



**Spectrum Psychology and Wellness, LLC**  
**Acknowledgement of Office Policies and Clinical Conditions of Evaluation and Treatment**

\_\_\_\_\_ I acknowledge having scheduled a voluntary Psychological evaluation for diagnostic and treatment purposes with a  
 Initial practitioner at Spectrum Psychology and Wellness, LLC (SP&W). I acknowledge understanding that after completion of the  
 initial evaluation session, a decision can be made by either party to establish, or not to establish, a practitioner-patient relationship.  
 In this event, we will be happy to provide you the name of at least 3 local mental health professionals for a second opinion.

\_\_\_\_\_ I acknowledge that SP&W does not provide Emergency Psychological or Continuous Crisis Management services, and agree  
 Initial to contact the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call, dial 911, or call  
 the EMPACT crisis hotline at 480-784-1500 for assistance. I also recognize that my practitioner's schedule is filled in advance and  
 may not allow for patients to be seen on an urgent basis unless there is a cancellation.

\_\_\_\_\_ I acknowledge understanding that SP&W's policy regarding **treatment of minors** requires that if legal documents exist  
 Initial regarding custodial agreements it is required that a copy be on file with our office. I also acknowledge understanding that  
 in the event of a parental separation or divorce, both parents **MUST** consent, in writing, to this assessment. Similarly, if one parent  
 retains sole legal custody, this parent **MUST** provide legal documentation of this in order for assessment to proceed. In the case of  
 joint custody, both parents **MUST** consent to the assessment. I understand that both parents, regardless of custody, have a legal right  
 to records (see Arizona Revised Statute 25-403.06)

\_\_\_\_\_ I acknowledge receiving a copy of the Psychologist-Patient Agreement packet and that I have reviewed and agreed to the  
 Initial fees listed under "Professional Fees."

\_\_\_\_\_ I understand that I will be able to provide payment of my choice at each time of service. I also understand that a  
 Initial credit/debit card **OR** cash deposit of \$100 is **REQUIRED** to be on file for any remaining balance after my claim or account  
 has been processed (e.g., co pays, co insurance, deductible, self-pay fees, no-show/late cancel fees).

\_\_\_\_\_ I understand that fees for patients who are using health insurance will vary based on the benefits provided by each specific  
 Initial health insurance plan. I understand this information can be obtained prior to my first appointment by contacting my health  
 insurance company. ***I acknowledge that SP&W will assist me in filing my insurance claim as a courtesy to me, but that  
 knowledge of my insurance contract and its limitations are not their responsibility.***

\_\_\_\_\_ I acknowledge understanding and agreeing to the following policy: ***SP&W requires at least 24 hours' notice prior to  
 Initial canceling an appointment. Because we offer appointment reminders and commonly have a waiting list, missed  
 appointments that were not canceled with 24 hours' notice will incur a charge to your credit/debit card on file at the rate of  
 \$135. Late cancelations and/or arriving 15+ min. past your scheduled appointment time will incur a charge at the rate of \$80.  
 This fee cannot be charged to insurance. Additionally, in the best of circumstances it is impossible to guarantee a 100%  
 delivery rate of appointment reminders, due to factors outside our control (i.e., bad phone numbers or email addresses, or  
 reminders being misclassified as "spam"). It is always best to view reminders as a "courtesy" rather than a "certainty." Missed  
 appointment fees will still apply. The benefit of reserving your therapist's time specifically for your session is that you rarely  
 have any significant wait time. However, if you fail to keep your appointment, or fail to cancel more than 24 hours prior to the  
 session, this block of time is no longer available to others and will still be billed to you.***

\_\_\_\_\_ I agree to assign insurance benefits to SP&W. I agree to pay the co-payment and/or deductible for each session at the time  
 Initial of service and/or upon claim processing. If I choose to file an insurance claim on my own, I understand that I will be provided a  
 receipt for services in order to file for insurance reimbursement. I will then be responsible for filing all insurance claims and for payment of  
 full fees at the time of service. There is no discount for filing insurance claims and I understand I am responsible for all deductibles and co-  
 payments at the time of service and/or upon claim processing. I have been advised of SP&W's policies and agree to the terms for fees and  
 payment listed in the paperwork given to me. I hereby authorize the release of information necessary to file or substantiate claims with my  
 insurance company. ***I understand that I am responsible for the balance of my account in full, whether covered by insurance or not, and  
 that billing my insurance company is a courtesy extended to me by SP&W.***

***Your signature below acknowledges that you have read, understand, and agree to these policies:***

\_\_\_\_\_  
 Patient/Legal Guardian Signature

\_\_\_\_\_  
 Date

**WE REQUIRE A CREDIT CARD TO BE ON FILE FOR ANY BALANCE NOT PAID BY YOUR INSURANCE COMPANY**

**Credit/Debit Card/Deposit Authorization Form**  
***All information will remain secured and confidential.***

You will be able to provide payment of your choice at each time of service. However, a credit/debit card OR \$100 cash deposit is **REQUIRED** to be on file, regardless if you are using insurance or not. This credit/debit card or cash deposit will be used for any remaining balance after any applicable insurance claims (if insurance is used) or fees have been processed (e.g., co-pays, co-insurance, deductible, self-pay fees, no-show/late cancel fees). If your credit/debit card is declined at the time of collection, you will be required to leave a cash deposit for any future transactions. If your cash deposit is depleted to cover any charges on your account, you will be required to re-establish this deposit to be held for any future fees that are not paid in advance. If a balance remains on your account, it will be refunded.

