Gerardo P. Sison, Jr., M.D. 34650 US Hwy. 19 North Suite 107 Palm Harbor, Florida 34684

IMPORTANT MESSAGE

Please note that if paperwork is not completed at the time of your appointment, the office may need to reschedule your appointment to another time. Please understand that each appointment is scheduled to give everyone appropriate time with the doctor and delay due to tardiness to your appointment time is unfair to the next patient. If you have any questions regarding completion of these forms prior to your appointment, please call the office 24 hours or sooner before your appointed time.

Gerardo P. Sison, Jr., M.D., P.A.

34650 US Hwy. 19 North Suite #107 Palm Harbor, Florida 34684

Please complete the attached forms and return to us at the time of your first visit along with your health insurance card and a photo ID.

DATE OF VISIST	TIME
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Most misunderstandings about your insurance coverage can be avoided if you understand what your policy provides. Many insurance policies pay according to a schedule of benefits that is based on various criterions and may have different criteria for behavioral and mental health. Please verify this information with your insurance company prior to your initial visit.

PLEASE GIVE 24-48 HOUR NOTICE TO CANCEL OR RESCHEDULE A NEW PATIENT APPOINTMENT.

In order for you to receive the best quality of treatment, we recommend that you leave small children at home; unless they are the patient.

If you have any questions before or after your appointment, please do not hesitate to contact us at (727) 787-3422 during normal office hours.

DIRECTIONS TO THE OFFICE: We are located on US HWY 19 North, between Alderman Road and Nebraska Avenue, in a 3-story white building (IMA Medical Group Building.)

We are the driveway before Beacon Grove Subdivision if you are heading south on US Hwy 19.

LANDMARKS NEAR US: We are next to the Fountains Shopping Plaza where Tiffany's Restaurant and the Wing House are located.

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical benefits to which I am entitles to Gerardo P. Sison, Jr., M.D. This assignment is to be considered as valid as an original. As a courtesy, I understand that medical claims to my insurance company are being filed on my behalf. I also understand that I am responsible for all unpaid balances of covered expenses, co-payments, or deductibles. Any request for reports to outside agencies are subject to a minimum of \$50.00 fee to be paid by the patient prior to report being sent.

Patient/Parent/Legal Guardian's Signature	Date

OFFICE FINANCIAL POLICY

You are responsible for all expenses incurred as part of your treatment. While my staff will assist you in filing for your insurance claims, payment is expected at time of service. If you belong to a managed care network, your insurance claims will be filed for you. Co-payments, non-covered services, and deductibles remain your responsibility and must be paid when services are rendered.

To aid in the billing process, please provide my staff with accurate information about your insurance carrier as well as your ID number. Please have you insurance card available at the time of visit. You are responsible for the balance remaining after payment from insurance company is received or if payment is not received from the insurance company in a reasonable amount of time.

A 24-hour notice is required for cancellation of appointment. A fee of \$25.00 will be charged for those who cancel less than 24 hours or do not show up for their scheduled appointment.

I acknowledge that I have read and understood the office financial po	olicy
for Gerardo P. Sison, Jr., M.D.	

Patient/Parent Signature or Guardian	Date

Gerardo P. Sison, Jr., M.D. 34650 US Hwy. 19 North Suite 107 Palm Harbor, Florida 34684

FEE SCHEDULE:

Parent/Guardian Signature

Patient's Signature	Date
I have read, understood, and agree to the above	e fees.
*\$95 Disability and/or FMLA Form prepara	ation (3-4 pages)
*\$50 Disability and/or FMLA form prepara	ation (1-2 pages)
* \$25 No show or late cancellation fee	90
* \$35 Return Check fee for checks greate	r than \$50 but less than \$300.00
* \$25 Return Check fee for checks of \$49.	.00 or less
This is not a comprehensive list of all fees in this current fees prior to authorizing any service that company. Please initial EACH item.	-

