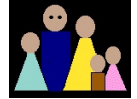




**CHILD CLIENT INFORMATION FORM**

<b>Today's Date:</b>			
<b>Presenting Problem:</b>			
<b>CLIENT'S INFORMATION</b>		<b>PARENT'S OR GUARDIAN'S INFORMATION</b>	
<b>Client's Name:</b>		<b>Non-Custodial Parent:</b>	
<b>Date of Birth:</b>		<b>Address:</b>	
	<b>Age:</b>		
<b>School:</b>		<b>City/State/Zip</b>	
<b>Grade</b>		<b>Non-Custodial Parent's Cell Phone:</b>	
<b>Custodial Parent's Name:</b>		<b>Non-Custodial Parent's E-Mail:</b>	
<b>Home Address:</b>		<b>Non-Custodial Parent's Occupation:</b>	
<b>City/State/Zip</b>		<b>Step Mother:</b>	
<b>Custodial Parent's Cell Phone:</b>		<b>Step Father:</b>	
<b>Custodial Parent's E-Mail:</b>		<b>Non-Custodial Parent's E-Mail:</b>	
<b>Custodial Parent's Occupation:</b>		<b>Non-Custodial Parent's Occupation:</b>	
<b>Siblings': Names/Ages:</b>			
<b>Pediatrician's Name:</b>		<b>Phone Number:</b>	



# ***OFFICE POLICIES AND PSYCHOLOGICAL SERVICES AGREEMENT***

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. The law requires that I obtain your signature acknowledging that I have provided you with this information at or before the end of the first meeting. Although these documents are long and sometimes complex, it is very important that you read them carefully. I can discuss any questions you have about the procedures during the first meeting. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me 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**

Under Dr. Kovner's supervision, I provide assessment, diagnosis and treatment of learning, relationship, psychological, and some neuropsychological disorders. By signing this agreement, you are giving consent for yourself and/or your child/to undergo psychological evaluation and/or treatment.

### **Psychological Testing**

A psychological evaluation is a comprehensive assessment of cognitive, educational, and social/emotional functioning. Over a period of 4 to 8 hours, standard testing procedures assess various abilities that relate to cognition, learning, memory, problem solving and critical thinking. The evaluation also measures psychological dimensions relating to social and emotional functioning. The evaluation may also be used to procure public school or college classroom/teaching accommodations for you or your child in order to obtain more effective learning experiences. Also, psychological testing may be used to provide medical clearance, fitness for duty to return to work, or parental competence in a court of law. If you have further questions about the purpose and potential benefits of a psychological evaluation, I will be happy to provide additional information.

### **Psychotherapy**

Psychotherapy, or mental health counseling, is a complex array of many activities that serve to build a trusting relationship between the client and their therapist. This array of activities may consist of play, dance or movement, physical exercise, education, learning, application and practice of that learning, assimilation of learning into behavior and integration of what is learned and practiced into ethical, morally mature, socially responsible and healthy personality functioning. The transformation that occurs through this complex array of activities with the therapist involves easing of personal defense mechanisms that permit insight into one's own emotional life and habitual ways of behaving socially.

Self-control and improved social and moral functioning comes through the development of self-awareness, rational thought, appropriate expression of emotions, planning, anticipation of consequences, mental flexibility, self-acceptance, genuine regard for others' feelings, beliefs, and opinions, and capitalizing on one's existing strengths and resources. By forming a therapeutic alliance with me, we will work to improve your chances of success in achieving the goals of emotional stability, personal and interpersonal growth, occupational and educational satisfaction and social responsibility. Furthermore, research has shown that improvement in mental health can have a beneficial affect on your physical health.

## **CONTACT INFORMATION AND EMERGENCY PROCEDURES**

Often I am not available immediately by telephone. I do not answer the phone when I am in a meeting with a client. On days that I am not in the office, I check voice mail frequently. When I am unavailable, the telephone is answered by the office manager or an answering machine. I will try to return your call within one business day of receiving it, with the exception of holidays and vacations.

If you are difficult to reach, please inform us of some times when you will be available. My practice does not have 24 hour crisis availability, support staff, or a psychiatrist. If it is possible you will need crisis services over the course of treatment it is important that you discuss this point with me as soon as possible. I may recommend that you seek services with a provider who can offer more crisis coverage than can be provided by me.