Since insurance policies and benefits differ among plans, we are unable to know the specifics of your insurance policy. While Spectrum Psychology & Wellness, LLC will assist you in filing your insurance claim as a courtesy to you, knowledge of your insurance contract and its limitations are not our responsibility, and you are responsible for the balance of your account in full, whether covered by insurance or not.

***SP&W requires at least 24 hours' notice prior to canceling an appointment. Because we offer appointment reminders and commonly have a waiting list, missed appointments that were not canceled with 24 hours' notice will incur a charge to your credit/debit card on file at the rate of \$135. Late cancelations and/or arriving 15+ min. past your scheduled appointment time will incur a charge at the rate of \$80. This fee cannot be charged to insurance.***

***Additionally, in the best of circumstances it is impossible to guarantee a 100% delivery rate of appointment reminders, due to factors outside our control (i.e., bad phone numbers or email addresses, or reminders being misclassified as "spam"). It is always best to view reminders as a "courtesy" rather than a "certainty." Missed appointment fees will still apply. The benefit of reserving your therapist's time specifically for your session is that you rarely have any significant wait time. However, if you fail to keep your appointment, or fail to cancel more than 24 hours prior to the session, this block of time is no longer available to others and will still be billed to you. For additional information about fees and insurance, please refer to the Psychologist-Patient Agreement under "Professional Fees."***

**I am authorizing Spectrum Psychology and Wellness, LLC to charge my credit/debit card for any balance due on my account from any services related to my treatment at Spectrum Psychology and Wellness, LLC.**

Cardholder/Depositors Printed Name: \_\_\_\_\_

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

Credit Card Type:    \_\_\_ Visa            \_\_\_ MasterCard            **\_\_\_ NOT ACCEPTED AT THIS OFFICE \_\_\_ AMEX**  
                             \_\_\_ HSA Card                \_\_\_ DEBIT CARD

Credit/Debit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV/CVC # (Three digits on back of card): \_\_\_\_\_

\_\_\_\_\_  
Cardholder/Depositors Signature

\_\_\_\_\_  
Date



Spectrum Psychology and Wellness, LLC  
Boston Professional Village  
1772 E. Boston Street Ste 105 | Gilbert, AZ 85295-6242  
o: 480.621.7257 | f: 480.584.5825 | http://www.SpectrumWellnessAZ.com

**General contact with Spectrum Psychology and Wellness:**

Spectrum Psychology and Wellness is a reception-less office.

What this means is that there is not a front office staff member that sits in the lobby at our offices.

Our office manager and support staff do not work on site but can be reached by leaving a message at our main number, 480-621-7257, and selecting option #1. The phone will not be answered directly and you will be instructed to leave a message that should be returned within a 24-hour period.

All scheduling (cancelations within the allowed period and rescheduling) is done by you, the patient, on the patient portal that you registered on at <http://www.SpectrumWellnessAZ.com>.

**New Patient Initial Visit Procedure:**

As mentioned above, Spectrum Psychology and Wellness is a reception-less office. When you arrive for your first visit with us, please locate the light switch panel under the TV in the lobby. Please flip up and leave on the light switch for your provider so they know you have arrived.

**1772 E Boston St #105**  
1772 E Boston St #105, Gilbert, AZ 85295  
Directions Save View larger map

SHOPPES AT VAL VISTA  
SPECTRUM FALLS PROFESSIONAL PARK CONDOMINIUM  
VAL VISTA CLASSIC  
VILLAGE AT SPECTRUM  
SANTAN VILLAGE  
Walmart Supercenter  
Pillar at Santan Village Apartments

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Spectrum Psychology and Wellness, LLC.  
1772 East Boston Street,  
#105  
Gilbert, AZ 85295

Telephone: +1 480 621 7257  
FAX: +1 480 584 5825  
E-mail: Admin@SpectrumWellnessAZ.com



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 o: 480.621.7257 | f: 480.584.5825 | <http://www.SpectrumWellnessAZ.com>

## Psychologist-Patient Agreement

*Please read and sign, and return only the last page*

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. You and your practitioner can discuss any questions you have about procedures. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless action has been taken in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

### PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the patient, and the particular problems you are experiencing. Psychotherapy as we practice it is a relationship focused, respectful, and goal oriented discussion process designed to help you address particular problems you are experiencing. There are different methods and treatment approaches your practitioner may use to deal with the problems you hope to address. In order for psychotherapy to be effective, it calls for a very active effort on your part. The more honest, truthful, and genuine you are with your practitioner about what you believe, think, say or do, in your daily life outside this office, and with your practitioner in this office, the more likely it is that you will really understand yourself, your practitioner will really understand you, and you and your practitioner can work together to help you heal. In the same way, your practitioner will be honest with you. At times, your practitioner may ask you to work on assignments in between sessions; this often speeds the therapeutic process and makes it more effective. Your first sessions will involve an evaluation of your treatment needs. By the end of the evaluation, your practitioner will be able to offer you their clinical impressions of what our work will include and a treatment plan to follow. Please consider this information along with your own opinions of whether you feel comfortable working with your practitioner. Therapy involves a commitment of time, money and energy, so please be careful about the practitioner you select. If you ever have questions about your practitioner's treatment approach, they will be glad to discuss their methods and techniques with you. Similarly, after completion of the initial evaluation session, a decision can be made by either party to establish, or not to establish, a practitioner-patient relationship. In this event, we will be happy to provide you the name of at least 3 local mental health professionals for a second opinion.

