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Licensed Psychologist
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Peachtree Corners, GA 30092
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Informed Consent for Psychological Testing-Adolescent

Welcome to my practice! Thank you for contacting me for the opportunity to help. I look forward to working with you and your child with the goals of understanding his or her abilities, including both the strengths and any areas of difficulty, and making recommendations that may include a range of interventions that can support the way your child learns and improve their experience in school and their confidence in everyday life. Although this document is long and sometimes complicated, please read it carefully in its entirety and ask any questions you have about the content. When you sign this document, it will represent an agreement between us.

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.

PRACTICE STRUCTURE:
I am in independent practice and am not affiliated with any other individual or practice.

WHAT IS PSYCHOLOGICAL TESTING?
Psychological evaluation is a process that includes a combination of clinical interview, completion of written questionnaires, and use of a variety of standardized measures in two or more one-on-one appointments with you or your child or adolescent. Depending upon the individual concerns and questions to be answered by the evaluation, testing may include measures of:

- Cognitive Ability
- Academic Achievement and Learning Progress
- Attention and Executive Functioning
- Visual and Auditory Information Processing
- Problem Solving Strategies
- Motor and Visual Perceptual Abilities
- Memory
- Behavioral and Emotional Functioning

WHAT IS THE PROCESS?
The first appointment is an initial evaluation, which typically includes a discussion with the client. For children or adolescents, the parents are interviewed to learn more about the current concerns and difficulties, as well as to gather background history and information about school functioning and, to review the findings from written questionnaires completed in advance. Information from this meeting helps with the final selection of measures for the test battery. At this first meeting, you may be asked to provide additional records, such as report cards and prior testing reports and, for your written authorization to provide permission to communicate with other professionals involved in your child's care.

The testing sessions are usually scheduled in two or three sessions on separate days, typically in the morning, lasting 3-1/2 – 4 hours each. The specific measures chosen depend on the concerns to be addressed.

The family feedback meeting is scheduled 2 – 4 weeks after the final testing session -- and after all other supporting data and reports have been received -- to review the test results and recommendations. At that appointment, you will be provided with a comprehensive written report.

USE OF THE EVALUATION REPORT:

After the written report has been prepared and shared, the usual next step is to share the report with other involved professionals including but not limited to the school team, the pediatrician and other medical professionals. On many occasions, parents set up a meeting at the school to go over the recommendations and determine if additional supports can be put in place.

Please be aware that it is not in my control whether the school will agree to implement the recommendations. The recommendations will be practical, driven by the test data and relevant to the needs of your child in the context of the evaluation results.

While I stay up to date on the rules for provision of accommodations for standardized testing and the types of test instruments recommended for consideration for accommodations, I do not have any special power to obtain approval for accommodations for standardized testing such as the ACT, SAT or AP tests. I want you to know in advance that I will not change the presentation of the results, the diagnoses or the recommendations purely so that they meet criteria for special supports or accommodations; to do so would be unethical.

The standardized testing companies continue to be particularly conservative in granting accommodations to students who do not have a long standing history of receiving and using those very accommodations in their school setting. If the College Board or ACT denies the student accommodations, you may ask me to write a Letter of Appeal on the behalf of the student.

Typically, these letters must be completed in a short period of time and require a substantive review of the report and the denial. This type of letter takes additional time and will require a separate fee, which can be discussed if or when these circumstances occur for your child.

FEES AND PAYMENT:

A complete psychological evaluation involves the initial appointment, preceded by scoring and interpretation of written questionnaire measures sent in advance of the first appointment, followed by face-to-face testing measures with the examiner, usually over two to three appointments and taking seven to eight hours total. Testing also involves scoring and interpretation of the results and the preparation of an integrative written report. The writing of the report usually takes at least as many hours as and often even more hours to complete than the testing time itself.

The fee for the comprehensive psychological evaluation is generally $2500.00. This includes the testing sessions, the family feedback meeting and the preparation of the comprehensive written report. The testing evaluation fee is due at the first testing session. The full fee is due when the testing is complete and before the scheduled feedback meeting.

INSURANCE INFORMATION:

If I am an out-of-network provider, this means that I am not a member of a provider network for your managed care plan. Your insurance plan may or *may not* cover visits to an out-of-network provider. Some insurance companies reimburse at different amounts depending on whether you see a provider with whom they have a contract, called an "in-network" provider.

You are responsible for payment of all charges, submission of bills to your insurance company, obtaining information about your coverage and making certain that we are both aware of any authorization requirements for psychological testing. I will provide you with detailed receipts including all the necessary information should you choose to submit to your insurance company for reimbursement. Many insurance plans cover psychological services and many require the *member* to make a telephone call before an initial appointment. If you are interested in submitting for reimbursement, I recommend that you contact your insurance company to request information about out-of-network benefits for psychological consultation and testing prior to the first appointment.

