

Arnold G. Shapiro, M.D.

1717 Dixie Highway
Lookout Corporate Building, Suite 200
Ft. Wright, Kentucky 41011
(859) 341-7453

8280 Montgomery Road
Kenwood Commons, Suite 304
Cincinnati, Ohio 45236
(513) 794-8777

DIPLOMATE AMERICAN BOARD OF
PSYCHIATRY AND NEUROLOGY

CHILD-ADOLESCENT-ADULT
PSYCHIATRY

Date: _____

Dear Parent or Guardian:

Prior to your first appointment at our office we have sent you this packet. This has been divided up into four sections for your convenience.

SECTION 1: Enclosed you will find material containing information about the procedures involved in a psychiatric evaluation as well as our office policies. Please read this carefully.

SECTION 2: The next set of materials is new patient information forms. Two of the forms are regarding basic information about you and a consent form for your insurance company. It is important that these forms be filled out completely and signed in order for us to efficiently file with your insurance company. There is also another consent form that allows Dr. Shapiro and his employees to receive and give information to the child's physician and school. All of these forms must be completed and returned to our office at your first appointment.

SECTION 3: These forms are questionnaires about your child. These forms should also be filled out completely and returned to the office. Some of the questions may appear redundant but this is done to ensure a comprehensive and thorough evaluation to best meet your child's needs. (There are a total of four of these forms plus a Conners' Parent Rating Scale.)

SECTION 4: The final set of materials begins with a cover letter to your child's school personnel. Please have the school fill them out carefully and return them to you or have the school mail/fax them to our office directly. These forms must be finished and returned to our office prior to the second visit and at the latest before the third visit. We hope this letter helps you understand what to do with the materials in this packet. If you have any questions, please feel free to call us.

Offices of Dr. Arnold G. Shapiro

SECTION I:
Information for Patients and Their Families

Arnold G. Shapiro, M.D. would like to provide you with information that will contribute to a successful treatment experience for your family. Please keep this information for future reference.

What Should I Expect?

The first three meetings are a comprehensive evaluation. By the end of the third meeting, you and Dr. Shapiro will be deciding if your child will be treated in this office. The evaluation is a comprehensive psychiatric evaluation taking into consideration your child's medical, social, emotional, developmental and educational needs. Initially, a licensed therapist will meet you to perform a two session evaluation — one session with the parent(s) and one with the child. Information is also collected from the school with parental consent. Dr. Shapiro and the therapist discuss and comprehensively evaluate all the information. This assists the doctor in his understanding and diagnosis of your child. This also facilitates the development of the best possible treatment plan. The treatment plan will be presented to the parent(s) and the child in the third session with Dr. Shapiro.

Dr. Shapiro is a board certified psychiatrist who specializes in children, and the therapists are licensed in their respective professions.

Three Session Patient Evaluation

The first session is held with the parent(s) alone for 1 (one) hour. Please bring the following:

The completed Child Psychiatry Questionnaire for Parent(s)

A picture of your child.

The completed Patient Information Forms

The second session is held with the child alone for 1 (one) hour. The accompanying parent enters the second session for the last 15 minutes to review the general progress of the session and to ask or clarify any further questions.

The third session is held with Dr. Shapiro, the parent(s) and the child. At the session, the diagnosis, treatment and recommendations are discussed. This session will last approximately 1 (one) hour.

Medication

If medication would be beneficial to the ongoing therapy, Dr. Shapiro will discuss the hoped for benefits and possible side effects with the family. If the family agrees, medication may be added to the treatment.

If medication is prescribed, Dr. Shapiro will monitor your child to provide the type and dosage of medication to effectively treat your child's symptoms. You will have, at the minimum, monthly 10 to 15 minute office visits with Dr. Shapiro for medication evaluation and to receive any refills. More frequent or longer visits can be set up as indicated or as requested by the family. You are encouraged to discuss your child's medication or any aspect of your child's treatment during the medication check visits with Dr. Shapiro or therapy visits. The information is discussed between Dr. Shapiro and the therapists.

Treatment

Dr. Shapiro and the staff develop a treatment plan, which is presented to the parent(s) and child at the third session of the evaluation. Treatment plans vary depending on the presenting problems and clinical indicators necessary for the reduction or elimination of the symptoms. It is typical that a recommendation for weekly therapy be utilized as a part of the overall treatment plan. The duration is usually four to six months of weekly therapy. Once the situation has improved, frequency of appointments can be lessened to every other week and eventually once a month, until therapy ends. Therapy is provided by a licensed therapist under the supervision of Dr. Shapiro.

Location of Offices

One office is located at the Lookout Corporate Center on 1717 Dixie Highway, Ft. Wright, Kentucky. The other office is located at the Kenwood Commons at 8280 Montgomery Road, Cincinnati, Ohio.

Hours

The office can be reached by phone Monday through Thursday from 9 a.m. to 6 p.m. On Friday we are open from 9 am to 12 pm. Dr. Shapiro and the therapists can be reached after office hours by calling the office phone number and leaving a message on their individual voice mail.

Please reserve after hour calls for problems or questions that are urgent and cannot wait until the next appointment or the next business day.