Psychotherapy can have risks and benefits. Many individuals and families who participate in psychotherapy benefit from the process. Therapy can facilitate self-discovery, emotional expression of difficult and painful feelings, coping skills, as well as strengthen interpersonal relationships. Furthermore, the process of therapy provides opportunities to uncover novel solutions to difficult and painful problems. However, a "cure" is not guaranteed, and participating in psychotherapy can yield risks as well. The process of talking about problems can elicit painful feelings and interpersonal conflict. Although this can be uncomfortable, it is often a natural and normal occurrence within the change process.

### MEETINGS

The initial assessment occupies the bulk of the first session. During this time, you can both decide if your practitioner is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, one 50-minute session (one appointment hour of 50 minutes duration) is usually scheduled per week at a time agree on, although some sessions may be longer or more frequent depending on the issues that arise or scheduling constraints. The frequency of sessions typically decreases as progress is being achieved. **If you need to cancel an appointment, please do so with at least 24 hours advance notice. Missed appointments, late cancellations or arriving 15+ min. past your scheduled appointment time will incur a charge.** This fee cannot be billed to insurance.

### PROFESSIONAL FEES

All fees are due at the time of service. Fees for clients who are using health insurance will vary based on the benefits provided by each specific health insurance plan. This information can be obtained prior to your first appointment by contacting your health insurance company. For patients who are paying for sessions out-of-pocket, the fee for the initial diagnostic consultation is \$180 and each subsequent appointment is \$150 per session. There is a \$75 fee for each additional 30 min. increment beyond the usual session time in crisis or emergency services. Fees for psychological testing and report writing are \$180/hr. A full test battery may range from 7-10 hours. Records review for diagnostic purposes will be charged at a \$50 fee per 15 min. increment. There is a \$30 fee per 15 min. increment for any special reports, clinical letters, forms or any other written document, including those related to FMLA, short or long-term disability, Social Security Disability or chronic health condition exemption forms. A returned check fee for insufficient funds (per occurrence) is \$25. Copies mailed over 15 pages (16th+) will be charged at a rate of \$0.50/page + postage. A records fee for printed copies is \$0.07 per page. Fees for other as needed services will vary by service and administration time required. The fee for legal proceedings/meetings (charged portal to portal) is \$250/hr, + \$1000 retainer for services requiring more than four

hours (charged and collected before the date of the trial or meeting). Other services may include telephone conversations lasting longer than ten minutes, consultations with other agencies/professionals (with your permission), etc. **Please provide at least 24 hours' notice prior to canceling an appointment. Because we offer appointment reminders and commonly have a waiting list, missed appointments that were not canceled with 24 hours' notice will incur a charge to your credit/debit card on file at the rate of \$135. Late cancellations and/or arriving 15+ min. past your scheduled appointment time will incur a charge at the rate of \$80. This fee cannot be charged to insurance. Additionally, in the best of circumstances it is impossible to guarantee a 100% delivery rate of appointment reminders, due to factors outside our control (i.e., bad phone numbers or email addresses, or reminders being misclassified as "spam"). It is always best to view reminders as a "courtesy" rather than a "certainty." Missed appointment fees will still apply. The benefit of reserving your therapist's time specifically for your session is that you rarely have any significant wait time. However, if you fail to keep your appointment, or fail to cancel more than 24 hours prior to the session, this block of time is no longer available to others and will still be billed to you.**

## CONTACTING US

Due to work schedule constraints, your practitioner is often not immediately available by telephone. When they are unavailable, the telephone is answered by a trusted Spectrum Psychology and Wellness, LLC, an Arizona limited liability company (the Practice) employee or a confidential voicemail system. Please leave your message and we will make every effort to return your call promptly. The confidential voicemail system works 24 hours a day, seven days a week. Please leave your call back number with your message as your practitioner may be away from the office when they receive your message, and therefore be unable to consult your chart for your telephone-contact information. The practice does not provide Emergency Psychological or Continuous Crisis Management services. If you are unable to reach your practitioner and feel you cannot wait for them to return your call, contact the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call, dial 911, or call the EMPACT crisis hotline at 480-784-1500 for assistance. In the event that a practitioner will be out of the office for an extended period of time, the voicemail greeting will provide the name(s) of the psychologist(s) covering for them, along with their contact information. Please note that your practitioner's schedule is filled in advance and may not allow for patients to be seen on an urgent basis unless there is a cancellation.

## SOCIAL MEDIA POLICY

This policy outlines our office practices related to use of Social Media. Please read it to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect the Practice to respond to various interactions that may occur between us on the Internet. If you have any questions about anything in this document, we encourage you to bring them up when you meet with your practitioner.

### FRIENDING

The Practice and its employees do not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, Plaxo, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of the therapeutic relationship.

