# OFFICE ADOLESCENT CLIENT INFORMATION FORM

| | |
|---|---|
| **Today's Date:** | |
| **Presenting Problem:** | |

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

**INSURED'S INFORMATION IF USING INSURANCE**

| | | | | | |
|---|---|---|---|---|---|
| **Primary Insurance Company:** | | | **Secondary Insurance Company:** | | |
| **Insured's Name:** | | | **Insured's Name:** | | |
| **Insured's Employer:** | | | **Insured's Employer:** | | |
| **Insured's Date of Birth:** | | | **Insured's Date of Birth:** | | |
| **Address:** | | | **Address:** | | |
| **State/Zip Code:** | | | **State/Zip Code:** | | |
| **Ins. Co. Tel. #:** | | | **Ins. Co. Tel. #:** | | |
| **Employer:** | | | **Employer:** | | |
| **Policy Number:** | | | **Policy Number:** | | |
| **Group Number:** | | | **Group Number:** | | |
| **Effective Date:** | | | **Effective Date:** | | |
| **Deductible:** | | **Met:** | **Deductible:** | Met: | |
| **Co-Pay:** | | | **Co-Pay:** | | |
| **Credit Card Info:** | **Name on Card:** | **CC Number:** | | **Exp Date:** | **Sec Code:** |

*Steven Kovner, Ph.D., Georgia Licensed Psychologist*

# *INFORMED CONSENT FORM*
# *OUTPATIENT SERVICES CONTRACT*

*Welcome to my practice.* This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us. Please initial this and each section below indicating your acknowledgment of receiving the information discussed, and that you consent, and agree with the terms and policies discussed.

**CREDENTIALS**

I am a Licensed Psychologist in Georgia. I hold a doctoral degree from the University of South Carolina in School Psychology with an additional year in the Clinical Psychology program for supervision in adult Psychodynamic Psychotherapy, Marital, and Sex therapy. Therefore, I am qualified at the highest levels of service to see children, adolescents, adults, and couples.

**Initials**

**PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**Initials**

**MEETINGS**

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one [60-minute] session per week, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide a 48 hour advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.



* 4046 Wetherburn Way, Suite 7, Peachtree Corners, Georgia 30092 *
* Website: www.your-psychologist.com * Email: kovnercenter@gmail.com
* * Office Phone: (770) 993-3002 *

**CANCELLATION AND NO SHOW FEES**

**You will be charged a $50.00 fee for not canceling your appointment 2 days (48 hours) in advance, or for not showing up for your appointment.**

**Initials**

**PROFESSIONAL FEES**

My hourly fee is $175.00. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. [I charge $250.00 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $.15 per page for records requests.]

**Initials**

**BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, 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 such services are requested. [In circumstances of unusual financial hardship, I 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, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

**Initials**

**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. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my 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, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

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 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. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information

confidential, I have 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. I will provide you with a copy of any records I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary. Once we have all of 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 my services yourself to avoid the problems described above [unless prohibited by the insurance contract].

**Initials**

**CONTACTING ME**

I am often not immediately available by telephone. Though I am usually in my office between [10 AM and 5 PM], I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by an answering machine, voice mail, or, if available, by the Office Manager, Janelle, who knows where to reach me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**Initials**

**ELECTRONIC COMMUNICATION POLICY**

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

**Initials**

**EMAIL COMMUNICATION**

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

**Initials**

**TEXT MESSAGING**

Because text messaging is a very unsecured and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

**SOCIAL MEDIA**

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromisethe professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

**Initials**

**WEBSITE**

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

**Initials**

**WEB SEARCHES**

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

**CONFIDENTIALITY** [for adult patients]

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person or disabled person] is being abused or has been abused, I am required to make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am [may be] required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I do not reveal the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney. [If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.]

**Initials**

**MINORS**

**Parent Authorization for Minor's Mental Health Treatment**

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

**Initials**

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

**Initials**

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below. Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.

- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.

- I am ordered by a court to disclose information. **Initials**

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.
>
> ***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also,

when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of [Georgia] may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

**Initials**

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $250.00 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date_____

**Parent/Guardian of Minor Patient:**

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

**Initials** _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

**Initials** _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

**Initials** _____

## 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.

**Initials**

## LATE FEES AND NON-PAYMENT ACTIONS

Client or responsible party agrees to accept for all costs of collection on unpaid balances including, but not limited to, 1 ½%interest (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees.

**Initials**

## GENERAL OFFICE POLICIES & HOUSEKEEPING

### Fire Arms and Other Weapons

This building is a Weapons-Free zone. With respect to our clients who may have adverse reactions to weaponry, please leave your weapons locked up in your vehicle.

**Initials**

### Recording of Sessions

Recording of therapy sessions is prohibited unless you, your therapist and Dr. Kovner have agreed to use recordings for therapeutic reasons. In that case a separate signed agreement will be obtained and all recordings will be destroyed after their use in therapy.

**Initials**

### Eating or Smoking

No Eating or Smoking is permitted in the Building. If you smoke outside, please throw your used cigarette into the receptacle on the porch. 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.

**Initials**

### Restroom

Parents must accompany young children to the bathroom and make sure all doors are closed and the facilities are left clean. Do not flush diapers or leave soiled diapers on the premises.
The Waiting Area

**Initials**

**Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.**

**CLIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____**

# The Kovner Center For Behavioral Health & Psychological Testing

4046 Wetherburn Way, Suite 7
Peachtree Corners, Geogia 30092

## Health Insurance Portability and Accountability Act (HIPAA)

### NOTICE OF PRIVACY PRACTICES

I. COMMITMENT TO YOUR PRIVACY: The Kovner Center is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that The Kovner Center maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, The Kovner Center is required to ensure that your PHI is kept private. This Notice explains when, why, and how The Kovner Center would use and/or disclose your PHI. Use of PHI means when The Kovner Center shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when The Kovner Center releases, transfers, gives, or otherwise reveals it to a third party outside of the The Kovner Center. With some exceptions, The Kovner Center may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, The Kovner Center is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by The Kovner Center. Please note that The Kovner Center reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that The Kovner Center has created or maintained in the past and for any of your records that The Kovner Center may create or maintain in the future. The Kovner Center will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of The Kovner Center's Notice of Privacy Practices.

IV. HOW The Kovner Center MAY USE AND DISCLOSE YOUR PHI: The Kovner Center will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: The Kovner Center may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, The Kovner Center may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, The Kovner Center will always ask for your authorization in writing prior to any such consultation.
2. For Health Care Operations: The Kovner Center may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
3. To Obtain Payment for Treatment: The Kovner Center may use and disclose your PHI to bill and collect payment for the treatment and services The Kovner Center provided to you. Example: The Kovner Center might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. The Kovner Center could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for The Kovner Center's office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, The Kovner Center will always do its best to reconcile this with you first prior to involving any outside agency.
4. Employees and Business Associates: There may be instances where services are provided to The Kovner Center by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, The Kovner Center will have a written contract that requires the

employee or business associate to maintain the same high standards of safeguarding your privacy that is required of The Kovner Center.

Note: This state and Federal law provides additional protection for certain types of health information, including alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how The Kovner Center may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – The Kovner Center may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. Law Enforcement: Subject to certain conditions, The Kovner Center may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: The Kovner Center may make a disclosure to the appropriate officials when a law requires The Kovner Center to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. Lawsuits and Disputes: The Kovner Center may disclose information about you to respond to a court or administrative order or a search warrant. The Kovner Center may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. The Kovner Center will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.

3. Public Health Risks: The Kovner Center may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.

4. Food and Drug Administration (FDA): The Kovner Center may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

5. Serious Threat to Health or Safety: The Kovner Center may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if The Kovner Center determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, The Kovner Center may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.