Fees

The fees for Dr. Shapiro and his therapists are as follows:

- \$800 — Three session evaluation (\$300 for the first meeting, \$200 for the second meeting and \$300 for the third meeting)
- \$200 — 1 (one) hour therapy sessions
- \$125 — 30 minute therapy sessions
- \$175 — 15 minute medication evaluation with Dr. Shapiro

Longer sessions with Dr. Shapiro can be scheduled as requested by the parent(s) or as deemed necessary by Dr. Shapiro. Any sessions extending beyond these ranges will be charged proportionately. Time utilized for extended phone conversations with or about patients will be at the same rate as for a therapy session in the office.

Office Fee Policy

It is the office policy that all copayments are paid at the time of each session. If you have a deductible that needs to be met, you must pay the full session fee until the entire deductible is met.

We will try to determine what your copay will be before you come in for your first visit. This will be an estimate of your copay. It is important to remember that your insurance may not pay as much as we estimated, of course if the insurance company does not pay; you are responsible for the entire fee.

When it becomes necessary to use a collection agency to resolve a past due account, an additional 15% of your balance will be assessed to cover the costs of this action.

You must remember that you are ultimately responsible for your charges. Monthly statements from our office will be sent to keep you informed about your account.

Insurance

Most insurance companies reimburse 50% to 80% of the cost depending on the individual policy. No insurance plan covers "everything". There are always limitations and exclusions to coverage. Even with two or more insurance plans, there may be amounts or services not covered and for which the patient is responsible. Also, remember coverage is on the amount set by the insurance company. This set amount, usually referred to as the UCR, is usually lower than our current fee. This is a common coverage limitation. The patient portion of the payment is whatever the insurance does not cover. "Assignment" simply means the patient requests insurance payment be made directly to

the physician. This is not payment in full. The patient is responsible for the designated balance. Insurance filing requires a medical diagnosis for each procedure. Your plan may exclude certain diagnoses and, if so, you will be responsible for the charges. We recommend that you contact your employer or insurance company to verify the amount and extent of your coverage.

Precertification: Some insurance require treatment plans or contact from your therapist and/or doctor to precertify further treatment. It is your responsibility to know this and keep track of the services you receive from the office and to alert your therapist and/or doctor and/or office manager at least two weeks prior to the time that the precertification service is needed. For example, if you need a precertification after five sessions it would be wise to discuss this policy with your therapist and/or doctor after session four to determine whether or not a precertification is warranted. If you do not do this and return for a sixth session, you will likely be financially responsible for that session.

We will file your insurance claims directly for office visits as a service we provide for you, however, the agreement of the insurance carrier to pay for medical care is a contract between you and the carrier and you should direct any questions or complaints regarding coverage to your insurance carrier. Our strongest recommendation is that if you choose to utilize insurance to pay for office visits, stay well informed regarding your policy. We will do what we can to assist you with this, but ultimately it is your responsibility.

Insurance payment made to the office will be credited to your account and any overpayment will be promptly refunded to the appropriate party.

Late Cancellation and No Shows

Patients are seen in the office by appointment only. It is the policy of the office to bill patients who cancel their appointment with less than 24 hours notice. While in treatment, all patients will be billed for scheduled sessions not canceled 24 hours prior to the appointment. If we can schedule another patient in a canceled scheduled session, there will be no charge. However, it is difficult to schedule another patient at short notice. If you do not attend a scheduled appointment and have not given 24 hours notice, you will be responsible to pay for that missed appointment in full. This is because the therapist or Dr. Shapiro would have been seeing another patient during that time. If you give 24 hours notice you will not be responsible for the time because that would give us a chance to schedule someone else in your place.

Please be aware that you will actually pay more, out of your pocket, if you do not attend the appointment than if you had attended. This situation exists because insurance companies will not reimburse for missed appointments, so you will pay the entire fee.

In the practice of psychiatry, advance notice of cancellation is especially important. For everyone's sake, attend scheduled appointments or cancel at least 24 hours before. Your consideration will be appreciated.

Your Billing Rights

This notice contains important information about your rights and our responsibilities under the Fair Credit Billing Act.

Please notify us in case of errors or questions regarding your bill.

If you think your bill is incorrect or you need additional information concerning a transaction on your bill, please write us in a separate letter at our address as soon as possible. We must hear from you no later than 60 days after sending you the first bill on which the error or problem appeared. You may telephone us, but doing so will not preserve your right.

In your letter, give us your name, account number, and dollar amount of the suspected error. Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item about which you are uncertain.

You do not have to pay any amount in question while we are investigating, but you are still obligated to pay the parts of your bill not in question. While we investigate your question, we cannot report you as delinquent or take any action to collect the amount you questioned.

Please call us at (859) 341-7453 or (513) 794-8777 if you have additional questions or concerns.

NOTICE OF PRIVACY PRACTICES

Arnold G. Shapiro, M.D.

