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Child Intake Packet: Patient History

Date: ___/___/____ Client name: _____ Guardian's name ___

Age of client: _____ DOB: ___/___/____ S ☐ M ☐ D ☐ Other: _____ SSN of client: ___/___/_____

Home Address: _____ Contact Phone: _____

Employer Name /Phone: _____

Emergency Contact Name/Address/Phone _____ Relationship to Patient: _____

Parents Email Address:_____

Can clinical information be sent to this email address? Yes/ No

Name of Spouse/parent: _____ DOB: ___/___/____ SSN: ___/___/_____

☐Address/Phone same if no: _____

Name of Insurance: _____ Subscriber: _____ DOB: ___/_____

Name of School: _____ Current or highest grade completed: _____

List any known health problems:

Date: _____ Treated For: _____

Please list current medications: _____

Reason for appointment: _____

List any previous psychological/psychiatric history: Date/Treated For:

_____

Who referred you: _____ Phone: _____ PCP: _____

May we exchange medical information, including psychological, psychiatric, alcohol, and drug abuse diagnosis/treatment with these physicians: ☐Yes ☐No May we leave a message if we need to contact you by: ☐ Home☐ Cell☐ Work

Your signature (Legal guardian, if patient is a minor): _____

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INFORMED CONSENT FOR PSYCHOTHERAPY

Charges

Rates vary by clinician (ranging from $100 to $150 per session, see Fee Schedule). Rates are $150.00 for an initial evaluation, $125.00 for 45-55 minutes sessions, and $75.00 for a 30 minute session. In the event of hardship charges are negotiated. Insurance will be filed through our office. Deductible and co-payment are due at time of service. Payment can be made by check, cash, or credit card (MasterCard or Visa). If you ever have any questions regarding your insurance or payments, please address them with me. I hereby assign, transfer, convey payment and authorize said payment to be made directly to Evans Psychology Group, LLC for any medical, sick benefits or injury benefits payable by any party, organization, etc., for the completion of all outstanding obligations related to this condition. I further agree that this assignment will not be withdrawn or voided at any time until this account is paid in full. I understand that a $20.00 service charge will be added for any check returned by the bank for insufficient funds. I understand that interest may apply to any unpaid balance at the rate of 1.5% monthly. I further understand that Evans Psychology Group, LLC reserves the right to place all unpaid debts, and all pertinent information necessary to collect these debts, on my account with an outside collection agency. Initial_____

Cancelled or Missed Appointments

If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice (during business hours, i.e., Monday's appointment to be cancelled on Friday)***. Anything less will result in a ***$75 fee*** charged to your account. It costs you money to make appointments available to you. Whether you attend or not we still accrue the e expenses (for staff wages, rent, etc.) We don't charge you the actual cost for that appointment but rather a ***$75 fee.*** Advance notice allows another client time to reserve it in place of you. Please be courteous and responsible. Thank you. If you fail to show for an appointment without notice all future appointments will be removed and a ***$75 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first service basis". If you miss three consecutive appointments by not calling 24 hours in advanced or not showing for the appointment, you will be referred to another clinician. I will give you a list of other doctors in the area that you could see. Initial_____

Late Policy "15-minutes"

Being later by more than 15 minutes will require you to either reschedule or wait for the next available opening. Initial_____

Release of Information

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I f I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. I further understand that I can withdraw this concern for release of records/information at any time. Initial_____

Confidentiality

The Health Information Portability and Accountability Act (HIPAA) is meant to insure that your records are maintained in a private and secure manner. My office treats these records as confidential property and they are not released without your written authorization. Exceptions and uses and disclosures are explained in the Georgia Notice Form. All information between practitioner and patient is held strictly confidential. There are legal exceptions to this as stated in the Georgia Notice From. I have read and/or been offered a copy of the Georgia Notice Form and understand that information obtained during treatment may be disclosed based upon these ethical and legal requirements. All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions. Initial_____

Evaluation and Treatment

I will evaluate your presenting problem in the first one or two sessions. Evaluations may involve testing. I will inform you of my observations and treatment recommendations. My treatment methods include cognitive behavioral, Sand Tray, EMDR, and play therapy. Treatment usually lasts 3-6 months. In the event of an emergency I may be reached at the above phone number. If I am not available or in the event of a life-threatening emergency call the Coliseum Life Line at 1.800.548.4221, call 911 or go to your local hospital emergency room. Initial_____

Consent for Treatment

I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

☐ Yes ☐ No May we ask for information, exchange information and/or discuss your treatment with members of your family? If yes, with whom: _____

I have read and understand each of the policies outlined above:

Signature(s): _____ Date: _____

Witness: _____ Date: _____

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statements apply to the patient I represent.