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

Ι,	•		, for the pur	pose of coordin	ating
I,(Patient Name - Print)	(Patient d.o.b.)	(Patient Social Sec	urity #)	•	Ü
care, authorize Gerardo P. Sis	on Jr. M.D. "	release informa	ation indicated in the "Con	sent" portion of	this form to
(Provider Name – Pri		Tolouse inform		portion of	uns form to.
2227					
PCP Name:					
PCP Phone:		PCP Fax:		and a special distance	
PCP Address:					
(Street)		(City)	(State)	(Zip))
	In	formation For	PCP:		
The patient was seen by me on (date	e):	for (Diagnos	is):		
Treatment Plan :		·····			
•		or Psychiatrists O			
The following medication(s) was/will be	started: (list medi	cations and dosage	c)		
Medication was not indicated	Patient refused med	licationPsych	notherapy suggested before tr	ying med.	
I recommend the following medical	intervention by PC	P before initiating	medications:		
Medical work-up for:		•			
	•				
Lab tests for: CBC Other:			anel EKG		
			or if you need any other info	rmation.	
		P. Sison Jr.			
(Provider signature)		Printed Name)		(Licensure)	
		CONORNA			
I, the undersigned, understand that I may	ravoka this consan	CONSENT	nt to the extent that action has	heen taken in reli	ianca unon it
and that in any event this consent shall en understand the above information and gi	xpire six (6) months	from the date of	signature, unless another date		
Patient please check <u>one</u> : () To release any applicable mental h	aalth/cuhctance ahi	see information to	my primary care physician		
() To release only medication inform			my primary care physician.		
() I do not give my consent to releas	ing any informatio	n to my primary c	are physician.		
Patient Signature (Patients over 18)	(Date)	Parent/Guardian S	gnature (Patients under 18)	(Date	:)
Witness	(Date)				
. r terreas	(Date)				
Notice To Recipient Of This Information:	This information has b	een disclosed to you	from records which are protected	d by federal (42 CFR	Part 2) and

state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

PROVIDER: Please Send a Copy of this Signed Form to the Primary Care Physician and Keep the Original in the Patient's Treatment Record

DATE		
NAME:		
PAST MEDICATIONS	DOSAGE	SIDE-EFFECTS
	1	
*********	*******	*******
CURRENT MEDICATIONS	DOSAGE	

:

Gerardo P. Sison, Jr., M.D. Child, Adolescent, and Adult Psychiatry

Patient's Last Name	First	First		
Address	City	7 State	ZIP	
	D. CD: 4			
Home Telephone	Date of Birth		Social Security No	
Marital StatusSN	<u></u>	Male or	Female	
Driver's License #		State of	*	
Employer		_ Work Phone:	,	
Address				
in case of emergency, contact				
at telephone#	R	elationship to patie	nt	
Who referred you to this office	?	,		
Name of Insurance Company_			**************************************	
Policy Number	G	roup Number		
Policy Number(PLEASE PRESENT	YOUR INSURANCE CA	RD AND DRIVE	R'S LICENSE)	
You are required to obtain	the first authorization num	ber from your insu	rance company:	
Name of Policy Holder	Date of Birth	Relations	hip to Patient	
Social Security 1	Number of Policy Holder			

CO-PAYMENTS AND/OR DEDUCTIBLES ARE DUE AT TIME OF EACH VISIT

CHILD INFORMATION FORM

This	form completed by	Date
Rela	tionship to child	
Α.	Identification data	
		Sex Race
		Current age years months
		Relationship to child
		Phone
		surance (including Medicaid)? Yes No
		Extent of psychiatric coverage
	Name of insurance company	
	Who referred you to our clinic?	
	vino referred you to our chine.	Name
	y.	- N
	Address	Phone
В.	Family composition	
		Yes _ No _) (Is he living with child? Yes _ No _)
		Age
	Occupation	Work hours
		Work phone
		chool Religion
		other Any other marriages? Yes No
		riages? Yes No Number
		3
	2. Natural mother (Is she living)	Yes _ No _) (Is she living with child? Yes _ No _)
		Age
	Address	
		Work hours
		Work phone
		chool Religion
	Any other marriages? Yes	
		riages? Yes No Number
	Any children from other man	11agus: 10s 110 11amou
	2 Are child's natural nares	nts currently living together? Yes No
		Child's age
		Child's age
	b. date of divorce	Omic suge
	4. Siblings (Please list here child	's full brothers and sisters only)
	Name Date of b	
	Name Date of t	