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

This notice describes our Practice's policies, which extend to:

- 1) Any health care professional authorized to enter information into your chart (including physicians, LISW's, RN's, LPCC' s, etc)
- 2) All areas of the practice (front desk, administration, billing, collections, etc.)
- 3) All employees, staff and other personnel that work for or with our Practice
- 4) Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

The Practice provides this notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA),

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following right regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodian) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer, ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the interview will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend: If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- 1) Was not created by us, unless the person or entity that created the information is no longer available to make amendment;
- 2) Is not part of the medical information kept by or for the Practice;
- 3) Is not part of the information which you would be permitted to inspect and copy;
- or
- 4) Is inaccurate and incomplete

Worker's Compensation: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: Law or public policy may require us to disclose information about you for public health activities. These activities generally include the following:

- 1) To prevent or control disease, injury or disability;
- 2) To report births or deaths;
- 3) To report child abuse or neglect;
- 4) To report reactions to medications or problems with products;
- 5) To notify people of recalls of products they may be using;
- 6) To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- 7) To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities: We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. The activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court of administrative order. This is particularly true if you make your health an issue. We may disclose medical information about you in response to subpoena, discovery request or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- 1) In response to a court order, subpoena, warrant, summons or similar process;
- 2) To identify or locate a suspect, fugitive, material witness or missing person;
- 3) About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- 4) About a death we believe may be the result of criminal conduct and
- 5) About criminal conduct at the Practice.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. Your request must state a time period no longer than six years back and may not include dates before April 14, 2003 (or actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, or electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care (a family member or friend). For example, you could ask that we not disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree; we will comply with your request except that we shall not comply, even with a written request, if the information is exempted from the consent requirements or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you must indicate the following:

- 1) What information you want to limit;
- 2) Whether you want to limit our use, disclosure or both, and;
- 3) To whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc)

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Name: _____

Patient, Parent or Guardian's Signature: _____

Relationship to Patient: _____

Date: _____

Behavioral Health/Primary Care Physician/Patient care communication form

Patient name: _____ Date of birth: _____

Primary Care Physician: _____ Address _____

Behavioral health clinician: Dr. Arnold Shapiro 1717 Dixie Hwy Suite #200 Ft. Wright, KY 41011

AUTHORIZATION TO DISCLOSE INFORMATION

I understand that records or information about my mental health and drug abuse treatment and counseling are confidential; they are protected by applicable state and federal laws and cannot be re-disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that any information about me concerning AIDS, HIV and AIDS related complex and the performance of any tests, counseling and the results of treatment thereof cannot be released without my authorization. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 60 days from the date signed.

To patient: Please check option below: I, _____

A. _____ DO authorize any information on my care to be shared between the providers listed above to facilitate my treatment.

B. _____ Do authorize information on my care with the following limitations (circle any)

Medications only Information to primary care only

Other _____

C. _____ DO NOT authorize any information on my care to be shared between my behavioral health clinician and my primary care physician, names above, for the purpose of facilitating my treatment.

Signature of Parent/Guardian

Date

To be completed by Behavioral Health Clinician:

Diagnosis:

Treatment Plan:

Current Medications:

Comments:

Behavioral Health Clinician Signature: _____

ARNOLD G. SHAPIRO, M.D.

CHILD, ADOLESCENT & FAMILY PSYCHIATRY

Real hope, real help, for children & adolescents

EFFECTIVE TREATMENT FOR CHILDHOOD DISORDERS

& CONCERNS:

- ADHD
- Depression
- Oppositional, acting out & destructive behavior
- Fears, panic & separation anxiety
- Tourette's syndrome
- Obsessive-Compulsive behavior
- Neurological disorders
- Adjustment problems school & home
- Behavior & discipline concerns
- Issues related to remarriage, divorce, adoption, sibling

CONFIDENTIAL HELP FOR YOUNG PEOPLE & THEIR FAMILIES:

- Individual, marital & family psychotherapy
- Play therapy for young children
- Group psychotherapy
- Medication evaluation & titration
- Crisis intervention
- Forensic evaluation & consultation

OFFERING COMFORT & CONVENIENCE:

- Morning, evening & weekend hours
- Most insurance plans accepted
- Visa & MasterCard honored
- 24-hour on call for emergencies

ARNOLD G. SHAPIRO, MD
Specialist in Child Psychiatry
Board Certified - American Board
of Psychiatry & Neurology
Member: Academy of Child Psychiatry
American Psychiatric Association, Ohio
State Medical Association, Kentucky
State Medical Association, Academy of
Medicine (Cincinnati),
ADD Council Board Member,
CHADD Advisory Board Member
Diplomate: National Board of Medical
Examiners
MD: University of Rochester
School of Medicine; BA: Magna
cum Laude, Ashington University
Author/Lecturer/Consultant

8280 MONTGOMERY ROAD.
CINCINNATI, OH 45236
(513) 794-8777
FAX (513) 794-8779

Cancellation Policy

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a 24 hour notice. Due to our limited availability, appointments not cancelled within 24 hours will be considered a "No Show/Missed Appointment." In the event you miss three appointments in our office with your therapist, you will no longer be allowed to schedule any future therapy appointments. In the event you miss three appointments in our office with Dr. Shapiro, you will no longer be able to remain under our care. You will then need to find a new doctor and a new therapist. A copy of your records will be available for your new doctor once a release is signed in our office. Dr. Shapiro will only then be available for emergencies for 30 days after your last missed appointment. This policy will be strictly enforced. We sincerely hope you find a way to keep all of your scheduled appointments so this won't ever affect you.