Signature of legal Guardian/legal Representative: _____

Relationship to Patient: _____ Date: _____

Policy on court involvement

Please be advised that during treatment, if the client should become involved in **any type** of court case (i.e., child custody), we will not appear in court, write a letter to the court, or have any involvement with court proceedings. We have found that becoming involved in the court process has a negative effect on the therapeutic alliance with the client. If you are looking for a therapist to be involved in a court/custody case, it may be in your best interest to find another therapist. If we should be subpoenaed, understand that we require a $1000 retainer prior to any participation in the court process and charge $200/hour for all involvement with the court process, including prep work, consulting with an attorney, travel time, and testimony.

By signing below, I understand and agree to this policy.

Signature: _____

Telehealth Contract

Definition of Telehealth:

Telehealth involves the use of electronic communications to enable clinicians of Evans Psychology Group, LLC to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth. Copy of Office Policies and Informed Consent can be provided.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. This practice utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via VSee.

4. Your clinician follows the State of Georgia regulations for tele-health, as well as the respective board regulations (NASW) and ethics.

5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

**(N/A payment made by SAIL) Payment for Telehealth Services: Evans Psychology Group, LLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. If needed, you can request a statement of service to submit to your insurance company.

Patient Consent to the Use of Telehealth: I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client's Signature/Date _____

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Fee Schedule

Initial meeting/intake:

Psychologist fee: $150

Licensed Counselor fee: $120

Therapy sessions:

Psychologist fee: $125

Licensed Counselor fee: $100

Comprehensive Psychological evaluation:

Starting at $1000

Medical records review or sending of medical records:

$50 fee (but if this time exceeds one hour then the fee will be $100)

Production of a new document (e.g., treatment plan):

$100/hour

Cancellation fee (within 24 hours)/ No show fee:

$75

By signing below, I understand and agree to this policy:

Signature: _____

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CREDIT CARD ON FILE

I agree to have the following credit card information on file (in a secure file) and for it to be charged the **$75 cancellation fee** when I have cancelled an appointment within 24 hours or no showed for an appointment. I also agree for my credit card to be charged for any other owed payments to Evans Psychology Group. **This includes if insurance does not reimburse or cover the full fee for intake, sessions, or psychological testing.**

Credit Card Type: ☐ MasterCard ☐ Visa

Name on Credit Card: _____

Number on Card: _____

3 Digit Security Code; _____

Zip code: _____

Expiration Date: _____

Signature: _____

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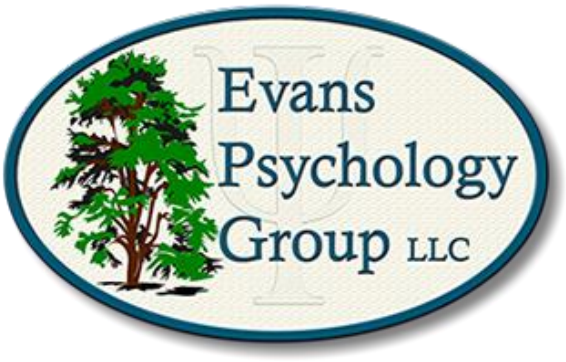
Policy on when clients are feeling medically ill

- Please be courteous to your clinician and other clients that the clinician sees and cancel your (or your child's) appointment if you (of they) have any type of contagious illness (i.e., cold, cough, strep throat, stomach virus, flu). Be advised that if the client is ill, the session will be cut short. To be courteous to you, I will always cancel (or offer to cancel) sessions when I am ill so that I do not get you or your family members sick (or provide you with that option).
- If you call the morning of the scheduled appointment *Due to Illness of client* you will not be charged the cancellation fee.
- However, if you call within two hours of the scheduled appointment to cancel, you will still be charged the cancellation fee. Please leave a voicemail on the office line if the office administrator is unable to pick up the phone or if it is prior to business hours.

By signing below, I understand and agree to this policy.

Signature: _____



Clinical Interview Guide (Caregiver/Parent)
Summary, Conclusions, and Recommendations

Child's Name: _____

Caregiver's Name: _____

DOB/Age: _____/_____ Race: _____ Gender (Circle One) **Male Female**

Evaluation Date(s): _____

Presenting Problems (including onset, precipitating events, duration, course, etc.)

_____ _____
_____
_____
_____
_____
_____
_____
_____
_____

Please put a check mark next to any symptoms your child currently experiences:

___ Problems with Sleep (↑↓)

___ Problems with Appetite (↑↓)

___ Depressed Mood

___ Decreased interest in activities

___ Self-Injurious Behavior (including cutting self)

___ Mania

___Grandiose thinking

___ Decreased need for sleep

____ Hallucinations

___ Anxiety

___ Fatigue

___ Fire-Setting

___ Lying

___ Stealing

___ Cruelty to Animals

___ History of Aggression

___ History of Running Away

___Impulsivity

___ Hyperactivity

___ Problems concentrating

___ Bedwetting

___ Anger issues

Legal History

Current Charge (and Status) Description of Incident(s)

1. _____ _____
2. _____ _____
3. _____ _____

Previous Charges:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Developmental History of child:

Pregnancy: Normal ___ Complications ____ Drug/Alcohol/Cigarette use during Pregnancy___

Delivery: (Normal, complications): Normal__Complications__Vaginal Delivery __ Cesarean ___

Developmental History (Walking/talking/potty trained): On time: ____ Early: ___ Late: ____

Medical History (including illnesses, injuries, surgeries, allergies, and medications:

_____

_____

_____

Current Household Composition:

Name	Age	Relationship to Child
1.		
2.		
3.		
4.		
5.		
6.		