	How long have these prob Have you sought previou If yes, name	as help for these pro	blems? N	o Ye date date	s —— ———
F.	1. What concerns you ab				
E.	Child's school Teach	ner(s)			
	Last complete checkup _	Name	Outcome _	Add	dress
D.	Apartment	Subi	urban		
	4. Home setting. (Check	any that apply)		-	up to eniid
	3. Other children presen	atly living in the chief the of birth Age	ild's current Sex	home (if not Relationsh	,
	2. Adults living in child' Name Ag		er than natur lationship to		g with child) ccupation

.

	Child's medical history			
	2. Did mother have medical prob- lems during pregnancy? (For ex- ample, bleeding, infections, high blood pressure, high blood sugar, convulsions, large weight	No	Hospital Yes	Describe
	gain, operations, X-rays, hospitalization, etc.)			
	3. Did mother take medications during pregnancy?			
	4. Did mother or father drink much alcohol during preg- nancy?	-		
	5. Did mother have other prob- lems during pregnancy? (For example, problems with spouse, job, money, or living arrange- ments, etc.)		r	
	 Did mother or child have prob- lems during labor or delivery? (For example, prolonged bleed- ing, etc.) 			
	7. Was child born premature?			-
	8. Birthweight: pounds ounces			
	9. Did child have problems during newborn period? (For example, yellow jaundice or blue colored, difficulty feeding, seizures, in- fections, or birth defects, etc.)			
1	10. Was child difficult to care for as a baby?			
	11. Has child had any severe illnesses?	_		-
	Illness Age	Treat	ment	Doctor

			No	Yes	Describe	
12	. Has child had repeated m					
	problems? (For example					A ====
	aches, infection, or heada	iches)				Ages
						3***
13	. Has child had any operat	ions?				0
						Age
14	Has child had any serious dents or injuries? (Espe head injury or uncons ness)?	cially				Age Age
15	. Has child been prescrib					
	medication for behavior	prob-				
	lems? Type	Date	Doc	tor	Resul	t
	-) P ·				_	
				-		
			No	Yes		
16	. Is child on medication no					
	Туре	Dose	Its p	ourpose	Its eff	ect
17	To shild allows to any m	adias	No	Yes	Describe	
17	. Is child allergic to any m tion?	ledica-				
18	Does child have any	other				
	allergies?				•	
19	. Is there anything else	about				
	your child's health that	t con-				
	cerns you?					
						,
	hild's developmental history Did you notice any prowith your child's develop	oblems				
2	2. Did your child have any culty in any of the foll areas (for example, were	lowing				

		No	Yes	Describe
	these areas especially hard for			
	the child or was the child slower			
	SERVICE BREEZE SHE SEE			
	to do them than you would			
	expect?)			
	 a. Walking alone 	-	93 	
	b. Saying words	1	100000000000000000000000000000000000000	
	c. Speaking phrases			
	d. Bowel training			
	e. Bladder training	-		
	f. Dry at night			
	g. Writing alphabet			
	h. Reading words			
	training visit			
	 Riding a bicycle 	-	-	
	j. Tying shoelaces		-	
	3. While your child was growing			
	up, did you notice any difficul-			
	ties in the following areas?			
	entra de la companya			
	a. Discipline		(Andreas and Andreas	
	b. Temper tantrums, fighting			
	c. Moods			-
	d. Relationships with others			
	e. Sex play			
	f. School problems			
	(30)			
	g. Other behavior problems			
	h. Has raising your child pre-			
	sented many difficulties?			
I.	The child's temperament			
	1. Is your child overactive?			
	1. 15 / 041 011112 0 0 0 1 0 0 1			
	0 D			
	2. Does your child have trouble			12
	paying attention?			
				•
	3. Does your child have trouble			
	staying with one activity - jump-			
	ing around from one thing to			
	another or failing to finish			
	things?			
	4. Does your child fluctuate from			
	happy to sad quickly with little			
	5 5			
	apparent cause?			
	Does your child get frustrated			
	easily?			