I understand this policy and agree to this policy.

Patient Name: _____

Parent/Guardian Signature: _____

Date Signed: _____

SECTION 2:

Arnold G. Shapiro, M.D.

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 Lookout Corporate Building
 Ft. Wright, Kentucky 41011
 859-341-7453

8280 Montgomery Road, Suite 304
 Kenwood Commons
 Cincinnati, Ohio 45236
 513-794-8777

New Patient Information

Welcome To Our Office

Date: _____

Patient's Name (please print)	Goes By	Social Security Number	Birth Date	Age
Street Address	City and State	Zip Code	Home Phone #	
Patient's or Parent's Employer	Occupation (Indicate if student)	Business Phone #		
Employer's Street Address	City and State	Zip Code		
Drug Allergies, If Any				
Spouse or Parent's Name	Social Security Number	Birth Date		
Spouse or Parent's Employer	Occupation	Business Phone #		
Employer's Street Address	City and State	Zip Code		
<i>*Please Read: All charges are due at the time of services. Whoever seeks treatment in the office is ultimately responsible for payments.</i>				
Person Responsible for Payment	Street Address, City and State	Zip Code	Home Phone #	
Name of Insurance Company and Policy Holder Name	Date of Birth	ID #	Group #	
Second Insurance Company and Policy Holder Name and Date of Birth	ID#	Group #		

PATIENT'S AUTHORIZATION TO RELEASE
MEDICAL INFORMATION
AND
CLAIM PAYMENT AUTHORIZATION

I hereby authorize the physician(s) whose name(s) appear on this statement to release any information acquired in the course of examination, if needed, to the insurance company only. Also, to allow a photocopy of my signature to be used for the insurance company.

Signature of Patient, Parent or Guardian if minor: _____

Date: _____

I hereby claim health insurance benefits due me for services rendered by the physician(s) and associate(s), and authorize and direct my insurer to issue payment check(s) directly to the physician(s) and associate(s) named below.
Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

Date: _____

Signature of Patient, Parent or Guardian if minor

Arnold G. Shapiro, MD
Physician's Name

Arnold G. Shapiro, M.D.

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Cincinnati, Ohio 45236
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I give permission for Dr. Shapiro and his employees to send information to and to receive information from my Child's Physician.

Name of Patient: _____

Parent/Guardian's Signature: _____

Name of Physician: _____

Address: _____

Phone Number: _____

I give permission for Dr. Shapiro and his employees to obtain information from (by phone or writing) and to share information with my child's school personnel.

Name of Patient: _____

Parent/Guardian's Signature: _____

Name of School: _____

Primary Teacher: _____

Address: _____

Phone Number: _____

I give permission for Dr. Shapiro and his employees to provide treatment to my child, whom is under the age of 18 years.

Name of Patient: _____

Parent/Guardian Signature: _____

Date of Signature: _____

SECTION 3: FORM 1

Arnold G. Shapiro, M.D.

Child Psychiatry Questionnaire

1. IDENTIFYING DATA

Date: _____

Child's Name: _____
Last First Middle

Birth Date: _____ Age: _____ School and Grade: _____

Person filling out this form: _____

Who lives with the child? _____

	NAME (first and last)	RELATIONSHIP	AGE
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Others	_____	_____	_____
	_____	_____	_____

If biological father or mother does not live in house place here:

Address _____

Frequency of contact _____

How do they get along with the child? _____

Do they know the child is being seen? _____

FATHER

Last school grade completed? _____

Occupation _____

Work Hours _____

MOTHER

Last school grade completed? _____

Occupation _____

Work Hours _____

2. CHIEF CONCERN

What is your main concern about the child? The reason you brought him/her to the psychiatrist. Your understanding of the child's problem.

Did anyone refer you to the office? YES NO

Name _____

Address _____

Telephone Number _____

Their concerns? _____

3. PRESENT FUNCTIONS

SCHOOL

How is the child doing academically? (grades, homework, etc.) _____

How does the child get along with his/her teachers? _____

FAMILY

How does the child get along at home? _____

PEER RELATIONSHIPS

What does the child do after school? _____

What does the child do on weekends? _____

Does the child have friends? (Age, sex, what do they like to do together?) _____

4. PAST HISTORY

Have any members of this child's family or the biological parents' families had any of the following?

