Child or Adolescent Client Packet

Please download and print the following pages.

Please **do not email** the completed packet to us.

Mail the completed packet to:

Yellow Springs Psychological Center
1310 Rice Road
Yellow Spring, OH 45387

If you have questions about the material, please call 937-767-7044.

YELLOW SPRINGS PSYCHOLOGICAL CENTER
New Client Information Form

Client Name

Address

City **Zip**

Phone(h) **Phone(w)** **Phone(c)**

Date of Birth **Age:** **Gender:**

PAYMENT IS DUE AT THE TIME OF SERVICE

☐ Check box if you would like a monthly statement sent to you.

Please provide your email address ***only*** if you would like your monthly statements via email:

Email address:

I give my permission to treat the child/adolescent minor above. Consent to treat may be revoked in writing at any time.

Signature **Date**

We can securely store your credit card information.
Your card will be charged immediately after a session.

Card #_____

Expiration Date_____3 or 4 digit Security Code_____

For Office Use Only

Therapist **Referred by**

Fee $

Yellow Springs Psychological Center ~ 937-767-7044

ADMINISTRATIVE POLICIES

SERVICES

We are providing psychological psychotherapy which is a process that fosters change and growth in the context of a supportive yet challenging interpersonal relationship with a therapist.

We believe that self-awareness, self-acceptance, and the immediate experiences in the therapy session are important ingredients in that growth process. While is it impossible to predict the outcome of therapy with certainty, we trust in the inherent capacity of each person to grow and change. Motivated individuals are most likely to benefit. There is, however, always the risk of experiencing uncomfortable feelings like sadness or anxiety and psychotherapy may require remembering unpleasant past experiences.

We accept and adhere to the ethical guidelines of our professions as set forth by the American Psychological Association, American Counseling Association and the Ohio State Boards of Psychology and Counseling

FEE & PAYENTS

Individual, couples and family sessions cost **$120** per 45-50 minute session unless otherwise negotiated with the therapist.

Payment is due at the time of service. We accept cash, checks and credit cards. We also have an internet Patient Payment Portal.

Report writing and legal proceedings (including preparation, travel and appearance) costs **$125 per hour and up** as agreed upon with your therapist.

There is a bank charge of **$35** for checks returned due to insufficient funds.

APPOINTMENTS & CANCELLATIONS

Please make, cancel or reschedule appointments directly with your therapist. If you must cancel, please do so at least 24 hours in advance to avoid being charged. If you are ill or if the weather makes driving dangerous, stay home. Please give us as much notice as possible. We regularly charge for ***missed*** appointments.

In case of a clinical emergency call 911 or go to the nearest Emergency Room.

CONFIDENTIALITY

What we discuss in therapy is held in the strictest confidence. This confidentiality is required by codes of ethics, the Health Insurance Portability and Accountability Act (HIPAA) and is

protected under the laws of the State of Ohio for licensed psychologists and those supervised by psychologists.

There are, however, a few exceptions. Your therapist may consult with his or her clinical supervisor or another professional in order to better assist you. Our Office Manager, bound by the same standards of confidentiality, may have limited access to your records for administrative and secretarial purposes. If your fees are paid by an insurance company, certain information, including dates of treatment, diagnosis and treatment plan may need to be furnished to obtain reimbursement. We routinely thank referral sources and may also need to communicate with your primary care physician. If we learn of child or elder abuse or neglect or other serious threats of harm to another person, we may take protective action. And we are ethically permitted to release information to prevent acts of suicide. If you testify about your therapy in a court of law we may be required to testify and we may be compelled to respond to an irrevocable court order. Finally, if you file a complaint or lawsuit against us we may disclose information in our defense.

Please raise any concerns you have about confidentiality and its limits with your therapist.

With these exceptions, what you say to your therapist is legally considered privileged communication. This means that nothing discussed in your psychotherapy sessions will be revealed without your explicit permission.

CLINICAL RECORDS

Clinical records are maintained and, except in unusual circumstances that involve danger to yourself or others, you may examine and/or receive a copy if you request it in writing, signed and dated no more than 60 days prior to our receipt. Because these are professional records and can be misinterpreted by or be upsetting to untrained readers, we recommend you review them only in our presence or have them forwarded to another mental health professional so you can discuss the contents.

In most circumstances we are allowed to charge a copying fee ($1 for the first 10 pages, 50¢ per page for pages 11-50 and 20¢ per page after that.), a $15 record search fee and postage. If we refuse your request for access to your records, you have a right of review which we will discuss upon your request. In addition, HIPAA grants you certain rights regarding your clinical record as detailed in the *HIPAA Notice Form* you received.

I have read, understood and agree to abide by the above policies. I have also received the *HIPAA Notice Form.*

Signature_____ Date_____

Yellow Springs Psychological Center

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

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

I. 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*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is 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* is 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* are 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 [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. 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 (of PHI or psychotherapy notes) 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.

III. 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, in my professional capacity, I know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, I am required by law to immediately report such belief to the County Department of Job and Family Services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you or your persona or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If I believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I am required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.

IV. 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 and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. 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 PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

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 notify you at our next appointment and give you a revised notice form.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Bob Barcus, Ph.D., Clinical Director, Yellow Springs Psychological Center, 937-767-7044.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 16, 2003.