6. Minors: If you are a minor (under 18 years of age), The Kovner Center may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.

7. Abuse and Neglect: The Kovner Center may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If The Kovner Center has a reasonable suspicion of child abuse or neglect, The Kovner Center will report this to the Georgia Department of Child and Family Services.

8. Coroners, Medical Examiners, and Funeral Directors: The Kovner Center may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. The Kovner Center may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.

9. Communications with Family, Friends, or Others: The Kovner Center may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, The Kovner Center may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

10. Military and Veterans: If you are a member of the armed forces, The Kovner Center may release PHI about you as required by military command authorities. The Kovner Center may also release PHI about foreign military personnel to the appropriate military authority.

11. National Security, Protective Services for the President, and Intelligence Activities: The Kovner Center may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.

12. Correctional Institutions: If you are or become an inmate of a correctional institution, The Kovner Center may

disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

13. For Research Purposes: In certain limited circumstances, The Kovner Center may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.

14. For Workers' Compensation Purposes: The Kovner Center may provide PHI in order to comply with Workers' Compensation or similar programs established by law.

15. Appointment Reminders: The Kovner Center is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.

16. Health Oversight Activities: The Kovner Center may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess The Kovner Center's compliance with HIPAA regulations.

17. If Disclosure is Otherwise Specifically Required by Law.

18. In the Following Cases, The Kovner Center Will Never Share Your Information Unless You Give us Written Permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, The Kovner Center will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying The Kovner Center in writing of your decision. You understand that The Kovner Center is unable to take back any disclosures it has already made with your permission, The Kovner Center will continue to comply with laws that require certain disclosures, and The Kovner Center is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in The Kovner Center's possession, or to get copies of it; however, you must request it in writing. If The Kovner Center does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from The Kovner Center within 30 days of receiving your written request. Under certain circumstances, The Kovner Center may feel it must deny your request, but if it does, The Kovner Center will give you, in writing, the reasons for the denial. The Kovner Center will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. The Kovner Center may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that The Kovner Center limit how it uses and discloses your PHI. While The Kovner Center will consider your request, it is not legally bound to agree. If The Kovner Center does agree to your request, it will put those limits in writing and abide by them except in emergency situations. 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. You do not have the right to limit the uses and disclosures that The Kovner Center is legally required or permitted to make.

3. The Right to Choose How The Kovner Center Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). The Kovner Center is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that The Kovner Center has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include

disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6year period and starting after April 14, 2003.

The Kovner Center will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. The Kovner Center will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Choose Someone to Act for You: 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. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that The Kovner Center correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of The Kovner Center's receipt of your request. Management Institute may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than The Kovner Center. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and The Kovner Center's denial will be attached to any future disclosures of your PHI. If The Kovner Center approves your request, it will make the change(s) to your PHI. Additionally, The Kovner Center will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

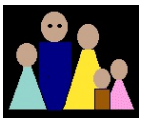
7. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

8. Submit all Written Requests: Submit to Dr. Kovner, the Center's Director and Privacy Officer, at the address listed on the bottom of the page.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision The Kovner Center madeabout access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. The Kovner Center will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint. Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. The Kovner Center's Responsibilities: We are required by law to maintain the privacy and security of your PHI. 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.

Date of Last Revision: 08/12/18



*Steven Kovner, Ph.D., Licensed Psychologist and Director*

## TELEPSYCHOLOGY INFORMED CONSENT

As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

2. If a need for direct, face to face services arises, it is my responsibility to contact his office for a face to face appointment. I understand that an opening may not be immediately available.

3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.

4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.