	Relationship to child	Age	When
Enuresis (bedwetting)	_____	_____	_____
Learning Difficulty	_____	_____	_____
Epilepsy (convulsions, fits, blackouts)	_____	_____	_____
Nervous Breakdown	_____	_____	_____
Psychiatric Care	_____	_____	_____
Psychological Testing	_____	_____	_____
Syphilis	_____	_____	_____
Mental Retardation	_____	_____	_____
Other	_____	_____	_____

Any difficulties during pregnancy? _____

Any difficulties during labor and delivery? _____

INFANCY

What type of baby was this child? (activity, temperament, sleep) _____

Did this child like to be held? _____

TODDLER

Age stood _____ Said words _____

Age walked _____ Said sentences _____

Did the child like to get into things and explore? _____

Did you have any concerns about the child's early years? Was the child's family under any unusual stress during these early years? _____

At age 3 - 4 did the child play with other children? How did it go? _____

Did the child's teachers tell you anything about the child? _____

- Kindergarten _____
- First Grade _____
- Second Grade _____
- Third Grade _____
- Fourth Grade _____
- Fifth Grade _____
- Sixth Grade _____
- Other _____

How do you hope that we can help you? _____

SECTION 3: FORM 2

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PARENT'S RATING SCALE

Date: _____

Patient's Name: _____

Parent's Name: _____

Behavior	Example of Behavior	Not At All (never, seldom)	Just A Little (once in a while)	Pretty Much (often, quite a bit)	Very Much (very often, frequently)
1. Restless (Overactive)					
2. Excitable – Impulsive					
3. Disturbs Other Children					
4. Fails to Finish Things Started – Short Attention Span					
5. Fidgeting					
6. Inattentive – Distractible					
7. Demands Must Be Met Immediately, Gets Frustrated					
8. Cries					
9. Mood Changes Quickly					
10. Temper Outbursts (Explosive and Unpredictable Behavior)					

SECTION 3: FORM 3

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Person filling out form: _____
Patient Name: _____ Date: _____

Please write: NO or YES on the lines below next to the behaviors. Also list specific examples of each.

YES = OFTEN OR VERY OFTEN; QUITE A BIT OR VERY INFREQUENT
NO = NEVER OR SELDOM

Note: Consider a criterion met if the behavior is considerably more frequent than that of most people of the same mental age. Example: A teacher would compare to others in the class.

INATTENTION

1. _____ Often fails to give close attention to details or makes careless mistakes in schoolwork, homework or other activities.
Examples: _____

2. _____ Often has difficulty sustaining attention in task or play activities.
Examples: _____

3. _____ Often does not seem to listen when spoken to directly.
Examples: _____

4. _____ Often does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace. (Not due to oppositional behavior or failure to understand instructions)
Examples: _____

5. _____ Often has difficulty organizing tasks and activities.
Examples: _____

6. _____ Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
Examples: _____

7. _____ Often loses things necessary for tasks or activities (toys, assignments, pencils, books or tools).
Examples: _____

8. _____ Is often easily distracted by extraneous stimuli.
Examples: _____

9. _____ Is often forgetful in daily activities.
Examples: _____

HYPERACTIVITY

10. _____ Often fidgets with hands or feet or squirms in seat.
Examples: _____

11. _____ Often leaves seat in classroom or in other situations in which remaining seated is often expected.
Examples: _____

12. _____ Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents, may be limited to subjective feeling of restlessness).
Examples: _____

13. _____ Often has difficulty playing or engaging in leisure activities quietly.
Examples: _____

14. _____ Is often "on the go" or often acts as if "driven by a motor."
Examples: _____

15. _____ Often talks excessively.
Examples: _____

IMPULSIVITY

16. _____ Often blurts out answers to questions before they have been completed.

Examples: _____

17. _____ Often has difficulty awaiting turn.

Examples: _____

18. _____ Often interrupts or intrudes on others (inserts oneself into conversations or games).

Examples: _____

How many months do you think this has gone on? _____

If known, what age do you think this started? _____

SECTION 3: FORM 4

ARNOLD G. SHAPIRO, MD

Person filling out form: _____

Patient Name: _____ Date: _____

MOOD DISORDERS

Please write: NO or YES on the lines below next to the behaviors. Also list specific examples of each.
YES = OFTEN OR VERY OFTEN; QUITE A BIT OR VERY INFREQUENT
NO = NEVER OR SELDOM

1. _____ Sad often.
Examples: _____

2. _____ Decreased interest in people or activities.
Examples: _____

3. _____ Change in appetite (increased or decreased).
Examples: _____

4. _____ Change in sleep pattern. Insomnia or hypersomnia (sleeping more than usual).
Examples: _____

5. _____ Low energy or tiredness.
Examples: _____

6. _____ Low self-esteem.
Examples: _____

7. _____ Poor concentration.
Examples: _____

8. _____ More trouble making decisions.
Examples: _____

9. _____ Feelings of hopelessness.
Examples: _____

10. _____ Talk of death or suicide.
Examples: _____

11. _____ Feelings of worthlessness.
Examples: _____

12. _____ Worries often.
Examples: _____

SECTION 3: FORM 5

ARNOLD G. SHAPIRO, MD

Person filling out form: _____

Patient Name: _____ Date: _____

OPPOSITIONAL DEFIANT DISORDER

Please write: NO or YES on the lines below next to the behaviors. Also list specific examples of each.
YES = OFTEN OR VERY OFTEN; QUITE A BIT OR VERY INFREQUENT
NO = NEVER OR SELDOM

1. _____ Often loses temper.
Examples: _____

2. _____ Often argues with adults.
Examples: _____

3. _____ Often actively defies or refuses adult requests or rules (e.g. refuses to do chores at home).
Examples: _____

4. _____ Often deliberately does things that annoy other people (e.g. grabs other children's hats).
Examples: _____

5. _____ Often blames other for his/her own mistakes or misbehavior.
Examples: _____

6. _____ Is often touchy or easily annoyed by others.
Examples: _____

7. _____ Is often angry or resentful.
Examples: _____

8. _____ Is often spiteful and vindictive.
Examples: _____

How many months have these behaviors gone on (continuously)? _____

If known, at what age do you think this started? _____

SECTION 3: FORM 6

ARNOLD G. SHAPIRO, MD

Person filling out form: _____
Patient Name: _____ Date: _____

YMRS – PARENT VERSION

Directions: Please read each question below and circle the answer number which most closely describes your child.

