**GENERAL INFORMATION: Child/Adolescent Form**

Name, Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT(S):**

Mother, Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_

Address (if different from above):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phones: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ msg ok

(work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ msg ok

(cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ msg ok

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Grade/Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phones: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ msg ok

(cell?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ msg ok

Father, Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_

Address (if different from above):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phones: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ msg ok

(work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ msg ok

(cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ msg ok

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Grade/Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents’ marital status: married separated divorced never married

If divorced, please describe custody arrangement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIBLINGS:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Grade:\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Grade:\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Grade:\_\_\_\_\_

Please list any other people living in the home(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCHOOL INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Teacher(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Accomodations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Repeated grade: yes/no

**Briefly describe any academic concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child attend daycare? YES NO**

**PEDIATRICIAN**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT(S)**

Name, relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRAL SOURCE**

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to acknowledge the referral? Yes No

Mental Health History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List Medical History:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth History: Full Term \_\_\_ Premature\_\_\_\_ NICU\_\_\_\_ Breathing tube\_\_\_\_ Apgar Scores\_\_\_\_

Please provide a history of developmental milestones met and at what age:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have or ever had any of the following:

ADHD \_\_\_ Heart disease\_\_\_  
Asthma\_\_\_ Heart murmur \_\_\_

Bleeding Problems\_\_\_ Kidney disease\_\_\_

Cancer\_\_\_ Liver disease\_\_\_

Depression/Anxiety\_\_\_ Neurological disorder\_\_\_

Diabetes\_\_\_ Seizure disorder\_\_\_

GERD\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrointestinal Disorders\_\_\_

Please describe answers from above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any medication allergies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following that your child has experienced:

Head injury \_\_\_ Convulsions\_\_\_ Loss of Consciousness\_\_\_ Seizures\_\_\_

Other Neurological diagnosis\_\_\_ Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe the primary reason for this visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below you agree to the following: I attest that the information I have provided is true and correct to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guarantor Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guarantor Signature Date

**Consent for Treatment of a Minor**

I hereby authorize Dr. Allison Wise to conduct an initial evaluation and provide ongoing behavioral health treatment for my child. I understand that this consent may be revoked in writing at any time.

Name of child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments (if any):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guarantor Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guarantor Signature Date

**Professional Policy and Procedure Agreement &**

**Patient’s Informed Consent of Practice**

Welcome to my practice. This Agreement sets forth the terms and conditions of our professional relationship, including the scope of my services and the billing policies that apply. By signing below, you are binding yourself to each and every item in this Agreement. As a result, it is imperative that you ***read this entire document before signing***.

**Professional Information.** I am currently a Licensed Psychologist with a background in child and adolescent assessment and therapy. My current areas of expertise include assessment and treatment of Autism Spectrum Disorders, Anxiety Disorders (including Obsessive Compulsive Disorder, Separation Anxiety, Selective Mutism, and Social Phobia), Depression/Mood Disorders, Eating Disorders, Family Issues and Learning Disabilities. I also have specialized experience and training in providing therapy to children with complicated, mixed diagnostic pictures, including children with co-occurring psychopathology and developmental issues. I also teach social skills training, address challenging behavioral issues and provide parent coaching.

I received my doctorate in clinical psychology from Forest Institute of Professional Psychology. I completed a predoctoral internship at Mercy Medical Center-North Iowa with specialties in health psychology, neuropsychological assessment, pain management, child psychology and assessment and geropsychology. I completed a postdoctoral fellowship in health psychology, child psychology and child neuropsychological assessment at Cook Children’s Medical Center. I am a member of the American Psychological Association, Missouri Psychological Association, and the National Register of Health Service Providers in Psychology. My undergraduate degree is in Psychology from Texas Christian University in Fort Worth, Texas. My doctoral dissertation “The Relationship Between Socioeconomic Status, Demographic Variables & Depressive Traits in a Young Adolescent Sample” focused on adolescents with depression. My Master’s Thesis focused on a case on the medical diagnosis of ADHD and the educational diagnosis of behavior disorder.

Additional areas of specialization include health psychology, neuropsychology, pain management, and assessment. I have training to help people adjust to life and to assist medical and surgical patients with spinal cord injuries, chronic pain or illness, stroke and other neurological conditions.

I practice cognitive behavioral therapy which is a goal-directed approach primarily aimed at helping patients achieve their needs in a brief, time limited manner. I am enthusiastic about helping my patients reach their goals within a professional and relaxed atmosphere.

**Psychological Services.** Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a personal commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**Meetings**. I conduct an initial evaluation. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy has begun, I will usually schedule one 45-50minute session (one appointment hour of 45-50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay the full amount for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule the appointment.