In case of an emergency, this is the protocol I follow. In an emergency, you may try to reach me at the office number. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In a situation where serious harm may occur, call 911 or get safe transportation to the nearest hospital emergency room. If you are able to wait for a return call, clients with life-threatening emergencies will be seen immediately, or directed to emergency care. Clients with non-life threatening urgent needs will be seen within 24 hours or be directed to emergency care.

If I will be unavailable for an extended time and you provide me with a written request I will provide you with the name of a colleague to contact.

## **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep Protected Health Information about you in a Clinical Record. Except in unusual circumstances where that disclosure would physically or emotionally endanger you and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In most circumstances, I am allowed to charge a copying fee and charge for certain other expenses such as postage and envelopes.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

You also may add information to your records when I review them with you if you believe they contain inaccurate or incomplete information.

It is my office policy to retain clients' records for seven years after the end of our therapy.

## **Children and Adolescent Clinical Records**

With regards to your child or adolescent, the review of the clinical record would violate the client's confidentiality. Without privacy, most children and adolescents would not talk or disclose matters of true concern and therapy would not be effective. There may be general discussion with you about the goals, progress and effectiveness of therapy at your therapist's discretion. However, if during the course of treatment, if I were to become concerned that your child's life or safety was endangered your child's confidentiality privileges would be waived. Therefore, before I would agree to treat your child (or adolescent) I request that you consent to waive your right to have a copy of or review the details of the clinical record by signing in the space below.

I, \_\_\_\_\_, the parent or legal guardian of \_\_\_\_\_  
(Print Parent's or Legal Guardian's Name)

whose date of birth is \_\_\_\_\_, waive my right to read, review or own a copy of the clinical record.

Please note that in some cases your files may include information from other treatment providers that clients have given me written permission to obtain. If you have given me permission to obtain such records, I cannot provide them to you if you ask to review your files. Instead, I would ask for you to contact the provider who created the records and obtain copies directly from her or him.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records 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 information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. I am happy to discuss any of these rights with you.

### **LIMITS OF CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about you or your child's treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Georgia law. However, in the following situations, no authorization is required: Disclosures required by health insurers or to collect overdue fees; if you are involved in a court proceeding and a judge waives your privilege to confidentiality. Generally, I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. In the case of suspected child abuse, the privilege is waived because all psychologists are mandated court reporters of child abuse.

Additionally, I would not need authorization to disclose your records under the following circumstances:

1. If a you file a complaint or lawsuit against me, I may disclose relevant information regarding you and your treatment in order to defend myself.
2. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of a client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
3. You should be aware that I practice with other mental health professionals and that I occasionally employ administrative staff. In some cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations in which we are legally obligated to take actions where your confidentiality privileges are waived. These situations include instances where we believe it is necessary to attempt to protect others from harm. Under such circumstances, I may have to reveal some information about a patient's treatment. These situations are unusual in our practice, and include:

4. If I know or have reasonable cause to suspect that a child under 18 has been or is likely to be abused or neglected or that a disabled person has been abused, neglected or exploited, the law requires that I file a report with the appropriate government agency, usually the Georgia Department of Child Protective Services. Once such a report is filed, I may be required to provide additional information.
5. If I determine that the patient poses a direct threat of imminent harm to the health or safety of any individual, including himself/herself, I may be required to disclose information in order to take protective action(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can assist in providing protection.
6. If you have filed a worker's compensation claim and I are being compensated for your treatment by your employer or its insurance company as a result of that claim, I must provide, upon appropriate request, legally required reports and other information related to your condition.

## **FEE FOR SERVICES**

**Your fee per session is based on income. You will need to bring a pay stub and your last 1040 tax return to prove your income.**

### **Sliding Scale**

- **If your yearly income is between \$35,000 and \$50,000, sessions will be charged at \$50 per session.**
- **If your yearly income is between \$25,000 and \$34,000, sessions will be charged at \$35 per session.**
- **If your yearly income is below \$25,000, your sessions will be charged at \$25 per session.**
- **If you are unemployed and not collecting unemployment, your sessions will be charged at \$20 per session.**

**Payment by cash or credit/debit card must be made at the time you make the appointment.**

**I also charge my session rate for other services including:**

- Psychological Testing
- Report Writing
- Telephone consultations lasting longer than 10 minutes
- Consultations with other professionals
- Preparing records or treatment summaries for court

It may be helpful to keep your credit card on file to make your payments. If so, please fill out the form below.