### FOLLOWING

The Practice and its employees may publish a blog on our website or post psychology news on Twitter. We have no expectation that you as a patient will want to follow our blog or Twitter stream. However, if you use an easily recognizable name on Twitter and we happen to notice that you've followed us there, we may briefly discuss it and its potential impact on our working relationship. Our primary concern is your privacy. If you share this concern, there are more private ways to follow us on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to our content. You are welcome to use your own discretion in choosing whether to follow us. Note that we will not follow you back, as we do not follow current or former clients on blogs or Twitter. Our reasoning is that we believe casual viewing of patients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy our personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with your practitioner, please bring them into your sessions where you and your practitioner can view and explore them together, during the therapy hour.

### INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, Plaxo or LinkedIn to contact the Practice. These sites are not secure and messages may not be read in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with the Practice in public online if we have an already established patient/practitioner relationship. Engaging with the Practice in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact our office between sessions, the best way to do so is by phone. Direct email at Admin [at] SpectrumWellnessAZ [dot com] is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

### USE OF SEARCH ENGINES

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If the Practice has a reason to suspect that you are in danger and you have not been in touch with us via usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if the Practice ever resorts to such means, it will be fully documented and discussed with you when you and your practitioner next meet.

### GOOGLE READER

The Practice or its employees do not follow current or former clients on Google Reader and do not use Google Reader to share articles. If there are

things you want to share with the Practice that you feel are relevant to your treatment whether they are news items or things you have created, we encourage you to bring these items of interest into your sessions.

### **BUSINESS REVIEW SITES**

You may find our psychology and wellness practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, Kudzu, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find the Practice on any of these sites, please know that our listing is NOT a request for a testimonial, rating, or endorsement from you as our client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence." Of course, you have the right to express yourself on any site you wish. But due to confidentiality, the Practice cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should be aware that if you are using these sites to communicate indirectly with the Practice about your feelings about our work, there is a possibility that we may never see it.

If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide you and your practitioner are not a good fit. None of this is meant to keep you from sharing that you are in therapy with the Practice wherever and with whomever you like. Confidentiality means that we cannot tell people that you are our client and our Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish that the Practice provides you therapy or how you feel about the treatment provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel the Practice have done something harmful or unethical and you do not feel comfortable discussing it with your practitioner, you can always contact the Ethics Committee at the Arizona Psychological Association, or the Arizona Board of Psychologist Examiners, which oversees licensing.

### **LOCATION-BASED SERVICES**

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, Facebook, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office. Please be aware of this risk if you are intentionally "checking-in," from our office or if you have a passive LBS app enabled on your phone.

### **EMAIL**

The Practice or its employees prefer using email only to arrange or modify appointments. Please do not email the Practice content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with us by email, be aware that all emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails the Practice receive from you and any responses that we send to you become a part of your legal record.

### **LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can release information about your treatment to others only if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advanced consent. Your signature on this Agreement provides consent for those activities, as follows:

- Your practitioner may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, your practitioner will make every effort to avoid revealing the identity of their patients. The other professionals are also legally bound to keep information confidential. If you do not object, your practitioner will not tell you about these consultations unless they feel it is important to your work together. They will note all consultations in your clinical record (which is called "PHI" in our Notice of Psychologist's policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that the Practice practices with other mental health professionals and that they may employ administrative staff. In most cases, your practitioner needs to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members are trained about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- The Practice or its employees also have contacts with skilled nursing facilities and hospitals. As required by HIPAA, we have formal business associate contracts with these business, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- If a patient threatens to harm himself/herself, the Practice may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where the Practice is permitted or required to disclose information without either your consent or authorization:

- If you are in a court proceeding and a request is made for information concerning the professional services we provided you, such information is protected by the psychologist-patient privilege law.
- Any information disclosed during the course of the professional services we provide you is protected by the psychologist-patient privilege law.

In each of the above situations, the Practice cannot provide any information without your or your legal representative's written authorization, or a court order. If you are involved in or contemplating rules of confidentiality. All staff members are trained about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- If a patient files a complaint or lawsuit against the Practice, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a governmental agency is requesting the information for health oversight activities, the Practice may be required to provide information for it.
- If a patient files a worker's compensation claim, and the Practice is providing services related to that claim, we must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which the Practice is legally obligated to take actions, which we believe necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment.

- Your practitioner is required by law to report any suspicions of child abuse to the Office of Child Protective Services.
- Your practitioner is required by law to report any suspicions of elder abuse.
- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identifiable victim, and your practitioner believes that the patient has the intent and ability to carry out such a threat, they must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, your practitioner will make every effort to discuss it with you fully before taking any action, and will limit their disclosure to what is necessary. If you have any questions about the exceptions to confidentiality, please ask and we can discuss and clarify these issues.

### **PROFESSIONAL RECORDS**

The laws and standards of our profession require that we keep Protected Health Information about you in your clinical record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to the Practice confidentially by others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in your practitioner's presence, or have them forwarded to another mental health professional so you can discuss the content.

In addition, your practitioner may also keep a set of Psychotherapy Notes. These notes are for your practitioner's own use and are designed to assist them in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of your conversations during sessions as well as your practitioner's clinical impressions. These notes also contain particularly sensitive information that you may reveal to your practitioner that is not required to be included in your clinical record. These Psychotherapy Notes are kept separate from your clinical record. While insurance companies can request and receive a copy of your clinical record, they cannot receive a copy of your Psychotherapy Notes without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes, though we recommend you discuss such notes together with your practitioner.