**Professional Fees**. In addition to weekly appointments, I charge for other professional services you may need. Other services include, but not limited to, report writing, telephone conversations, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. Please refer to the menu of services for the breakdown on these costs.

**Billing and Payments**. I am a fee for service provider. I do not file insurance claims for you, but upon request, I will provide you with all of the information that you should need to make a claim. You may receive reimbursement from your insurance provider if you have “out of network” benefits. This has been successful for a number of my patients. Of course, plans vary, particularly with regard to mental health coverage, and you will need to discuss reimbursement with your insurance provider if you would like to pursue this option. I collect full payment at the time of your visit and then your insurance company will reimburse you directly after you submit your claim. Also, if you plan on billing your insurance for reimbursement of your visit, you will need to obtain a prescription from your physician prior to your first appointment. If you do not plan on billing insurance, you do not need a prescription. Again, I will give you the paperwork and medical diagnosis codes for you to send to your insurance company.

You will be expected to pay for each session at the time it is held at the beginning of your session. Payment schedules for other professional services will be agreed to when they are requested. I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. A medical release form will need to be obtained prior to this communication taking place.

**Contacting Me**. I am often not immediately available by telephone. I also have an office assistant that is available by telephone. I will make every effort to return your call. If you are unable to reach me and feel that you can’t wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. You may also call the Access Crisis Intervention (ACI) hotline at 1-800-494-7355. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**Telephone Therapy.** When therapy is provided over the telephone during or after office hours, you will be responsible for paying for these therapy services prior to the telephone call.

**Professional Records Retention and Destruction.** I maintain a paperless office. By signing below, you hereby give me permission to destroy the original of any document that you provide to me, and to retain such documents only in an electronic imaged format. After termination of our professional relationship, I will likely only retain an electronic copy of your file for the minimum period required by law.

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents.

**Minors**. If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment either verbally or in writing per their request. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

**Confidentiality.** Discussions in psychotherapy and psychotherapy records are considered confidential by law. This means that no one else is allowed to know what is talked about. There are some limits to confidentiality. Three of the most commonly encountered involve the abuse or neglect of child or vulnerable adult, suicidality, and homicidality. Psychologists are mandated reporters, and must break confidentiality when they suspect abuse or neglect of child or vulnerable adult. They also must intervene when a credible threat of harm is made to one's self or someone else. This may require the psychologist to contact family members, an intended victim, or the police. Please feel free to ask questions or discuss your concerns about these and other confidentiality limits.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

I will make progress notes in your chart after each session. These notes will be brief and will only convey general information that communications the progress you are making. If another physician referred your case to me, your progress will be communicated to the physician in writing or by phone. When written consent is obtained I can share information about you with whoever you wish. Otherwise, our communication will be confidential between us.

*MANDATORY BINDING ARBITRATION.THIS CLAUSE REQUIRES THAT, IN ORDER TO RETAIN US, YOU MUST GIVE UP IMPORTANT LEGAL RIGHTS, INCLUDING THE RIGHT TO A TRIAL BY JURY. AS A RESULT, YOU ARE ENCOURAGED IN THE STRONGEST TERMS POSSIBLE TO SEEK INDEPENDENT LEGAL ADVICE BEFORE AGREEING TO THESE TERMS.*

The “parties” (as defined below) hereby acknowledge and agree to all of the following:

The parties hereby stipulate and agree to submit to mandatory, final and binding arbitration (as defined below) any and all “disputes”, which shall be given the broadest meaning allowable under the law, and includes, but is not limited to, any claim, controversy or disagreement, whether sounding in contract, statute, tort, or any other legal theory, and whether for money damages, injunctive relief, specific performance, otherwise, provided such dispute (a) arises out of, or (b) is related (directly or indirectly) to (i) this Agreement, (ii) our representation, or (iii) the provision/non-provision of any products or services.

The confidentiality of any such dispute is absolute. Such strict and absolute confidentiality applies to all stages of a dispute, including initial demands, and continues to apply even after the conclusion of arbitration. Such confidentiality requires, at a minimum, the following: all documents relating to the matter (including discovery, pleadings, motions, summaries, videos and any proceedings) shall, unless additional disclosure is compelled by law, (a) be disclosed to no one other than the parties, their attorneys, one testifying expert per side, and the single arbitrator deciding the matter, (b) be sealed pursuant to a protective order that the Arbitrator shall immediately issue without awaiting request, (c) and/or otherwise protected from disclosure to anyone other than. to the greatest extent allowable under the law Such prohibitions include pre-litigation communications and conduct (such as making demands), and post-arbitration communications and conduct (in perpetuity). Any disclosure of documents subject hereto, even if inadvertent and without fault, shall result in an award of presumed damages to the non-disclosing party.