Other parent and/or siblings (ages, location, frequency of contact, date of last contact):

_____

_____

History of Family Living Situations, and General Family Information (including whereabouts and nature of relationships with immediate family members, including **grandparents, both biological parents, and all siblings**): _____

Relationship with Parents and/or Caregivers?

Relationship with Siblings?

Behavior at Home (Regarding Chores, Directives, Disciplinary Actions, Etc.)

History of Abuse/Neglect/ DFACS involvement/Traumatic events?: Yes No (Circle One) If "yes," type/date/severity/duration/treatment/:

Recent Bereavement, Losses, deaths in the family: Yes___ No ___ If "yes," indicate event type/date/severity/duration/treatment information:

<u>Only answer following questions/checklist if have a history of trauma(s) or bereavement:</u>

When traumatic event occurred: Were you scared you would die or be hurt badly: Yes ___ No ____ Did someone else die or was someone else hurt badly? Yes ____ No ___
Were you **scared** someone else would die or be hurt badly? Yes ____ No ___

Reexperiencing Trauma Increased Arousal relating to trauma N/A _____

___ Nightmares

___When think about trauma, become very upset

___ Intrusive Thoughts

___Flashbacks

___ Having headaches/stomachaches/heart beats fast when think about the trauma

___ Hypervigilance (watching out for danger)

___ Feeling jumpy/startle easily

___ Feelings of anger

___ Problems concentrating

___Problems sleeping

Avoidance

___ Isolating yourself

___ Feeling alone inside

___Thinking you will not live a long life

___ Forgetting parts of the trauma(s)

___ Avoiding thoughts/feelings relating to trauma(s)

___ Avoiding people/places/activities relating to trauma(s)

___Problems feeling love/happiness/sadness/anger

___ Being scared the bad thing (Trauma) will happen again

Educational History: Current School: _____ Current Grade: ____

History of Repeated Grades? Yes No (Circle One) If so, which grade(s): _____

Special Education? YES NO (Circle one) If "Yes," Type/IEP: _____

Previous Schools Attended:

_____

_____

Grades (i.e., As, Bcs, Cs): _____School Attendance Record: _____

History of School Behavior: _____

_____

_____

_____

Suspensions _____ Expulsions _____

History of Psychoeducational testing? Yes No (Circle One)

Relationship with Peers/Friends:

_____

_____

Sexual Orientation: _____

Gender Identity: _____

Child's Strengths (Best Things About Him/Her, What He/She Does Well):

_____

_____

Child's Goals/Aspirations:

_____

_____

Psychiatric History (including diagnoses, medications, and inpatient/outpatient treatment [type, duration, clinician, outcome]): _____

_____

_____

_____

_____

History of Suicide/Homicide Attempts: YES NO If yes, provide detailed information (date, type/method, description, outcome, etc.): _____

_____

Family Medical/Psychiatric History: _____

_____

_____

History of Alcohol and Substance Use/Abuse/Dependence History of family members: _____

_____

_____

Alcohol and Substance use/abuse by child: _____

_____

Treatment Goal(s):

_____

_____

_____

(Following for clinician to fill out):

Mental Status: Mood: ___ Depressed ___ Euphoric ___ Cheerful ___ Irritable

Affect: ___ Appropriate ___Blunted ___ Flat

Appearance: ____ Well groomed ____Disheveled ____ Bizarre

Attitude: ____ Cooperative ___ Defensive ___ Indifferent ___ Hostile

Thought Process: ___ Logical ___ Incoherent ___ Obsessive __ Paranoid

Insight: ____ Poor ___ Fair ____ Good

Memory: ____ Not impaired ___ Slightly impaired ___Severely impaired

Judgment: ___ Fair ___ Good ___ Poor

Concentration: ___ Normal ___ Problems concentrating

Speech: __ Normal ___ Pressured ___ Incoherent

Oriented Times Three ____

DSM-V diagnoses are as follows:

AXIS I:_____

_____

_____

_____

_____

AXIS II: _____

_____

AXIS III: _____

AXIS IV: (Check appropriate symptoms):

___Problems with primary support group

___Educational Problems

___Problems related to the social environment

___ Legal Problems Other: _____

AXIS V: GAF = _____