Your treatment records and/or testing materials are maintained for a minimum of three years past a minor's 18th birthday OR for at least seven years from the date of the last visit (adult or minor), whichever is longer (See Arizona Revised Statute 12-2297). In the untimely event of death or incapacity, or the termination or selling of the practice, client records of those who are actively receiving services (e.g. seen within the last month) will be given to one or more local behavioral health professional(s) to facilitate the continuation of treatment. In such situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for referral. Records for inactive clients will be handled by a "records custodian," which may be an individual or company. The custodian will be responsible for satisfying records requests and destroying records when the legal time frames for records retention have been satisfied. Please refer to ARS 32-3211 for more information.

### **AUDIO TAPED RECORDS**

There are times during the assessment portion of a psychological, psychoeducational, or neuropsychological evaluation where your responses may be audio recorded to assist with the accuracy of your responses and for accurate scoring of your performance on the assessments. You have the right to decline consent for this at any point. The contents of the audiotape will not be shared and will remain part of the confidential patient record that will be protected in the same manner as all other confidential records. Similarly, the storage of the audiotape will abide and adhere to the Ethical Code standards, along with appropriate statute regarding storage of patient files.

### **PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of protected health information. These rights include requesting that your practitioner amend your record; requesting restrictions on what information from your clinical record is



disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected health information disclosures are sent; having any complaints you make about the Practice's policies and procedures recorded in your records; and the right to a paper copy of the Agreement, the attached notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

#### **MINORS AND PARENTS**

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records and/or testing materials. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, we typically request that parents respect their children's privacy. We typically provide parents with general information about the progress of the child's treatment and general issues being addressed. Since we often conduct collateral individual and family meetings, we maintain the child's privacy during collateral family sessions as well. In situations where your practitioner hears information that leads them to suspect the child's safety is in danger, the child's confidentiality is breached and your practitioner informs the parent(s) of their concern.

As children are part of a family system, decisions about psychological, medical, and/or educational care, etc. must be made by the child's legal guardian(s), who must be physically present to provide consent, have an opportunity to be fully informed of the assessment process, be provided with an opportunity to ask questions, and in order for identity to be verified. In the event of a parental separation or divorce, both parents MUST consent, in writing, to this assessment. Both parents are invited and encouraged (as they are able) to participate in the process of assessment and treatment planning. If one parent retains sole legal custody, this parent MUST provide legal documentation of this in order for assessment to proceed. In the case of joint custody, both parents MUST consent to the assessment. Both parents, regardless of custody, have a legal right to records (see Arizona Revised Statute 25-403.06)

#### **BILLING AND PAYMENTS**

You will be able to provide payment of your choice at each time of service. However, if you are using insurance, a credit/debit card is REQUIRED to be on file for any remaining balance after my claim or account has been processed (e.g., co pays, co insurance, deductible, self-pay fees, no-show/late cancel fees). You will be expected to pay for each session at the time it is held and/or upon claim processing, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, the Practice may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the Practice has the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require the Practice to disclose otherwise confidential information. In most circumstances, the information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

#### **INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. The Practice or its employees will fill out forms and provide you with whatever assistance we can in helping you received the benefits to which you are entitled as a courtesy to you; however, knowledge of your insurance contract and its limitations are not The Practice's responsibility, and you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course the Practice will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMO's and PPO's often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel they need more services after insurance benefits end. Some managed-care plans will not allow your practitioner to provide services to you once your benefits end. If this is the case, the Practice will do their best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that your practitioner provide it with information relevant to the services we provide to you. Your practitioner is required to provide a clinical diagnosis. Sometimes your practitioner is required to provide additional clinical information such as treatment plans or summaries, or copies of the entire Clinical Record (in rare cases). In such situations, the Practice will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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, the Practice has 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. We will provide you with a copy of any report submitted, if you request it. By signing this Agreement, you agree that the Practice can provide requested information to your carrier. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract.