1. Mood – Is your child's mood higher (better) than usual?
 - 0 No
 - 1 Mildly or possibly increased
 - 2 Definite elevation-more optimistic, self-confident, cheerful, appropriate to their conversation
 - 3 Elevated but inappropriate to content, joking, mildly silly
 - 4 Euphoric, inappropriate laughter, singing/making noises, very silly

2. Motor Activity/Energy – Does your child's energy level or motor activity appear to be greater than usual?
 - 0 No
 - 1 Mildly or possibly increased
 - 2 More animated, increased gesturing
 - 3 Energy is excessive, hyperactive at times, restless but can be calmed
 - 4 Very excited, continuous hyperactivity, cannot be calmed

3. Sexual Interest – Is your child showing more than usual interest in sexual matters?
 - 0 No
 - 1 Mildly or possibly increased
 - 2 Definite increase when the topic arises
 - 3 Talks spontaneously about sexual matters, gives more detail than usual, more interested in girls/boys than usual
 - 4 Has shown open sexual behavior-touching others or self inappropriately

4. Sleep - Has your child's sleep decreased lately?
 - 0 No
 - 1 Sleeping less than normal amount by up to one hour
 - 2 Sleeping less than normal amount by more than one hour
 - 3 Need for sleep appears decreased, less than four hours
 - 4 Denies need for sleep, has stayed up one night or more

5. Irritability – Has your child appeared irritable?

- 0 No more than usual
- 2 More grouchy or crabby
- 4 Irritable openly several times throughout the day, recent episodes of anger with family, school, or with friends
- 6 Frequently irritable to the point of being rude or withdrawn
- 8 Hostile and uncooperative about all the time

6. Speech (rate and amount) – Is your child talking more quickly or more than usual?

- 0 No change
- 2 Seems more talkative
- 4 Talking faster or more to say at times
- 6 Talking more or faster to the point he/she is difficult to interrupt
- 8 Continuous speech, unable to interrupt

7. Thoughts – Has your child shown changes in his/her thought patterns?

- 0 No
- 1 Thinking faster, some decrease in concentration, talking “around the issue”
- 2 Distractible, loses track of the point, changes topics frequently, thoughts racing
- 3 Difficult to follow, goes from one idea to the next, topics do not relate, makes rhymes or repeats words
- 4 Not understandable, he/she doesn't seem to make any sense

8. Content – Is your child talking about different things than usual?

- 0 No
- 2 He/she has new interests and is making more plans
- 4 Making special projects, more religious or interested in God
- 6 Thinks more of him/herself, believes he/she has special powers, believes he/she is receiving special messages
- 8 Is hearing unreal noises/voices, detects odors no one else smells, feels unusual sensations, has unreal beliefs

9. Disruptive-Aggressive Behavior – Has your child been more disruptive or aggressive?

- 0 No, he/she is cooperative
- 2 Sarcastic, loud, defensive
- 4 More demanding, make threats
- 6 Has threatened a family member or teacher, shouting, knocking over possessions/ furniture or hitting a wall
- 8 Has attacked a family member, teacher, or peer; destroyed property, cannot be spoken to without violence

10. Appearance – Has your child’s interest in his/her appearance changes recently?

- 0 No
- 1 A little less or more interest in grooming than usual
- 2 Doesn’t care about washing or changing clothes, or is changing clothes more than three times a day
- 3 Very messy, needs to be supervised to finish dressing; applying make-up is overly done or poor fashion
- 4 Refuses to dress appropriately, wearing bizarre styles

11. Insight – Does your child think he/she needs help at this time?

- 0 Yes, admits difficulties and wants treatment
- 1 Believes there might be something wrong
- 2 Admits to change in behavior but denies he/she needs help
- 3 Admits behavior might have changes but denies need for help
- 4 Denies there have been any changes in his/her behavior or thinking

Signature of Parent/Guardian: _____

SECTION 4

Arnold G. Shapiro, MD

1717 Dixie Highway, Suite 200
Lookout Corporate Building
Ft. Wright, Kentucky 41011
(859) 341-7453

DIPLOMATE AMERICAN BOARD OF
PSYCHIATRY AND NEUROLOGY

8280 Montgomery Road, Suite 304
Kenwood Commons
Cincinnati, Ohio 45236
(513) 794-8777

CHILD-ADOLESCENT-ADULT
PSYCHIATRY

Dear Teacher or School Counselor:

_____ DOB: _____ is being seen by our office for an evaluation and possible treatment. Attached are a set of questionnaires, which are crucial to the comprehensive evaluation of this child. These questionnaires may be distributed to: (1) all of the main teachers — who would fill out the forms together in order to come to a consensus on the child's most frequent behavioral/social/learning patterns; (2) the school counselor — who would discuss the child with all of the teachers and fill out the forms based on that information; or (3) one teacher who knows the child best.