The federal arbitration act, not state law, governs the question of whether a claim is subject to arbitration. You hereby agree to waive any right to trial in a court of law and any right to a trial by jury that may otherwise exist. The decision of the arbitrator shall be final and non-appealable.

The arbitration will be filed with and the arbitrator selected in accordance with the commercial arbitration rules of the American Arbitration Association. The arbitration shall be to a single arbitrator who is a licensed attorney with at least ten years’ experience in the jurisdiction in which the office of our attorney primarily responsible for your engagement is located, and the arbitration shall be held in that city.

Discovery (the parties’ right to obtain information for each other and third parties) is or may be limited or precluded in arbitration. Arbitration may be more or less expensive than an action in court. The arbitrator may allocate the costs of arbitration, including the fees of the arbitrator, to one or both of the parties.

**Interpreting and Enforcing this Agreement**. You acknowledge and agree that this entire Agreement is contractual, and nothing herein is merely a recital. Furthermore, this Agreement is the final, complete and exclusive statement of our contractual arrangement regarding our representation. This Agreement supersedes any and all prior promises, representations, warranties, Agreements, understandings, undertakings, or otherwise, between or among us, with respect to our representation. With respect to our representation, and all matters addressed in this Agreement, there are no promises, representations, warranties, Agreements, understandings, undertakings, or otherwise, beyond or contrary to the written terms herein.

**Counterparts, Facsimiles and Electronic Signatures**. Electronic signatures, as well as copies or facsimiles of signatures, shall be deemed originals. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original Agreement, and all of which shall constitute one Agreement. Counterparts of the signature pages may be combined to create one single, fully integrated Agreement, and is binding therefore as such. The final, binding form of this Agreement, which shall supersede and novate any prior understandings or agreements, shall be the unsigned Agreement that we email to you, and any changes made thereto are null and void.

**Venue and Jurisdiction**. This Agreement is governed by the laws of the State of Missouri, without respect to any rules regarding the conflicts of laws. You and all signatories to this Agreement hereby (1) consent to the personal jurisdiction of all federal and state courts in Missouri, (2) acknowledge and agree that any action arising out of, or related to, this Agreement shall be commenced, prosecuted, and defended exclusively in the state or federal courts of the State of Missouri, County of Greene. In any dispute arising out of this Agreement (including credit card charge disputes that are not litigated), the prevailing party shall be entitled to attorneys’ fees and all costs (including non-taxable costs). In the event of such a dispute, this firm may represent itself and is entitled to be reimbursed at its’ then-prevailing rate if it is the prevailing party.

**Amendments**. Neither this Agreement, nor any terms set forth herein, may be changed, waived, discharged, or terminated, orally or in writing, except by a writing signed by all Parties, and the observance of any such term may be waived (either generally or, in a particular instance, either retroactively or prospectively), by a writing signed by the Parties against whom such waiver is to be asserted.

**No Third-Party Beneficiaries**. This Agreement is intended to be for the sole and exclusive benefit of the Parties. Thus, except as expressly provided herein, nothing in this Agreement shall give, or is intended to give, any person or entity, other than the parties hereto.

**Successors and Assigns**: This Agreement shall inure to our benefit by binding all of your predecessors, successors, beneficiaries, grantees, transferees, assigns, heirs, executors, administrators, directors, officers, shareholders, employees, agents, partners, representatives, attorneys, corporations, subsidiaries, divisions and joint venturers, as well as any affiliated individual or entity.

**Limitation on Waivers**. You hereby acknowledge and agree that if we fail to enforce, exercise or otherwise act on (a) any breaches of this Agreement, and/or (b) any options, rights, remedies, or otherwise that are provided by, related to, or arising out of this Agreement, such failure shall not constitute a waiver, and also shall not limit or prevent us from, at a later date, enforcing, exercising or otherwise acting on such breaches, options, rights, remedies, or otherwise.

**Conclusion**. I very much look forward to working with you. Please indicate your Agreement to all of the foregoing terms and conditions by signing and returning this Agreement. If you have any proposed changes to this Agreement, you must notify us in a separate written correspondence detailing your proposed changes. If you do not provide such written notice, your signature herein acknowledges and affirms your consent to this Agreement in the original form in which it was sent to you.

