____

I look forward to working with you.

Elaine F. Mateo, M.D.

PROFESSIONAL SERVICES FEE SCHEDULE

You will be expected to pay for each session at the time it is held, unless we agree otherwise.

The fee schedule is as follows:

Initial Assessment (child) \$225 for the first hour and \$175 each subsequent hour
Initial Assessment (90 minutes) \$285
Individual Psychotherapy with or without medication management (50 minutes) \$160.00
Medication Management (20 -30 mins.) \$110.00
Family Therapy with or without patient present (60 mins.) \$175.00
Returned Check Fee \$30.00
Prescriptions called in outside of business hours \$25

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require such as letter writing, telephone conversations which last longer than 10 minutes, attendance to meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other service.

Dr. Mateo

CHILD AND ADOLESCENT HISTORY FORM

Directions: Please complete this form as best you can. It will facilitate the evaluation process and provide a complete permanent record. Thank you.

Elaine F. Mateo, M.D.

Identifying Information:

Name of child/adolescent: _____

Address of child/adolescent: _____

Date of Birth: _____ Age: _____ Sex: _____

School: _____ Grade: _____

School Telephone: _____ Teacher: _____

Name of Father: _____ Home Phone: _____

Address of Father: _____

Work Phone: _____

Name of Mother: _____ Home Phone: _____

Address of Mother: _____

Work Phone: _____

Legal Guardian (if different from above): _____

Home Phone: _____

Work Phone: _____

Address of legal guardian: _____

Presenting Problems:

Please list and describe the primary issues which have caused you to seek a psychiatric evaluation for your child. Be as specific as possible as to the beginning of problems, possible reason(s) for problems and duration:

In your opinion, how specifically can I help your child with this/these problem(s)?

Past History:

Birth History

Were there any difficulties with the pregnancy, labor or delivery? If so, please describe the difficulties: _____

How much did you child weight at birth? _____

Was the pregnancy an unplanned pregnancy? Yes _____ No _____

Developmental History (as best you can remember):

Eating:

Problems such as colic, loss of weight, allergies, eating peculiarities, spitting, etc.

Yes _____ No _____

If yes, please elaborate: _____

Motor:

Sat up unassisted: _____

Crawled: _____

Walked without help: _____

Clumsy? Yes _____ No _____

If yes, please elaborate: _____

Social/Adaptive:

Age of spontaneous smile _____

Age used spoon _____

Age imitates parent's activities _____

Age of parallel play _____

Age fed self _____

Language:

Age said first word(s) _____
Age said full sentence _____
Stuttering Yes _____ No _____

Other: If your child has had or now has any of the following, explain below:

Body rocking: _____

Head banging: _____

Failure to thrive (lack of weight gain): _____

Sleep problems: _____

 Couldn't sleep through the night after 6 months: Yes _____ No _____

 If yes, explain: _____

Nightmares: (how often) _____

 Describe the nature of nightmares: _____

Insomnia: _____

Sleep walking: _____

Sleep talking: _____

Unusual fears: _____

Blank spells: _____

Tics: _____

Pica: _____

(eating inedible substances after age 2)

Hair pulling: _____

Bedwetting (after age 6) _____ Day? _____

 Night? _____ Frequency: _____

Soiling (after age 6): _____

Excessive daydreaming: _____

Learning disability: _____

Firesetting: _____

Hearing problems: _____

Visual problems: _____

Attention/ Concentration problems: _____

Medical History

Current or past medical problems (including surgeries, injuries to the head, food allergies). Where possible write approximate dates. _____

List current medications (dosages, times, and dates); include psychiatric medications.

List past medications (dosages, times, and dates); include psychiatric medications.

Psychiatric History

List any prior mental health contacts (counselors, therapists, psychologists) including approximate dates:

Has your child been hospitalized for psychiatric reasons? If so, describe reason, where, and when?

Has your child had psychological testing? If so, for what reason, where, when, and by whom?

School History

PRESCHOOL Where _____
 When _____
 Any difficulties? If so describe. _____

KINDERGARTEN Where _____
 When _____
 Any difficulties? If so describe. _____

PRIMARY Where _____
 When _____
 Any difficulties? If so describe. _____

SECONDARY Where _____
 When _____
 Any difficulties? If so describe. _____

HIGH SCHOOL Where _____
 When _____
 Any difficulties? If so describe. _____

Has your child repeated a grade? Yes _____ No _____
If so, give grade and reason for repeating? _____

List grades on last report card: _____

Social History

Does your child have any difficulty getting along with other children?

Yes _____ No _____

If so, please describe: _____

What are your child's major areas of interests/talents?

What does he/she like to do for fun? _____

Does he/she like sports? _____

Family History:

Father's name: _____ Age: _____

Educational background of father: _____

Occupation of father: _____

Mother's name: _____ Age: _____

Educational background of Mother: _____

Occupation of Mother: _____

Step-parent's name: _____

Types of relationship with step-parent: _____

Date of marriage of parents: _____

Has either parent been previously married? _____ If so, give

significant details. _____

If parents are divorced, give details as to their current marital status, parent's custody and contact with the children. _____

List the current members of the household (include names, ages, relationship).

Has anyone on either side of the family been hospitalized for emotional problems?

Yes _____ No _____ If yes, elaborate: _____

Has anyone on either side of the family had any of the following diseases?

If so, state relationship.

Learning disability _____

Mental retardation _____

Attention deficit/hyperactivity _____

Alcoholism _____

Drug abuse _____

Panic attacks _____

Depression _____

Bipolar disorder _____

Suicide _____

Schizophrenia _____

Delinquent/criminal/jail _____

Eating disorders _____

Tics _____

Other _____

Do any of these medical disorders run in your family? Check the appropriate box.

	Father	Mother	Father's Parents	Mother's Parents	Siblings
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name of person completing this form: _____

Relationship to patient: _____

Date completed: _____