5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

   a. Iunderstand that the Kovner Center does not provide 24/7 emergency coverage and in the event of an emergency situation I will contact the emergency operator by calling 911, call the National Suicide Prevention Lifeline at 800-273-8255, or go to my local hospital emergency room.

   b. Should service be disrupted you will not be billed for the service and an attempt will be made to reconnect you with your therapist by calling you on your cell phone to complete the session.

   c. For other communication, the Kovner Center will only communicate administrative matters with you, such as booking appointments or sending you educational/ therapeutic materials that contain none of your private health or mental health information. Since your Email may not be safe and could be subject to hacking or theft, we advice you not to send clinical information over through your email unless you know that it is encrypted and compatible with the HIPAA standards of privacy. If you do send information to me using your email, you assume all responsibility for any breach or theft of your information.



*4046 Wetherburn Way, Suite 7, Peachtree Corners, GA 30092*
*Web Site: your-psychologist.com * E-Mail: kovnercenter@gmail.com*
*Office and Fax (770) 993-3002*

6. My psychologist/therapist will respond to communications and routine messages within 24 hours.

7. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

8. My communications exchanged with my psychologist/therapist will be stored in the office located at 4046 Wetherburn Way, Suite 7, Peachtree Corners, Georgia 30092 and kept for 10 years.

9. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

_____ _____

**Signature of Client or Legal Guardian (Printed name will represent client's electronic signature)** **Date**

_____ _____

**Signature of Parent or Legal Guardian (Printed name will represent client's electronic signature)** **Date**

# PARENT'S QUESTIONNAIRE

Today's Date:_____

| | | | | | |
|---|---|---|---|---|---|
| Child's Name: | | Date of Birth: | | Age: | |
| Referred By: | | | | | |
| Presenting problem: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 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 one-word speech | | | | | |
| 3 word sentences | | | | | |
| Any hearing difficultifes? | | | | | |
| Any trouble with eyesight? | | | | | |

| | | | |
|---|---|---|---|
| Anything unusual about speech development? | | | |
| Is child over or under active? | | | |
| Is child excessively aggressive? | | | |
| How does 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 | | | | |

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**?** _____

Has your child ever been in a Special Education Program? ____ If so, in which subject(s)? _____

_____ 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 _____

Describe your child's weaknesses _____

## *SUGGESTED CLASSROOM ACCOMMODATIONS AND INTERVENTIONS AT HOME*

***Please check all interventions which have been used or you believe may be helpful for your child in the classroom:***

| | | |
|---|---|---|
| ☐ **Strategic/Preferential Seating** | ☐ **Personal Organizer** | ☐ **Reinforce with praise** |
| ☐ **Prompts/Reminders** | ☐ **Audio Enhancement** | ☐ **Note-Taking** |
| ☐ **Self-Monitoring/Regulation** | ☐ **Paraphrasing Instructions** | ☐ **Environmental Cues (Posters, etc.)** |
| ☐ **Modified Assignments** | ☐ **Response-Cost** | ☐ **Teacher-Parent Contact** |
| ☐ **Repeat Directions/Instructions** | ☐ **Peer Tutoring** | ☐ **Class-Wide Token Economy** |
| ☐ **Peer Helper/Peer Model** | ☐ **Verbal Reprimand** | ☐ **Quiet Study/Work Area** |
| ☐ **Predetermined Signal from Teacher** | ☐ **Increased Teacher Proximity** | ☐ **Modify Presentation Rate** |
| ☐ **Written Directions/Instructions** | ☐ **Increase Eye-Contact** | ☐ **Quiet Verbalization of Reading** |
| ☐ **Behavior Contract** | ☐ **Cardboard to Track Text** | ☐ **Skills Progress Charting** |
| ☐ **Time-Out** | ☐ **Preventive Intervention** | ☐ **School-To-Home Reports** |
| ☐ **Personal Activities Schedule** | ☐ **Computer Software** | ☐ **Behavior Charting** |
| ☐ **Ignoring Behavior** | ☐ **Attention Training System** | ☐ **Assistive Technology** |
| ☐ **Adult Tutor** | ☐ **Peer Mediation** | ☐ **ADD Support Group** |