## NOTICE OF PRIVACY PRACTICES

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

<p><b>Your Rights</b> You have the right to:</p> <ul style="list-style-type: none"> <li>• Get a copy of your paper or electronic medical record</li> <li>• Correct your paper or electronic medical record</li> <li>• Request confidential communication</li> <li>• Ask us to limit the information we share</li> <li>• Get a list of those with whom we've shared your information</li> <li>• Get a copy of this privacy notice</li> <li>• Choose someone to act for you</li> <li>• File a complaint if you believe your privacy rights have been violated</li> </ul> <p><b>Your Choices</b> You have some choices in the way that we use and share information as we:</p> <ul style="list-style-type: none"> <li>• Tell family and friends about your condition</li> <li>• Provide disaster relief</li> <li>• Include you in a hospital directory</li> <li>• Provide mental health care</li> <li>• Market our services and sell your information</li> <li>• Raise funds</li> </ul> <p><b>Our Uses and Disclosures</b> We may use and share your information as we:</p> <ul style="list-style-type: none"> <li>• Treat you</li> <li>• Run our organization</li> <li>• Bill for your services</li> <li>• Help with public health and safety issues</li> <li>• Do research</li> <li>• Comply with the law</li> <li>• Respond to organ and tissue donation requests</li> <li>• Work with a medical examiner or funeral director</li> <li>• Address workers' compensation, law enforcement, and other government requests</li> <li>• Respond to lawsuits and legal actions</li> </ul> <p><b>Your Rights</b> <b>When it comes to your health information, you have certain rights.</b> This section explains your rights and some of our responsibilities to help you.</p> <p><b>Get an electronic or paper copy of your medical record</b></p> <ul style="list-style-type: none"> <li>• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.</li> <li>• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.</li> </ul> <p><b>Ask us to correct your medical record</b></p> <ul style="list-style-type: none"> <li>• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.</li> <li>• We may say "no" to your request, but we'll tell you why in writing within 60 days.</li> </ul> <p><b>Request confidential communications</b></p> <ul style="list-style-type: none"> <li>• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.</li> <li>• We will say "yes" to all reasonable requests.</li> </ul>	<p><b>Ask us to limit what we use or share</b></p> <ul style="list-style-type: none"> <li>• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.</li> <li>• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.</li> </ul> <p><b>Get a list of those with whom we've shared information</b></p> <ul style="list-style-type: none"> <li>• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.</li> <li>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.</li> </ul> <p><b>Get a copy of this privacy notice</b> You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.</p> <p><b>Choose someone to act for you</b></p> <ul style="list-style-type: none"> <li>• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.</li> <li>• We will make sure the person has this authority and can act for you before we take any action.</li> </ul> <p><b>File a complaint if you feel your rights are violated</b></p> <ul style="list-style-type: none"> <li>• You can complain if you feel we have violated your rights by contacting us at Spectrum Psychology and Wellness, LLC 1772 E. Boston Street Ste 105 Gilbert, AZ 85295-6242, calling 480-621-7257, or emailing at Admin [at] SpectrumWellnessAZ [dot com]. You may also contact the Ethics Committee of the Arizona Psychological Association (AzPA) for further information.</li> <li>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <a href="http://www.hhs.gov/ocr/privacy/hipaa/complaints/">www.hhs.gov/ocr/privacy/hipaa/complaints/</a>.</li> <li>• We will not retaliate against you for filing a complaint.</li> </ul> <p><b>Your Choices</b> <b>For certain health information, you can tell us your choices about what we share.</b> If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.</p> <p>In these cases, you have both the right and choice to tell us to:</p> <ul style="list-style-type: none"> <li>• Share information with your family, close friends, or others involved in your care</li> <li>• Share information in a disaster relief situation</li> <li>• Include your information in a hospital directory</li> </ul>
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*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

## **Do research**

We can use or share your information for health research.

## **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

## **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

## **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

## **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

## **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*This notice originally went into effect on August 1, 2010. Revised on September 23, 2013.*

**Please sign and return after reading the Psychologist-Patient Agreement and the HIPPA Notice above. Pages 4-11 are yours to keep for your reference.**

**1) Consent for Treatment:**

- I have freely chosen to receive psychotherapy or assessment services and understand that you are free to terminate services at any time.
- I understand that during the course of diagnostic assessment or therapy that at times it is necessary to discuss material that may be upsetting in order to receive help.
- I understand that records and/or testing materials or information collected about you will be held or released in accordance with the state laws regarding confidentiality of such records.
- I understand that state and local laws require that practitioners report all cases in which there is a danger to self or others as well as any information that might be related to child or elder abuse.
- I understand that you have the following patient rights:
  - The right to be informed about various steps and activities involved in receiving treatment.
  - The right to be informed about the limits of confidentiality under federal and state laws related to the receipt of services.
  - The right to be given information in order to make informed decisions about whether to accept or refuse treatment.
  - The right to be informed in advance of charges for services.
  - The right to all available services without discrimination of race, color, sex, creed, age, handicap, marital status, or origin.
  - The right to referrals as appropriate for other behavioral health providers or other services.
  - The right to humane treatment that affords reasonable protection from harm, freedom from verbal or physical abuse, and appropriate privacy.

<b>TREATMENT OF A MINOR</b>			
If you are consenting to receive services <b>for your minor child</b> , please select the custodial arrangement that applies to your current situation. If legal documents exist regarding custodial agreements it is required that a copy be on file with our office. <b>*Please bring a copy of Custody Decree to your first appointment.</b>			
<input type="checkbox"/> Biological parents residing together.  -Consent for treatment form may be signed by one biological parent.	<input type="checkbox"/> Biological parents not residing together - - sole custody arrangement. -*Consent for treatment form must be signed by the parent with sole custody.	<input type="checkbox"/> Biological parents not residing together - - joint custody arrangement. -*Consent for treatment form MUST be signed by BOTH biological parents.	
_____	_____	_____	_____
Custodial Parent/Legal Guardian Signature	Date	Custodial Parent Signature	Date

**2) HIPAA Privacy Acknowledgement:**

- I have received the HIPAA Privacy Notice regarding the uses and disclosures of your Protected Health Information and understand my rights and responsibilities with respect to my medical records.
- I hereby authorize Spectrum Psychology and Wellness, LLC (SP&W) to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.
- I also authorize the release of information that may be necessary in the processing of any insurance claims.
- I also authorize the release of medical records to Spectrum Psychology and Wellness, LLC upon request.
- When expedient, I authorize the transmittal of my records by FAX. I understand that transmission by FAX, by its very nature, is not confidential.