Please complete the questionnaires using one of the modes listed above and return them to the parent(s) or mail/fax them directly to us. We realize that some of the questions may appear redundant but this is done to ensure a comprehensive and thorough evaluation. We very much appreciate your help, time and patience.

If you have any questions or concerns, you may contact our office by phone Monday through Thursday, 9 a.m. to 6 p.m. and Friday, 9 a.m. to 12 p.m.

If anyone else would like to complete the questionnaires in order to help us with this evaluation, please feel free to duplicate the questionnaires as necessary.

Please fax this packet back to us at (859) 344-3183.

Sincerely,

Arnold G. Shapiro, M.D.

SECTION 4: FORM 1

SCHOOL REPORT – QUESTIONNAIRE

Date: _____

Pupil's Name: _____

Teacher's Name: _____

I. ACADEMIC ACHIEVEMENT

1. Grade: _____ 2. Is the child working up to his/her capacity? YES NO

Please complete the following by circling the term which best describes this child:

- Reading ability for grade is? Failing Below Average Average Above Average
- Arithmetic ability for grade is? Failing Below Average Average Above Average
- Spelling ability for grade is? Failing Below Average Average Above Average
- Handwriting ability for grade is? Failing Below Average Average Above Average
- Native intelligence your estimate is? Subnormal Borderline Average Above Average
- Child seems not to comprehend spoken grade level words? Rarely Sometimes Often
- Child has difficulty relating experiences? Rarely Sometimes Often
- Child uses irregular grammar? Rarely Sometimes Often
- Child uses incomplete sentences? Rarely Sometimes Often
- Child has difficulty judging relative values such as tall, heavy, far, near? Rarely Sometimes Often
- Child has difficulty with spatial directions such as right/left, up/down? Rarely Sometimes Often
- Child requires extra explanations from teacher? Rarely Sometimes Often
- Child compares with other children in fine coordination: drawing, cutting, typing, etc.
Poorly Well Above Average
- Child compares with other children in gross coordination: walking, running, climbing, etc.
Poorly Well Above Average
- Ability to cope with new or exciting situations: parties, fieldtrips, visitors?
Poorly Well Above Average

3. If the child is underachieving, what factors do you believe might account for the difficulty?

4. How does his/her present academic work compare with his/her earlier performance? Is he/she making more or less progress than previously? _____

5. Describe the child's academic work as compared to the standards of grade level? _____

II. SCHOOL ADJUSTMENT

1. Has the child adjusted to the school, with teacher and students? YES NO
2. Describe the child's behavior in the classroom. (is he/she disruptive, or docile, overly quiet, submissive, etc.) _____

3. Does the child respond well to authority? YES NO
4. Does the child make friends easily, and is he/she liked by other children? YES NO
5. Is the child a leader or a follower among other children his/her own age? (please describe) _____

6. Does the child prefer to be alone or "off to him/herself" or does the child prefer to be with a few friends or with a larger group? (please describe) _____

7. Does the child associate more with others of the same or opposite sex? SAME OPPOSITE
8. Does the child prefer companionship with other children who are older, younger or same age? _____

9. In your opinion is this a child who is enjoyable to be with? What would you say are the child's strengths and vulnerabilities? _____

III. HEALTH

1. Does the child seem to have any problems with hearing or vision? _____

2. Does the child seem to be well-nourished and getting adequate sleep? YES NO
3. Does the child have adequate health habits? YES NO
Describe any poor health habits? _____

IV. PARENTS INFLUENCE

1. Have the parents been active and interested in the child's school adjustment? YES NO
2. Do the parents seem to uphold the school's authority and trust the school's judgment, or are they critical of the school and overprotective of their child? _____

3. What has been the child's attendance record? _____

4. Does the child arrive at school on time? _____
5. Has the child talked at school about home life, and if so, what has he/she said, and how much do you feel the child's home life has a positive or negative effect on the child's adjustment at school? _____

V. OTHER COMMENTS

Please list any special abilities, talents, assets which the child has: _____

Please give any additional information or observations which you feel would contribute to an understanding of this child: _____

Do you believe the child could benefit from help in:

1. Improving his/her mood? _____

2. Improving his/her behavior? _____

3. Improving his/her ability to pay attention and/or keep their mind on their work? _____

4. Anything else? _____

Please use the remainder of this page and the other side for any additional responses.

Signature: _____

Title: _____

School: _____

Phone Number: _____

Date: _____

SECTION 4: FORM 2

Arnold G. Shapiro, M.D.