☐ ***Other:*** ***1.*** _____ ***2.*** _____ ***3.*** _____

**4.** _____ **5.** _____ **6.** _____

## *Home:*

| | | | |
|---|---|---|---|
| ☐ **Behavior Charting** | ☐ **Visual Prompts** | ☐ **Time-Out** | ☐ **Organizer** |
| ☐ **Note-Taking** | ☐ **Response-Cost** | ☐ **Reward Program** | ☐ **Self-Monitoring** |
| ☐ **Ignoring Behavior** | ☐ **Reduce Distractions** | ☐ **Specific Homework Time** | ☐ **Home-To-School Reports** |
| ☐ **Time Management** | ☐ **Contact with Teacher** | ☐ **Counseling** | ☐ **Adjust Sleep Time** |
| ☐ **Vision Testing** | ☐ **Hearing Testing** | ☐ **General Physical** | ☐ **Medical Treatment** |

☐ ***Other:*** ***1.*** _____ ***2.*** _____ ***3.*** _____

***4.*** _____ ***5.*** _____ ***6.*** _____

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

| | | | | | |
|---|---|---|---|---|---|
| Baseball | _____ | Karate | _____ | Dance | _____ |
| Football | _____ | Piano | _____ | (type) | _____ |
| Basketball | _____ | Cheerleading | _____ | Music | _____ |
| Soccer | _____ | Scouts | _____ | 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 them on a scale from 1 (Unlikey) to 5 (Likely). Also, please indicate how effective each of the discipline strategies is for your child by rating them from 1 (Ineffective) to 5 (Effective).

| | Unlikely Likely | Ineffective Effective |
|---|---|---|
| Let situation go | 1 2 3 4 5 | 1 2 3 4 5 |
| Use token system | 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 |
| Use charts & stickers | 1 2 3 4 5 | 1 2 3 4 5 |
| Earn privileges | 1 2 3 4 5 | 1 2 3 4 5 |
| Earn time with friends | 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 |
| Earn special time with parents | 1 2 3 4 5 | 1 2 3 4 5 |
| Send to room | 1 2 3 4 5 | 1 2 3 4 5 |
| Give verbal praise | 1 2 3 4 5 | 1 2 3 4 5 |
| Physical punishment | 1 2 3 4 5 | 1 2 3 4 5 |
| Reason with child | 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 |
| Teach desired behavior by discussion | 1 2 3 4 5 | 1 2 3 4 5 |
| Ground child | 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 |
| Yell at child | 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 |
| Earn participation in social activities | 1 2 3 4 5 | 1 2 3 4 5 |
| Send to time-out | 1 2 3 4 5 | 1 2 3 4 5 |
| Reward positive behavior | 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 |

# SK SYMPTOM CHECKLIST: ADOLESCENT©

by Steven Kovner, Ph.D.

Adolescent's Name:_____Today's Date: _____

Date of Birth: _____ Age:_____

**DIRECTIONS:** (To be filled out by the adolescent.) This inventory is designed to get a picture of the presenting symptoms you are experiencing. Read each item carefully and don't spend too much time on any one item. If you are displaying the symptoms at all, place a check before that item.

ADD

- ☐ Fails to give close attention to details or makes careless mistakes
- ☐ Has difficulty sustaining attention
- ☐ Does not appear to listen
- ☐ Struggle to follow through on instructions
- ☐ Has difficulty with organization
- ☐ Avoids or dislike tasks requiring sustained me effort
- ☐ Is easily distracted
- ☐ Is forgetful in daily activities
- ☐ Fidgets with hands or feet or squirms in the chair
- ☐ Has difficulty remaining seated
- ☐ Runs around or climb excessively
- ☐ Has difficulty engaging in activities quietly
- ☐ Acts as if driven by a motor
- ☐ Talk excessively
- ☐ Blurts out answers before questions have been completed
- ☐ Has difficulty waiting or taking turns
- ☐ Interrupts or intrude upon others
- ☐

