



4571 C. Cox road · Evans, GA 30809 · 706-888-0299

Welcome!!

Welcome! Your child has been scheduled to receive an evaluation at Evans Psychology Group. Please come to the office at 4571 Cox Road, Suite C, Evans, Georgia, which is across from the Evans High School parking lot. Please expect that the testing will take approximately 2-3 hours. Please make sure that your child receives a good night's rest the night prior to the evaluation and that he or she has eaten a solid meal prior to the start of the evaluation session.

Please fill out the paperwork that is included in this packet and bring it back/email it back prior to the evaluation. Please fill out the Child Intake Packet prior to the intake.

The following is included:

- Child intake packet
- BASC-3- Self report (Labeled Self 1, Self 2) (For child to complete)
- BASC-3- Parent Report (Labeled PRS and Parent pg 2)
- Vanderbilt for Parent
- GARS-3 (if applicable)
- ABC (if applicable)

Prior to the appointment, please fill out the credit card form within the intake packet and return to the office. If you are not able to complete/email this form, you can also call the office administrator, Sondra, and provide her with the information. If you have any questions or concerns, please contact the office administrator, Sondra, at the above listed number. If you are unable to make it to the appointment, please call at least 24 hours prior to the appointment to cancel/reschedule.

Be advised that there is a \$100 fee for cancellations within 24 hours, and a \$150 fee for no shows. and the credit card on file will be charged if needed.

Thank you.

Sincerely,

Evans Psychology Group, LLC



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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 Psychological Evaluation with Covid-19 Precautions

At Evans Psychology Group, our highest priority is to keep our patients and staff as safe as possible. Please read the following testing procedures prior to completing psychological evaluation. Please know that at Evans Psychology Group, we are following guidelines for best practices for hygiene and infection control. At this time, I would like to provide you with a plan to complete the psychological evaluation. Please read the following and call the office to set up an appointment if you are comfortable with these safety measures.

1. All measures will be emailed to you (Parent and child forms) to complete. Once completed, forms will be emailed/faxed back or mailed to the office prior to the intake.
2. The initial intake meeting with the parent will be by telehealth (Please see telehealth consent included in the child intake packet). During the telehealth appointment, I would collect any and all information that is possible over telehealth means. I would complete the intake with the parent and review any assessment measures that are needed.
3. An in-person appointment will be set up for the child to complete intelligence, achievement, and any other in-person testing that is required.
 - a. For the in-person meeting, the following protocol is in place and rules must be followed if meeting in person.
 - i. All testing items will be sanitized by Evans Psychology Group prior to the child being evaluated.
 - ii. Client will have their temperature taken when they enter the building, and if the temperature is 99.9 or higher, the testing will be rescheduled. *Client will not come into the office if they display any symptoms of illness (i.e., coughing, sneezing, nausea, stomachaches).
 - iii. Please cancel the appointment if the child or family members displays any symptoms of Covid-19 or has been exposed to anyone with Covid-19 in the last 14 days.
 - iv. Therapist and child will both wear masks at all times of the evaluation. Child will wash their hands when entering the building and use hand sanitizer throughout the testing session.
 - v. The parent will wait in their car during the testing.
4. Unfortunately, even with strict social distancing and cleaning protocol, as with any other public place, Evans Psychology Group cannot guarantee that you (or your child) will not be infected with COVID-19 while attending in-person sessions. By signing this release form, you agree to waive any claims of liability against Evans Psychology Group and to hold Evans Psychology Group harmless if your child contracts COVID-19 despite our great efforts to prevent it. Additionally, you agree to notify Evans Psychology Group if your child or any member of your household contracts COVID-19 or comes into contact with someone who tested positive for COVID-19. This information will remain confidential and will help ensure the utmost safety of all our clients and Therapists.

I agree to the following terms of the psychological evaluation with Covid-19 precautions.

Parent's Signature: _____



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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 **\$100 fee** charged to your account. It costs you money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.) We don't charge you the actual cost for that appointment but rather a **\$100 fee**. Advance notice allows another client time to reserve it in place of you. Please be courteous and responsible. Thank you. If you no show for an appointment, all future appointments will be removed, and a **\$150 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. If 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 Form. 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



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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: _____



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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.

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: \$175

Therapy sessions:

Psychologist fee: \$150

Comprehensive Psychological evaluation:

Starting at \$1200

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)

\$100

No show fee:

\$150

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 **\$100 cancellation fee** when I have cancelled an appointment within 24 hours or **\$150 fee if I have 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: _____



**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.)/Reason for referral:

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

- | | |
|---|--|
| <input type="checkbox"/> Problems with Sleep (↑↓) | <input type="checkbox"/> Fire-Setting |
| <input type="checkbox"/> Problems with Appetite (↑↓) | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Decreased interest in activities | <input type="checkbox"/> Cruelty to Animals |
| <input type="checkbox"/> Self-Injurious Behavior (including cutting self) | <input type="checkbox"/> History of Aggression |
| <input type="checkbox"/> Mania | <input type="checkbox"/> History of Running Away |
| <input type="checkbox"/> Grandiose thinking | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Problems concentrating |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> 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: ___

Adaptive Behaviors: Are there any delays in adaptive behaviors (ie., grooming, getting dressed, avoiding danger, safe food handling, following school rules, cleaning, practice social skills, and take personal responsibility.

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

Current Household Composition:

Name Age Relationship to Child

1.		
2.		
3.		
4.		
5.		

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:

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

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 _____

- | | |
|--|---|
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Hypervigilance (watching out for danger) |
| <input type="checkbox"/> When think about trauma, become very upset | <input type="checkbox"/> Feeling jumpy/startle easily |
| <input type="checkbox"/> Intrusive Thoughts | <input type="checkbox"/> Feelings of anger |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Problems concentrating |
| <input type="checkbox"/> Having headaches/stomachaches/heart
beats fast when think about the trauma | <input type="checkbox"/> Problems sleeping |

Avoidance

- | | |
|---|--|
| <input type="checkbox"/> Isolating yourself | <input type="checkbox"/> Avoiding thoughts/feelings relating to trauma(s) |
| <input type="checkbox"/> Feeling alone inside | <input type="checkbox"/> Avoiding people/places/activities relating to trauma(s) |
| <input type="checkbox"/> Thinking you will not live a long life | <input type="checkbox"/> Problems feeling love/happiness/sadness/anger |
| <input type="checkbox"/> Forgetting parts of the trauma(s) | <input type="checkbox"/> 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 (including preschool if applicable):

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:

School strengths: _____

School weaknesses: _____

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

Child's General weaknesses (Things child struggles with):

Child's Goals/Aspirations:

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

History of Occupational Therapy/ Speech Therapy/ Physical Therapy, or related (adaptive swim, hippotherapy, etc): _____

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):