Yellow Springs
Psychological Center, LLC

937-767-7044

CHILD AND ADOLESCENT HISTORY

CHILD'S NAME _____ **AGE** _____ **BIRTHDATE** _____ **M** ___ **F** ___

ADDRESS _____ **PREFERRED PHONE** _____

_____ **ALTERNATE PHONE** _____

PARENT/GUARDIAN _____

REFERRED BY _____

PERSON COMPLETING THIS FORM _____ Today's Date _____

REASONS FOR THERAPY

_____

_____

When did these problems begin? _____

What seems to help? _____

What makes it worse? _____

Has your child received evaluation or treatment for these problems before? _____

If so, when and with whom? _____

Other experience in therapy (who, when, where?) _____

_____

Child's Strengths _____

Child's Weaknesses _____

Learning or communication challenges (speech, hearing, vision, comprehension) _____

_____

Any ethnic, religious, cultural, or social issues that may affect treatment _____

_____

What are your hopes in coming for treatment? _____

_____

_____

PROBLEM BEHAVIORS

What are the main problem behaviors that concern you about your child? _____

_____

List any sleep, appetite or eating disturbances_____

_____

List any habits, obsessions or compulsions _____

_____

Suicidal thoughts, plans or gestures (explain) _____

_____

FAMILY HISTORY

List family members

NAME	AGE/SEX	RELATIONSHIP TO CHILD	LIVING IN HOME If not, where?	EDUCATIONAL LEVEL	OCCUPATION

Parents married _____(# of years) Parents divorced _____(# of years) Parents separated _____ Parents never married _____

Custody/Visitation arrangements _____

Is this child adopted? _____ Circumstances _____

Other child care providers _____

Who does most of the disciplining and what method? _____

Child's response _____

Any history of mental or emotional disorders in the extended family? _____

_____

_____

Parents places of employment _____

CHILD'S GROWTH AND DEVELOPMENT

Problems during the pregnancy, labor, delivery, or birth _____

Parental use of alcohol, tobacco, or drugs during pregnancy _____

Birth Weight _____

At what age did your child do the following: _____ crawl _____ walk _____ say single words _____ feed self _____ toilet train

Current bowel or bladder problems _____

Compared to other children, has been slower in learning any of the following (check all that apply):

___ talking ___ understanding ___ building with blocks, puzzles, drawing pictures ___ walking, hopping, riding a bike, etc.

___ using buttons, zippers, drawing, etc. ___ naming colors, saying ABC's ___ sitting still for TV or stories

___ playing or socializing with other children

Describe interactions with peers:

Preschool _____

Grade school _____

Junior High _____

High School _____

Does your child have difficulty separating from you? (explain) _____

_____

MEDICAL HISTORY

HEIGHT _____ WEIGHT _____ ALLERGIES _____ Are immunizations current? _____

Family Physician _____
NAME ADDRESS PHONE

PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS USED

NAME	DOSE	START DATE	REASON	RESPONSE

PAST HEALTH OR MEDICAL PROBLEMS (surgeries, hospitalizations, injuries, or chronic conditions)

_____

_____

Recent testing/results (labs, EEG, MRI, etc.) _____

_____

Recent significant weight gain or loss _____

Do you believe your child has an eating disorder? _____

Are there any current medical concerns? _____

_____

Is your child sexually active? _____

Is there any history of drug or alcohol use, abuse or treatment by your child or any family member? _____

_____

SOCIAL BEHAVIOR

Who does your child spend time with? _____

_____

Does he or she have difficulty making or keeping friends? _____

_____

Interests (activities, sports, clubs, etc) _____

_____

_____

EDUCATIONAL HISTORY

Current School _____ Grade _____

Address _____ Phone _____

Grades are: _____ Average _____ Below Average _____ Above Average Repeated Grades _____

Problems reported (behavior, attention, interruption, social skills) _____

_____

_____

Special Classes, or on an IEP _____

Special Services received (speech and language, occupational or physical therapy, tutoring, other) _____

_____

Favorite subjects _____

Recent decline in grades? (explain) _____ Difficult subjects _____

Psychological Testing (when, where, results) _____

_____

Please list any learning problems of other family members _____

_____

LEGAL PROBLEMS

Current legal charges? _____

Court date pending? _____ On Diversion? _____

Probation History? _____ House Arrest? _____

Probation officer? _____ Name of P.O. _____ Phone _____

Juvenile Detention? (when, why, how long?) _____

_____

Any other family members with legal charges, legal difficulties or arrest history? _____

Is there anything else you would like us to understand about your child or family? _____

_____

_____

Thank you for completing this form. We look forward to working with you and your child.

Revised Oct 15, 2012

Yellow Springs
Psychological Center, LLC

(937) 767-7044

CONFIDENTIALITY WITH TEENAGE CLIENTS

Legally parents hold the rights to confidential communication between minor clients and their therapist. However, we have found that psychotherapy works best when teenagers feel that information they share with their therapist will not be told to their parents.

In cases where the teenager is in immediate, life-threatening danger, the parents, of course, will be informed. Otherwise parents will not be told the full content of their teens conversations.

When the therapist feels it is important to have certain information shared with the parents, the client will be encouraged to do so and family sessions may be held to facilitate this process.

The therapist will periodically meet with the parents to give them a general update on progress, to assist them with parenting issues, or to share information the teenager has authorized.

We have read, understand, and agree to accept the above policy.

_____

Name date

_____

Name date

_____

Name date