CD

- ☐ Negativity
- ☐ Defiance
- ☐ Disobedience
- ☐ Hostile feelings toward authority figures
- ☐ Temper tantrums
- ☐ Argumentative with adults
- ☐ Refuses to comply with adult requests or rules
- ☐ Deliberately annoys other people
- ☐ Blames others for own mistakes or misbehavior
- ☐ Acts touchy and easily annoyed
- ☐ Is angry and resentful
- ☐ Acts spitefully or vindictively
- ☐ Is aggressive toward peers
- ☐ Has difficulty maintaining friendships
- ☐ Has academic problems
- ☐ Displays aggressive behavior that harms or threatens other people or animals
- ☐ Has destructive behavior that damages or destroys property
- ☐ Lies
- ☐ Is truant from school or work or has other serious rule violations
- ☐ Has tobacco, alcohol, or substance use and abuse
- ☐ Is sexually active
- ☐ Exhibits physical acts of cruelty to people or animals
- ☐ Frequently involved in fights, bullying intimidation
- ☐ Will use a weapon in fights
- ☐ Steals
- ☐ Runs away from home
- ☐ Ignores set curfew times
- ☐ Is planning an attack on others

DEP

- [ ] Has persistent sad, anxious or "empty" feelings
- [ ] Has feelings of hopelessness and/or pessimism
- [ ] Has feelings of guilt, worthlessness and/or helplessness
- [ ] Is irritable and restlessness
- [ ] Has lost interest in activities or hobbies once pleasurable
- [ ] Fatigue and decreased energy making decisions
- [ ] Difficulty concentrating, remembering details and making decisions
- [ ] Insomnia
- [ ] Early–morning wakefulness
- [ ] Excessive sleeping
- [ ] Overeating, or appetite loss
- [ ] Thoughts of suicide, suicide attempts
- [ ] Persistent aches or pains,
- [ ] Headaches
- [ ] Cramps
- [ ] Digestive problems that do not ease even with treatment

ANX

- [ ] Shyness
- [ ] Compulsions
- [ ] Phobias
- [ ] Stress
- [ ] Anorexia
- [ ] Fear of heights
- [ ] Negative self image
- [ ] Fear of spiders
- [ ] Insomnia
- [ ] Fear of needles
- [ ] Has morbid thoughts
- [ ] Obsessions
- [ ] Thumb sucking
- [ ] Blushing
- [ ] Excessive Gaming, TV Watching, or Internet
- [ ] Fear of being sick
- [ ] Migraines
- [ ] Lack of confidence
- [ ] Fatigue
- [ ] Fear of flying
- [ ] Panic attacks

SEP

- [ ] An unrealistic and lasting worry that something bad will happen to my parent or caregiver if I leave.
- [ ] An unrealistic and lasting worry that something bad will happen to me if I leave my parent.
- [ ] Refusal to go to school in order to stay with your parent.
- [ ] Refusal to go to sleep without your parent being nearby or discomfort sleeping away from home.
- [ ] Fear of being alone.
- [ ] Nightmares about being separated.
- [ ] Bed wetting
- [ ] Complaints of physical symptoms, such as headaches and stomachaches, on school days.

PSY

- [ ] Seeing or hearing things that don't exist (hallucinations), especially voices
- [ ] Having beliefs not based on reality (delusions)
- [ ] Lack of emotion Emotions inappropriate for the situation
- [ ] Social withdrawal Poor school performance
- [ ] Decreased ability to practice self-care
- [ ] Strange eating rituals Incoherent speech
- [ ] Illogical thinking Agitation

ED

- ☐ Refusing to eat and denying hunger
- ☐ An intense fear of gaining weight
- ☐ Negative or distorted self-image
- ☐ Excessively exercising
- ☐ Flat mood or lack of emotion
- ☐ Preoccupation with food Social withdrawal
- ☐ Thin appearance
- ☐ Dizziness or fainting
- ☐ Soft, downy hair present on the body (lanugo)
- ☐ Menstrual irregularities or loss of menstruation (amenorrhea)
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Dry skin
- ☐ Frequently being cold Irregular heart rhythms
- ☐ Low blood pressure
- ☐ Dehydration