**CREDIT CARD AND AUTHORIZATION FORM**

<b>Credit Card Number</b>		<b>Expirations Date</b>	/	<b>Security Code</b>	
<p align="center">_____</p> <p align="center"><b>Authorizing Signature</b></p>		<p align="center"><b>The services rendered are checked below.</b></p>			
		<p>( ) Diagnostic Interview            ( ) Psychotherapy 50-60 Min.</p> <p>( ) Psychological Evaluation      ( ) Court Testimony</p> <p>( ) Two-Day Couples Retreat      ( ) Written Correspondence</p> <p>( ) Test Results Feedback          ( ) School Board, IEP or Tribunal Hearing</p> <p>( ) Phone Consultations greater than 10 minutes</p>			
<p align="center">_____</p> <p align="center"><b>Date</b></p>					

**CANCELLATION POLICY AND RESCHEDULING APPOINTMENTS**

When you schedule an appointment you will be asked to pay for the session at that time. If you cannot keep your appointment, we require a 48 hour advanced notice of your cancellation or else you forfeit your session fee. We refer to this as the **Cancellation Fee**. The fee may be waived at Ms. Deragon’s discretion if you were unable to attend due to circumstances beyond your control.

Your will need to pay for your next appointment at the time you schedule it.

**RETURNED CHECK FEES**

There will be a \$35.00 charge for each returned check to cover all of the expenses involved in paying bank fees and other resulting insufficient funds charges.

**EATING OR SMOKING**

No Eating or Smoking is permitted in the Building. If you smoke outside, please throw your used cigarette into the plastic receptacle out front. Children are to wait quietly in the waiting room. Parents must accompany young children to the bathroom and make sure all doors are closed and the facilities are left clean. Do not leave children unsupervised in or outside of the office.

**THE WAITING AREA**

Clients are to wait quietly in the waiting room. Please be courteous and turn your cell phones to vibrate. Please use ear buds to listen to music and voices down to a whisper if you talk on your cell phone. We use the radio to provide the Office Manager privacy. She has limited time. Please respect her time and privacy.

All clinical information is to be presented *in therapy sessions by appointment*.

**ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICES OF  
PRIVACY PRACTICES, OFFICE AND CANCELLATION POLICIES**

A summary of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules is available for you to read on line at your-psychologist.com or in the office on the credenza in the waiting room. A paper copy of your HIPAA rights is available to you upon request. The entire privacy rule, as well as guidelines and additional materials may be found on the government website at [http://: www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa).

By signing below, I acknowledge that I have been provided information about Ms. Deragon's and Dr. Kovner's privacy practices, made the HIPAA information available to read in detail and have therefore been advised of how health information about me may be used and disclosed and how you may obtain access to and control this information according to law; and I have been informed of and agree to their Office Policies and financial agreements.

\_\_\_\_\_  
Client or Parent's Signature

1. Please list who you want to have access to your pertinent medical information?  
(i.e.: family member, spouse, significant other)

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

2. May we leave a message on your phone or answering machine? YES \_\_\_ NO \_\_\_

3. Preferred method of contact?

Email \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

.....

**Having read Ms. Deragon's and Dr . Kovner's office policies, I consent to treatment.**

**X** \_\_\_\_\_



## PARENT'S QUESTIONNAIRE

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

Child's Name:		Date of Birth:		Age:	
Referred By:					
Presenting problem:					
Has child failed any grades?					
Family Relationships					
Biological Mother's Name:		Biological Father's Name:			
Education:		Education:			
Occupation:		Occupation:			
Stepfather:		Stepmother:			
Guardian:		Siblings:			
How does child get along with siblings?					
CHILD'S BIRTH AND EARLY DEVELOPMENT					
Was pregnancy planned?					
Premature?	If yes, how weeks?				
Adopted?					
Birth Weight					
How was mother's health during pregnancy?					
Any problems at birth?					
Any feeding difficulties?					
Any sleep difficulties?					
Approximate age when child: Sat alone					
Walked alone					
Correctly used "mama" & "dada"					
Used "yes" & "no"					
3 word sentences					
Any trouble with eyesight?					