6 Dans 131	140	i es	Describe
6. Does your child get upset by abrupt changes in his or her life?	-		
7. Are your child's emotional responses generally unpredictable?			
8. Does it take your child a long time to warm up to a new situation or people?			
9. Does your child react strongly to physical pain?			
10. Does your child react strongly to things?	_		
Child's family history			
Has anyone in the family had the following? 1. Neurological disease, such as	No	Yes	Describe who
seizures, fits, weaknesses, etc.	-	WARE A	
 Medical disease, such as dia- betes, thyroid disease, heart dis- ease, etc. 			
3. Mental illness, such as schizo- phrenia, manic-depressive dis-			
ease, depression, etc.		-	
4. Mental retardation			
5. Learning problems			
6. Behavior problems			
7. Excessive use of alcohol		-	
8. Excessive use of drugs			
9. Trouble with the law			
10. Trouble holding a job			

J.

K.	Current living situation 1. Does your present marriage dissatisfy you?	No	Yes	Describe				
	2. Does your present work situation dissatisfy you?							
	3. Do your present living cir- cumstances dissatisfy you?	-						
	4. Has anyone else in your family seen a psychologist, psychiatrist, or other mental-health worker?							
	5. Have there been recent major changes or stresses in your living situation or family?		F					
L.	Summary: 1. Do you have any ideas about why	your chil	d is havin	g behavior problems now?				
	2. What are your child's strengths?							
	3. Is there anything else we should know about your child or his or her life? No Yes							
	If yes, describe:							

PARENT SYMPTOM QUESTIONNAIRE

OFFICE	USE
Patient No).
Study No.	****

Name of Child			_ Date	
Your Name		Rela	ationship	
I. Instructions: Listed below are items concerning childred times have. Read each item carefully and decide in bothered by this problem during the past month—I MUCH, or VERY MUCH indicate your choice by placing a check mark (/) in the item.	ow much y NOT AT AL	ou Unink y L, JUST /	our child A LITTLE,	hás beer PRETTY
ANSWER ALL ITEMS	-			
Observation	Not at all	Just a littlo	Pretty much	Very much
PROBLEMS OF EATING .				
Picky and linicky				
2. Will not eat enough				
3. Overweight	and the same of th			
PROBLEMS OF SLEEP				
4. Restless				
5. Nightmares				
6. Awakens at night				
7. Cannot fall asleep				
FEAR AND WORRIES				
8. Alraid of new situations				
9. Afraid of people		•		
10. Alraid of being alone		•		
11. Worries about illness and death				
MUSCULAR TENSION				
12. Gets stiff and rigid		*		
13. Twilches, jerks, etc.				
14. Shakes				
SPEECH PROBLEMS				
15. Stuttering				
16. Hard to understand				

PARENT SYMPTOM QUESTIONAIRE¹ (Continued)

OFFICE USE
Patient No.
Study No.

Observation	Not at all	Just a little	Pretty much	Very much
WETTING				
17. Bed wetting				
18. Runs to bathroom constantly				
BOWEL PROBLEMS				
19. Solling self				
20. Holds back bowel movements				
COMPLAINS OF FOLLOWING SYMPTOMS EVEN THOUG DOCTOR CAN FIND NOTHING WRONG	H ,·	mod452 2		
21. Headaches				
22. Stomach aches				i
23. Vomiting				
24. Aches and pains				
25. Loose bowels				
PROBLEMS OF SUCKING, CHEWING, or PICKING	ā			
28. Sucks thumb			0.51	
27. Bites or picks nails				
28. Chews on clothes, blankets, or other items				
29. Picks at things such as hair, clothing, etc.				
CHILDISH OR IMMATURE				
30. Does not act his age				
31. Cries easily				d
32. Wants help doing things he should do alone				
33. Clings to parents or other adults				
34. Baby talk				

PARENT SYMPTOM QUESTIONAIRE1 (Continued)

OFFICE USE
Patient No.
Study No.