**ACKOWLEDGEMENT OF UNDERSTANDING**

*Your signature below indicates that you have read the information contained in this document and agree to abide by its terms during our professional relationship.*

I HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED IN THE PROFESSIONAL POLICY AND PROCEDURE AGREEMENT & PATIENT’S INFORMED CONSENT OF PRACTICE FOR WISE PSYCHOLOGICAL SERVICES, LLC AND AGREE AND UNDERSTAND THE LIMITS OF CONFIDENTIALITY. A PHOTOCOPY OR FACSIMILE OF THIS AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL.

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Printed Name Date of Birth

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Printed Name Date of Birth

**Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information**

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

1. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may use or disclose your protected health information (“**PHI**”), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

* ***PHI***: Information in your health record that could identify you.
* ***Treatment***: Occurs when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
* ***Payment***: When I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
* ***Health Care Operations***: Activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
* ***Use***: Applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* ***Disclosure***: Applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

1. **Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

1. **Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

* ***Child Abuse*:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare/ the law requires that I report such knowledge or suspicion to the Missouri Department of Economic Security, Child Protective Services or other authorities.
* ***Adult and Domestic Abuse*:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Missouri Department of Economic Security, Adult Protective Services or other authorities.
* ***Health Oversight*:** If a complaint is filed against me with the Missouri Board of Psychologists (“**Board**”), the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.
* ***Judicial or Administrative Proceedings***: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such *information* is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been property notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court or administrative agency ordered.
* ***Serious Threat to Health or Safety***: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, law enforcement agency or other appropriate authorities.
* ***Worker's Compensation***: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation *provider,* or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

1. **Patient's Rights and Psychologist's Duties**

**Patient's Rights:**

* ***Right to Request Restrictions***: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request
* ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations***: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
* ***Right to Inspect and Copy***: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
* ***Right to Amend***: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
* ***Right to an Accounting***: You generally have the right to receive an accounting of disclosures of PHl regarding you. On your request, I will discuss with you the details of the accounting process.
* ***Right to a Paper Copy***: You have the right to obtain a paper copy of the notice from me upon request even if you have agreed to receive the notice electronically.

**Psychologist's Duties:**

* I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
* I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
* If I revise my policies and procedures, I will provide you with the revised policy by mail at the address you provide.

V. **Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me directly. If you believe that your privacy rights have been violated and wish to file a complaint with me or my office, you may send your written complaint to me at: 1200 East Woodhurst T300, Springfield, MO, 65804

VI. **Effective Date, Restrictions, and Changes to Privacy Policy**

This notice is effective as of June 1, 2019. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I can provide you with any revised notice by request at the time of your next office visit.

**HIPPA Policies and Procedures**

I have received a copy of Wise Psychological Services, LLC, “Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information” consistent with the Health Insurance Portability and Privacy Act (HIPPA).

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**Printed Name Date of Birth**

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**Signature Date**

**PRIOR MENTAL HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐No prior mental health services

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| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
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| Permission to obtain records: | ☐ Yes | ☐ No |

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| Permission to obtain records: | ☐ Yes | ☐ No |

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Signature Date

**CHILD THERAPY CONTRACT**

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child’s confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child’s therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a “zone of privacy” whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child’s treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child’s consent. I will tell you if your child does not attend sessions. At the end of your child’s treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad l item, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision.[[1]](#footnote-1) Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse the rates listed on the menu of services per hour for time spent traveling, preparing reports, testifying, being in attendance and/or any other case-related costs.

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Signature Date

**Authorization To Release/Receive Medical Records**

I authorize:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wise Psychological Services, LLC

Name Date of Birth 1200 East Woodhurst T300 Springfield, MO 65804

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City State Zip

\_\_\_\_\_\_\_\_ To release and/or \_\_\_\_\_\_\_\_ To receive

information/records which may include protected health information under HIPAA. I request release of the following:

\_\_\_\_ Billing/Scheduling \_\_\_\_ Protected Health Information \_\_\_\_ Verbal

I am requesting my provider to release this information for the following reasons:

\_\_\_\_ At the request of the individual (At the request of the individual is all that is required if you are my patient and you do not desire to state a specific purpose.)

\_\_\_\_ To another health care provider for the purpose of obtaining health care.

\_\_\_\_ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information should be released and/or received by:

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Name of person/physician/agency/institution

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Address

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City State Zip

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Phone Fax

This authorization shall remain in effect for 12 months or until the date indicated here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing person/agency address. However, your revocation will not be effective to the extent that the person/agency has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider generally may not condition health services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.

For the purpose hereof “Records” and/or “Information” shall include all confidential HIV related information (as defined in A.R.S. Section 36-661), confidential communicable disease related information (as defined in A.R.S. Section 36-661), and confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 ET SQ).

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Signature of Parent, Legal Guardian or Personal Representative (please indicate which) Date

1. [↑](#footnote-ref-1)