*1. Have you used drugs other than those required for medical reasons?* Y☐ N☐
*2. Have you abused prescription drugs?* Y☐ N☐
*3. Do you abuse more than one drug at a time?* Y☐ N☐
*4. Can you get through the week without using drugs?* Y☐ N☐
*(other than those required for medical reasons)?* Y☐ N☐
*5. Are you always able to stop using drugs when you want to?* Y☐ N☐
*6. Do you abuse drugs on a continuous basis?* Y☐ N☐
*7. Do you try to limit your drug use to certain situations?* Y☐ N☐
*8. Have you had "blackouts" or "flashbacks" as a result of drug use?* Y☐ N☐
*9. Do you ever feel bad about your drug abuse?* Y☐ N☐
*10. Does your spouse (or parents) ever complain about your involvement with drugs?* Y☐ N☐
*11. Do your friends or relatives know or suspect you abuse drugs?* Y☐ N☐
*12. Has drug abuse ever created problems between you and your spouse?* Y☐ N☐
*13. Has any family member ever sought help for problems related to your drug use?* Y☐ N☐
*14. Have you ever lost friends because of your use of drugs?* Y☐ N☐
*15. Have you ever neglected your family or missed work because of your use of drugs?* Y☐ N☐
*16. Have you ever been in trouble at work because of drug abuse?* Y☐ N☐
*17. Have you ever lost a job because of drug abuse?* Y☐ N☐
*18. Have you gotten into fights when under the influence of drugs?* Y☐ N☐
*19. Have you ever been arrested because of unusual behavior while under the influence of drugs?* Y☐ N☐
*20. Have you ever been arrested for driving while under the influence of drugs?* Y☐ N☐
*21. Have you engaged in illegal activities in order to obtain drug?* Y☐ N☐
*22. Have you ever been arrested for possession of illegal drugs?* Y☐ N☐
*23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?* Y☐ N☐
*24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?* Y☐ N☐
*25. Have you ever gone to anyone for help for a drug problem?* Y☐ N☐
*26. Have you ever been in a hospital for medical problems related to your drug use?* Y☐ N☐
*27. Have you ever been involved in a treatment program specifically related to drug use?* Y☐ N☐
*28. Have you been treated as an outpatient for problems related to drug abuse?* Y☐ N☐

## *A SHORT QUESTIONNAIRE ABOUT YOUR ALCOHOL USE*

*C - Have you ever thought you should CUT DOWN on your drinking?* ☐ *Y* ☐ *N*

*A - Have you ever felt ANNOYED by others' criticism of your drinking?* ☐ *Y* ☐ *N*

*G - Have you ever felt GUILTY about your drinking?* ☐ *Y* ☐ *N*

*E - Do you have a morning EYE OPENER?* ☐ *Y* ☐ *N*

## ADVERSE CHILDHOOD EXPERIENCES

1. Did a parent or other adult in the household often or very often swear at you, insult you, or put you down? ☐ *Y* ☐ *N*

2. Did one of your parents often or very often push, grab, slap or throw something at you? ☐ *Y* ☐ *N*

3. Did one of your parents often or very often hit you so hard that you had marks or were injured? ☐ *Y* ☐ *N*

4. Did an adult or person at least 5 years older ever have you touch their body in a sexual way? ☐ *Y* ☐ *N*

5. Did an adult or perosn at least 5 years older ever attempt oral, anal, or vaginal intercourse with you? ☐ *Y* ☐ *N*

6. As a child, did you witness your mother sometimes, often , or very often pushed, grabbed, slapped, or had something thrown at her? ☐ *Y* ☐ *N*

7. As a child, did you witness your mother sometimes, often , or very often kicked, bitten, hit with a fist, or hit with something hard? ☐ *Y* ☐ *N*