Observation	Not at all	Just a little	Pretty much	Very
TROUBLE WITH FEELINGS				
35. Keeps anger to himself		T T		
36. Lets himself get pushed around by other children		 		
37. Unhappy				
38. Carries a chip on his shoulder				
OVER-ASSERTS HIMSELF				
39. Bullying				
40. Bragging and boasting				
41. Sassy to grown-ups				
PROBLEMS MAKING FRIENDS	•			
42. Shy				
43. Afraid they do not like him				
44. Feelings easily hurt				•
45. Has no friends				
PROBLEMS WITH BROTHERS AND SISTERS				
46. Feels cheated				
47. Mean				
48. Fights constantly				
PROBLEMS KEEPING FRIENDS		•		
49. Disturbs other children				
50. Wants to run things				
51. Picks on other children		-		
RESTLESS				
52. Restless or over active				
53. Excitable, impulsive	-			
54. Fails to finish things he starts—short attention span				<u>,</u>

PARENT SYMPTOM QUESTIONAIRE¹ (Continued)

OFFICE USE	
Patient No.	_
Study No.	

Observation	Not at all	Just a little	Pretty much	Very much
TEMPER				
55. Temper outbursts, explosive and unpredictable behavior				
56. Throws himself around				
57. Throws and breaks things				
58. Pouts and sulks	•			
SEX	•			
59. Plays with own sex organs				
60. Involved in sex play with others	1			
61. Modest about his body	<u>.</u>		<u> </u>	
PROBLEMS IN SCHOOL				
62. Is not learning				
63. Does not like to go to school				
64. Is afraid to go to school				
65. Daydreams				
66. Truancy				
67. Will not obey school rules			-	
LYING				
68. Denies having done wrong				
69. Blames others for his mistakes				
70. Tells stories which did not happen				
STEALING				
71. From parents				
72. At school			:	
73. From stores and other places				
FIRE-SETTING		~,~		·
74. Sets fires				

PARENT SYMPTOM QUESTIONNAIRE1

OFFICE USE
Patient No.
Study No.

Observation	Not at all	Just a little	Pretty much	Very much
TROUBLE WITH POLICE				
75. Gets into trouble with police				
Why?	 		1	.
PERFECTIONISM				
76. Everything must be just so				
77. Things must be done same way every time				
78. Sets goals too high				
ADDITIONAL PROBLEMS				
79. Inattentive, easily distracted]
80. Constantly fidgeting				
81. Cannot be left alone .				
82. Always climbing				
83. A very early riser				
84. Will run around between mouthfuls at meals				
85. Demands must be met immediately—easily frustrated				
86. Cannot stand too much excitement				
87. Laces and zippers are always open				
88. Cries often and easily				
89. Unable to stop a repetitive activity				
90. Acts as if driven by a motor				
91. Mood changes quickly and drastically				
92. Poorly aware of surroundings or time of day				

PARENT SYMPTOM QUESTIONNAIRE1 (continued)

OFFICE USI	Ξ
Patient No.	:
Study No.	

MINOVIEW ALL HEIVIS	R ALL ITEMS	ANSWER
---------------------	-------------	--------

	Not at all	Just a little	Pretty much	Very much
ur child has at t	nis time?		· · · · · · · · · · · · · · · · · · ·	
		at all	at all a little	at all a little much

your child has by placing a circle around the number (1-93) of those items.