**PERSONAL REPRESENTATIVES (family members, attorneys, etc.):** I hereby authorize SP&W and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

Name _____	Relationship to Patient _____	Name _____	Relationship to Patient _____
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**3) Coordination of Care:**

Many insurance companies require contracted behavioral health practitioners and facilities to coordinate treatment with other behavioral health practitioners, primary care physicians (PCPs), and other appropriate medical practitioners involved in a member's care.

Name of other practitioner/PCP involved in your care _____	Phone/Fax number _____
<input type="checkbox"/> I hereby freely, voluntarily and without coercion, authorize SP&W to facilitate continuity and coordination of treatment with the individual listed above. I understand no medical records will be requested through this consent.	
<input type="checkbox"/> I do <u>not</u> want to have information shared with my PCP/other medical or behavioral health practitioner	

<b>YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS PSYCHOLOGIST-PATIENT AGREEMENT AND YOU AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.</b>		
_____	_____	
Patient Name (please print)	Patient/Custodial Parent Signature	Date



## Developmental and Psychosocial History Form

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_

School: \_\_\_\_\_

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

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

Today's Date: \_\_\_\_\_

Your name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

*The information you give here about your son or daughter is important to help us work together. Please answer honestly, but if there are some questions that you would prefer not to answer at this time, simply leave them blank. We will be able to go into further detail in our session together. We appreciate your time, effort, and honesty in filling out this form.*

What are your primary concerns for your child at this time?

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How long has this been an issue? \_\_\_\_\_

If you have concerns about your child's learning or academic achievement, please explain:

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Has your child or family recently experienced significant stress or change (e.g. recent move, significant conflict, death of a loved one, illness of a family member, birth of a sibling, etc.)? Please explain:

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Please list the members of the child's current household:

<u>Names:</u>	<u>Relationship to Child:</u>	<u>Age:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other relatives not living the child, i.e., biological mother or father, stepsiblings, etc.

<u>Names:</u>	<u>Relationship to Child:</u>	<u>Age:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

### **Family History**

Biological parent's name \_\_\_\_\_ DOB \_\_\_\_\_

Highest educational level achieved \_\_\_\_\_

Current (and past) occupation(s) \_\_\_\_\_

Ethnic background \_\_\_\_\_

Biological parent's name \_\_\_\_\_ DOB \_\_\_\_\_

Highest educational level achieved \_\_\_\_\_

Current (and past) occupation(s) \_\_\_\_\_

Ethnic background \_\_\_\_\_

What is the relationship status of the child's biological parents (i.e. married, separated, divorced, dating, partnered, single, never in a relationship)? Please include dates if relevant:

\_\_\_\_\_

\_\_\_\_\_

Other family members or individuals that have helped raise your child (e.g. step-parents, grandparents, aunts/uncles, etc.)

Family member's name \_\_\_\_\_ DOB \_\_\_\_\_

Highest educational level achieved \_\_\_\_\_

Current (and past) occupation(s) \_\_\_\_\_

Ethnic background \_\_\_\_\_

Family member's name \_\_\_\_\_ DOB \_\_\_\_\_

Highest educational level achieved \_\_\_\_\_

Current (and past) occupation(s) \_\_\_\_\_

Ethnic background \_\_\_\_\_

What is the relationship status of the child's other caregivers?:

\_\_\_\_\_

What, if any, is your family's religious or spiritual affiliation? \_\_\_\_\_

To what extent are your spiritual and/or religious beliefs important to you?

\_\_\_\_\_

Please provide any information about your family's religion or culture that you feel is important for us to know.

\_\_\_\_\_

\_\_\_\_\_

Do any immediate or extended family members (maternal/paternal grandparents, uncles, aunts, cousins) experience any of the following problems:

\_\_\_ inattentiveness

\_\_\_ hyperactivity

\_\_\_ epilepsy or seizures

\_\_\_ alcoholism

\_\_\_ drug abuse

\_\_\_ arrests or incarceration

\_\_\_ developmental disabilities

\_\_\_ anxiety

\_\_\_ depression

\_\_\_ schizophrenia

\_\_\_ bipolar disorder

\_\_\_ personality issues

\_\_\_ learning disabilities

\_\_\_ other: \_\_\_\_\_

## Early Developmental History

Were there any difficulties or medical concerns with mother's pregnancy? If yes, please explain.

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Was mother experiencing significant stress during pregnancy? If yes, please explain.

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Did mother use any medications or substances (alcohol, drugs) during pregnancy?

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Was child wanted by parents? \_\_\_\_\_

If adopted, at what age was the child adopted? \_\_\_\_\_

Does child know of adoption? \_\_\_\_\_

Was the pregnancy full term? \_\_\_\_\_ Weeks at birth: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Were there any difficulties with the child's delivery? If yes, please explain.

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Did your child have any medical problems as an infant? If yes, please explain.

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Approximate age child said first words \_\_\_\_\_ age of first phrase \_\_\_\_\_

Were parents or pediatrician concerned about slower than normal language development? \_\_\_\_\_

Approximate age child first sat up alone \_\_\_\_\_ walked \_\_\_\_\_

Were parents or pediatrician concerned about slower than normal motor development? \_\_\_\_\_

Rate of development overall: \_\_\_ slow \_\_\_ normal \_\_\_ fast

Did you have any concerns about your child's temperament, development, or behavior as a young child? If yes, please explain.