Anything unusual about speech development?			
Was child over or under active?			
Was child excessively aggressive?			
How did child react to new situations and changes in routine?			
Please check any of the problems below that your child has:			
Fingernail biting	Thumb sucking	Body rocking	Sleep walking
Fire setting	Temper tantrums	Stealing	Truancy
Accident proneness	Concerns about eating	Concerns about sleep habits	
Self-injury	Unusual perceptions	Night terrors of nightmares	

**EDUCATIONAL HISTORY** List in chronological order all

schools your child has attended.

Name of School	Dates Attended		Grade Level	GPA	Conduct
	From	To			
	From	To			
	From	To			
	From	To			
	From	To			
	From	To			
	From	To			

Name of current teachers \_\_\_\_\_

\_\_\_\_\_ Child's favorite subjects \_\_\_\_\_

\_\_\_\_\_ Child's least favorite

subjects \_\_\_\_\_

\_\_\_\_\_ Has your child ever repeated a grade? \_\_\_\_\_ If so, which? \_\_\_\_\_

\_\_\_\_\_ Has your child ever skipped a grade?

\_\_\_\_\_ If so, which? \_\_\_\_\_

\_\_\_\_\_ Has your child ever received tutoring? \_\_\_\_\_ If so, in which subject(s)? \_\_\_\_\_

\_\_\_\_\_ Has your child ever been in a Special Education Program?

\_\_\_\_\_ If so, during which years? \_\_\_\_\_ What type of

Program? (Gifted, LD, BD/EH, MR?) \_\_\_\_\_

\_\_\_\_\_ Child's attitude toward school \_\_\_\_\_

\_\_\_\_\_ How well does your child get

along with other children? \_\_\_\_\_

\_\_\_\_\_ Please describe your child's strengths \_\_\_\_\_

\_\_\_\_\_ and weaknesses \_\_\_\_\_

Child's extracurricular activities including sports, hobbies, clubs, lessons, etc.

Baseball _____	Karate _____	Dance _____
Football _____	Piano _____	(type) _____
Basketball _____	Cheerleading _____	Music _____
Soccer _____	Scouts _____	(Type) _____
Other _____	Other _____	

List any additional special abilities, skills, strengths your child has. \_\_\_\_\_

### ***PSYCHOLOGICAL/PSYCHIATRIC HISTORY***

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings? \_\_\_\_\_

Has your child been hospitalized for a psychiatric condition? If yes, when and where? \_\_\_\_\_

\_\_\_\_\_ Is your child taking medication? If yes, what medications are they, what dose, and for what condition?

For what Condition Medication is Prescribed for?	Date Prescribed?	Name of Medication?	Dose?

Are there any family members on either side of the family who have ever been treated for mental or emotional problems? If yes, specify. \_\_\_\_\_

---

Parents' Self-Descriptions

How would you rate your overall level of happiness on a scale from 1 (Happy) to 10 (Unhappy).

Mother \_\_\_\_\_ Father \_\_\_\_\_

On a scale from 1 (Low) to 10 (High), how would you rate your stress in the following areas ?

Mother's Ratings   Father's Ratings

Job		
Home Life		
Parenting		
Friends/Social Life		
Day to day hassles		
Your marriage		
Finances		
Intimacy		
Communication		
Time Together		
Overall Stress		

## *DISCIPLINE*

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed by circling the appropriate number from 1 (Unlike) to 5 (Likely). Also, please indicate how effective each of the discipline strategies is for your child by circling them from 1 (Ineffective) to 5 (Effective).

	Unlikely					Likely					Ineffective					Effective				
Let situation go.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Use token system.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Take away a privilege (e.g., T.V.).....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Use charts & stickers.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Earn privileges.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Earn time with friends.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Take away something material (e.g., no dessert).....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Earn special time with parents.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Send to room.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Give verbal praise.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Physical punishment.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Reason with child.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Earns material or food reward.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Teach desired behavior by discussion.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Ground child.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Teach appropriate behavior by modeling.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Yell at child.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Teach desired behavior by role-playing.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Earn participation in social activities.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Send to time-out.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Reward positive behavior.....	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
List anything else you may do: _____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
_____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
_____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
_____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
_____	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5