PARENTS' RATING SCALE

Patient's Name		Date	Physicia	n
To be filled out by the mothe Instructions: Listed below are sometimes have your child was 10 years old. Rathat describes your child was that the child was the child was that the child was that the child was that the child was th	r of the subject (of the subject (of the subject) items concerning the subject of	or father only if ng children's be n carefully and se problems wh the problem by	mother is unava havior and the p decide how mu en he/she was b	ailable). problems they uch you think between 6 and
	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
Restless (overactive)				
2. Excitable, impulsive				
3. Disturbs other children				
 Fails to finish things started (short attention span) 	•			
5. Fidgeting				
6. Inattentive, distractible				
 Demand must be met immediately gets frustrated 	;			
8. Cries				
9. Mood changes quickly				
O. Temper outbursts (explosive and unpredictable behavior)				

INFORMED CONSENT AND AUTHORIZATION TO RELEASE OR RECEIPT OF INFORMATION

THE UNDERSIGNED PATIENT OR LEGAL REPRESENTATIVE OF THE PATIENT, HEREBY AUTHORIZES THE RECEIPT OF RELEASE OF THE INFORMATION SPECIFIED BELOW TO THE FOLLOWING PHYSICIAN OR MENTAL HEALTH PROFESSIONAL PURSUANT TO FLORIDA STATUES 90.42, 490.32, 90.503, 456.16, 458.21 AND 394.459 (B), 381.609 (2) (F), 396.112, 397.053 AND FEDERAL LAW 42. I UNDERSTAND THAT MY RECORDS HAVE A PRIVILEGED AND CONFIDENTIAL STATUS. I AM WAIVING THAT STATUS FOR THE PURPOSE CONTAINED WITHIN THIS AUTHORIZATION.

RELEASE TO FROM			
ADDRESS	CITY	STAT	E ZIP
RELEASE TO: GERARDO P. SISON, J FRON: 34650 U.S. 19 NORTH	R., M.D. CHILD, ADOL #107 PALM HARBOR, F RMATION TO BE RELEA	LORIDA 34684 F	(727) 787-3422 (727) 787-5624
MEDICAL / PHARMACOLOGICAL PSYCHIATRIC EVALUATION HOSPITAL DISCHARGE SUMMARY	PSYCHOLOGICAL TE HOSPITAL ADMISSIC OTHER:	N PSYCHIATRIC	
INFORMATION CONCERNING AIDS, I RELATED COMPLEX AND THE PERFO AND TREATMENT THEREOF IS / IS N	ORMANCE OF ANY TES	TS, COUNSELIN	
A GENERAL MEDICAL AUTHORIZAT AUTHORIZATION TO RELEASE PSYC PATIENT OR LEGAL REPRESENTATI	HIATRIC INFORMATIO		147.0147. 74.14. 14.17.17.11.11. 17.14.14.14.11.
PROHIBITION ON RE-DISCLOSURE: T RECORDS WHO CONFIDENTIALITY I ANY FURTHER RE-DISCLOSURE FRO	F PROTECTED BE FEDI	ERAL REGULAT	ION (42 CFR PART 2) AND
THIS CONSENT IS SUBJECT TO REVONOTIFICATION BUT WILL HAVE NOTIFICATION BUT WILL HAVE NOTIFICATION ACCOUNTING DISCLAREFUSE TO SIGN THIS AUTHORIZATION THE RELEASE OF THE INFORMATION TH	EFFECT OR ACTION AI OSURE. I FURTHER UN ION AND THAT THE PH RELEASED FROM ALL	READY TAKEN IDERSTAND THA IYSICIAN OR ME	. THIS AUTHORIZATION AT I HAVE RIGHT TO ENTAL HEALTH
PATIENT'S NAME:			
SOCIAL SECURITY OF PATIENT:		_ DATE OF BIR	TH
SIGNATURE OF PATIENT OR LEGAL	REPRESENTATIVE		
WITNESS:	INFORMATION	RELEASE BY:_	

TODAY'S DATE