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Child's temperament (first years of life):

Quiet and content	0	0	0	0	0	Colicky and irritable
Very easy to feed	0	0	0	0	0	Daily feeding problems
Slept well	0	0	0	0	0	Frequent sleeping problems
Usually relaxed	0	0	0	0	0	Often restless
Underactive	0	0	0	0	0	Overactive
Cuddly, easy to hold	0	0	0	0	0	Did not enjoy cuddling
Easily calmed down	0	0	0	0	0	Hard to calm down
Cautious and careful	0	0	0	0	0	Adventurous and impulsive
Coordinated	0	0	0	0	0	Uncoordinated/clumsy
Enjoyed eye contact	0	0	0	0	0	Avoided eye contact
Liked people	0	0	0	0	0	Disliked contact with people

\*please indicate where on the continuum your child falls for each characteristic

### Medical History

Does your child have any chronic illnesses? yes no

Please explain. \_\_\_\_\_

Has your child had any major surgeries or head injuries? yes no

Please explain. \_\_\_\_\_

Please list all medications your child is currently taking, including the dose and frequency.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Child's current health is:  poor  fair  good  excellent

How well does your child sleep:  poor  fair  good  excellent

Describe any nighttime issues or concerns about sleep:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Mental Health History

Has your child ever participated in any form of mental health services in the past (e.g. Counseling, family therapy, psychiatry, medications, etc.)? If yes, please list provider and dates.

Dates:

Provider:

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Has your child ever been diagnosed by a psychologist, physician, or other professional?

yes  no

If yes, when and what was the diagnosis? \_\_\_\_\_

Has your child ever been hospitalized for mental health reasons?  yes  no

Please describe any unusual, traumatic, or possibly stressful events in your child's life that you think may have had an impact on his or her development or current functioning. Include incident, child's age, and comments.

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Has your child ever been bullied or abused (physically, emotionally, or sexually)?  yes  no

Has your child ever been arrested or involved in any criminal activity?  yes  no

Has your child ever used any alcohol or recreational drug?  yes  no

Are there any concerns regarding sexual behavior?  yes  no

Does your family have any past or current involvement with CPS?  yes  no

Do you have any concerns about your child's use of technology or social media?  yes  no

If yes, please explain.

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Please check any traits that describe your child **now**:

- |                                       |  |  |   |                                    |
|---------------------------------------|--|--|---|------------------------------------|
| <input type="checkbox"/> sad          | <input type="checkbox"/> happy           | <input type="checkbox"/> leader              | <input type="checkbox"/> follower           | <input type="checkbox"/> moody     |
| <input type="checkbox"/> friendly     | <input type="checkbox"/> quiet           | <input type="checkbox"/> overactive          | <input type="checkbox"/> independent        | <input type="checkbox"/> dependent |
| <input type="checkbox"/> sensitive    | <input type="checkbox"/> affectionate    | <input type="checkbox"/> fearful             | <input type="checkbox"/> cooperative        | <input type="checkbox"/> defiant   |
| <input type="checkbox"/> lethargic    | <input type="checkbox"/> too responsible | <input type="checkbox"/> trouble sleeping    | <input type="checkbox"/> hard to discipline | <input type="checkbox"/> tantrums  |
| <input type="checkbox"/> aggressive   | <input type="checkbox"/> even tempered   | <input type="checkbox"/> prefers to be alone | <input type="checkbox"/> anxious            | <input type="checkbox"/> shy       |
| <input type="checkbox"/> other: _____ |  |  |   |                                    |
| _____                                 |  |  |   |                                    |

Please describe your child's strengths, special talents, skill areas.

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***Thank you for taking the time to complete this form. It will help us get to know you better and allows us to spend more time talking during our first session together. When you come to your first session we will be glad to answer any questions you may have. We look forward to meeting with you and your child.***



## Provisions for Treating Children

As psychologists we recognize that families come in many configurations, and that when families seek help for their children the family can be undergoing significant stress and states of change. When caretakers bring their children in for assessment and treatment for psychological difficulties, it is preferable that both parents consent for treatment knowing that the role of the psychologist in this practice is that of the family or child therapist and not as an expert witness.

When a family is confronted by parental separation, divorce, or changes in child custody, it can be hard on everyone, particularly on the children. Therefore, it is important that therapy present a safe environment for children in which they do not have to worry about what they say in therapy will be revealed in court or used against one of their parents. In order to protect that safety, it is preferred that everyone agree that either party will not call the treatment provider as an expert witness. As therapists it is unethical to offer opinions in court regarding custody or access of the children, for that is the realm of an expert witness, not a treating clinician.

It needs to be understood that a judge may not honor this agreement and the treating psychologist may be required to be a witness, although the provider will try to prevent that from happening. If the court appoints a professional to advise about child custody, the psychologist will provide information to him/her so that the best possible decision is made. However, this will only be done so if both parties sign a release of information and the psychologist will not make any recommendations about the final decision.

In signing this agreement, I acknowledge that my child's treating psychologist has discussed with me the difference between the roles of treating clinician and expert witness, and I agree not to subpoena the clinician, nor the clinician's records for the use in litigation. I understand the boundary between treating clinician and expert witness is necessary so that the treating clinician can maintain the integrity of the therapeutic relationship.

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Signature of Parent/Guardian

Date

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Printed Name

---

Signature of Parent/Guardian

Date

---

Printed Name

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Psychologist

Date