TEACHER'S RATING SCALE

Date: _____

Patient's Name: _____

Teacher's Name: _____

Behavior	Example of Behavior	Not At All (never, seldom)	Just A Little (once in a while)	Pretty Much (often, quite a bit)	Very Much (very often, frequently)
1. Restless (Overactive)					
2. Excitable – Impulsive					
3. Disturbs Other Children					
4. Fails to Finish Things Started – Short Attention Span					
5. Fidgeting					
6. Inattentive – Distractible					
7. Demands Must Be Met Immediately, Gets Frustrated					
8. Cries					
9. Mood Changes Quickly					
10. Temper Outbursts (Explosive and Unpredictable Behavior)					

SECTION 4: FORM 3

Arnold G. Shapiro, MD

1717 Dixie Highway, Suite 200
Lookout Corporate Building
Ft. Wright, Kentucky 41011
(859) 341-7453

8280 Montgomery Road, Suite 304
Kenwood Commons
Cincinnati, Ohio 45236
(513) 794-8777

Person filling out form: _____

Patient Name: _____ Date: _____

Please write: NO or YES on the lines below next to the behaviors. Also list specific examples of each.

YES = OFTEN OR VERY OFTEN; QUITE A BIT OR VERY INFREQUENT

NO = NEVER OR SELDOM

Note: Consider a criterion met if the behavior is considerably more frequent than that of most people of the same mental age. Example: A teacher would compare to others in the class.

INATTENTON

1. _____ Often fails to give close attention to details or makes careless mistakes in schoolwork, homework or other activities.

Examples: _____

2. _____ Often has difficulty sustaining attention in task or play activities.

Examples: _____

3. _____ Often does not seem to listen when spoken to directly.

Examples: _____

4. _____ Often does not follow through on instructions and fails to finish schoolwork, chores or duties.

Examples: _____

5. _____ Often has difficulty organizing tasks and activities.

Examples: _____

6. _____ Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).

Examples: _____

7. _____ Often loses things necessary for tasks or activities (toys, assignments, pencils, books)

Examples: _____

8. _____ Is often easily distracted by extraneous stimuli.

Examples: _____

9. _____ Is often forgetful in daily activities.

Examples: _____

HYPERACTIVITY

10. _____ Often fidgets with hands or feet or squirms in seat.

Examples: _____

11. _____ Often leaves seat in classroom or in other situations in which remaining seated is often expected.

Examples: _____

12. _____ Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents, may be limited to subjective feeling of restlessness).

Examples: _____

13. _____ Often has difficulty playing or engaging in leisure activities quietly.

Examples: _____

14. _____ Is often "on the go" or often acts as if "driven by a motor."

Examples: _____

15. _____ Often talks excessively.

Examples: _____

IMPULSIVITY

16. _____ Often blurts out answers to questions before they have been completed.

Examples: _____

17. _____ Often has difficulty awaiting turn.

Examples: _____

18. _____ Often interrupts or intrudes on others (inserts oneself into conversations or games).

Examples: _____

How many months do you think this has gone on? _____

If known, what age do you think this started? _____

SECTION 4: FORM 4

ARNOLD G. SHAPIRO, MD

Person filling out form: _____

Patient Name: _____ Date: _____

MOOD DISORDERS

Please write: NO or YES on the lines below next to the behaviors. Also list specific examples of each.
YES = OFTEN OR VERY OFTEN; QUITE A BIT OR VERY INFREQUENT
NO = NEVER OR SELDOM

1. _____ Sad often.
Examples: _____

2. _____ Decreased interest in people or activities.
Examples: _____

3. _____ Change in appetite (increased or decreased).
Examples: _____

4. _____ Change in sleep pattern. Insomnia or hypersomnia (sleeping more than usual).
Examples: _____

5. _____ Low energy or tiredness.
Examples: _____

6. _____ Low self-esteem.
Examples: _____

7. _____ Poor concentration.
Examples: _____

8. _____ More trouble making decisions.
Examples: _____

9. _____ Feelings of hopelessness.
Examples: _____

10. _____ Talk of death or suicide.
Examples: _____

11. _____ Feelings of worthlessness.
Examples: _____

12. _____ Worries often.
Examples: _____

SECTION 4: FORM 5

ARNOLD G. SHAPIRO, MD

Person filling out form: _____

Patient Name: _____ Date: _____

OPPOSITIONAL DEFIANT DISORDER

Please write: NO or YES on the lines below next to the behaviors. Also list specific examples of each.
YES = OFTEN OR VERY OFTEN; QUITE A BIT OR VERY INFREQUENT
NO = NEVER OR SELDOM

- 1. _____ Often loses temper.
Examples: _____

- 2. _____ Often argues with adults.
Examples: _____

- 3. _____ Often actively defies or refuses adult requests or rules (e.g. refuses to do chores at home).
Examples: _____

- 4. _____ Often deliberately does things that annoy other people (e.g. grabs other children's hats).
Examples: _____

- 5. _____ Often blames other for his/her own mistakes or misbehavior.
Examples: _____

- 6. _____ Is often touchy or easily annoyed by others.
Examples: _____

- 7. _____ Is often angry or resentful.
Examples: _____

- 8. _____ Is often spiteful and vindictive.
Examples: _____

How many months have these behaviors gone on (continuously)? _____

If known, at what age do you think this started? _____