If you call your insurance company, let them know that you are calling for "preauthorization for psychological testing." They may ask you for CPT Codes. These are listed below.

90791 Initial Diagnostic Interview
96101 Psychological Testing
90847 Family Feedback Meeting

I suggest that you obtain any special forms and a fax number for paperwork that they tell you is required. If your insurance company authorizes the testing, they will use the date they *receive* the forms for the start date of the authorization. I am not in control of how quickly they will process this request or whether they will authorize testing at all. I will fill out forms if you provide them for me and will give you a copy of forms that I submit so that you can follow up with them directly.

CANCELLATION POLICY:

If you must cancel an appointment, please give a *minimum* of *48 hours advance notice.* If this minimum is not provided, you will be charged a cancellation fee of $ 50 for the initial appointment or family feedback meeting and a $200 fee for the cancellation of a testing appointment. Given the large amount of reserved time made available to you for testing appointments, short notice cancellations for the testing sessions may result in the cancellation of subsequent appointments.

CONFIDENTIALITY:

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information to others with your (the patient or the parent for children and adolescent) written permission. There are a few exceptions that have rarely or never occurred in my practice but about which you should be informed:

- In proceedings involving custody or those in which your child's emotional condition is an issue, a judge may determine that my testimony will be ordered. If you choose to include your child's mental or emotional status as part of a court proceeding, doing so waives your privilege of confidentiality.

- If a patient or patient's parent or guardian files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I have reason to believe that a child has been subjected to abuse or neglect, the law requires that I file a report with the appropriate government agency.
- If you submit your bill to your insurance company for reimbursement, they require that I provide a clinical diagnosis and may also request clinical information. If your company requires forms to be completed to request authorization for psychological testing, these forms may include clinical information and diagnoses that are faxed to the company for review or discussed in a telephone call with a reviewer employed by the company.
- If you are divorced, both parents have equal ability to obtain information from mental health records and both parents *must* give permission for the provision of psychological services.

If a situation like one of those described above occurs, I will make every effort to fully discuss it with you before taking any action. Otherwise, I will not tell *anyone anything* about you or your child's evaluation or even that you are a patient, without your knowledge and written consent.

CONTACTING ME:

The best way to reach me is through the confidential voice mail answering system. Please be aware that I do not answer calls when I am in appointments, but I check voice mail often. I will make every effort to return your call within 24 – 48 hours, except for weekends and holidays, but cannot guarantee that this is always possible. If you are not able to reach me and feel that your child is having an acute mental health emergency and you cannot wait for a return call, please contact your child's medical provider or go to the nearest emergency room.

SPECIAL CIRCUMSTANCES:

I provide consultation, psychological evaluation, and psychotherapy services to assist with problem resolution and do not do specialized evaluations to be used in legal proceedings, such as for forensic issues or court proceedings for custody determination. If you anticipate that this is needed, I will refer you to professionals who have this area of specialization in their practice.

Although very unlikely, it is important that I share the following information in advance: In the event that I am required by subpoena or court order to testify in any matter related to the psychological evaluation services, you will be expected to pay for all of the professional time used, including preparation and transportation costs, even if I am called to testify by another party. If I am subpoenaed by another party in litigation with you and you do not wish the subpoena answered, it is your responsibility to contract with your lawyer to quash the subpoena or to sign a waiver of confidentiality.

Because of the substantial difficulty of managing such legal involvement while maintaining scheduled appointments in my practice at the same time, the fees are $ 250 per hour for preparation and attendance at any legal proceeding.

Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. By your signature below, you indicate that:

- You have been informed of and understand the type of services to be provided.
- You have been informed of the limits of confidentiality.
- You understand and agree to the payment and cancellation policies.
- You accept full responsibility for all fees incurred in completing the psychological evaluation as spelled out in the agreement.
- You understand that, if you are provided with a digital copy of the report, you are not permitted to make any changes to the report.

Name of Patient: _____

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Printed name serves as an electronic signature if you cannot sign Relationship to Patient

_____ _____
Signature of Second Parent/Guardian Date

_____ _____
Printed name serves as an electronic signature if you cannot sign Relationship to Patient

KOVNER CENTER FOR BEHAVIORAL HEALTH AND PSYCHOLOGICAL TESTING
Steven Kovner, Ph.D., Psychologist and Director

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:		**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:**		
Precert? Auth. #:			**Initial Diagnostic Impression:**		

OFFICE POLICIES, PRIVACY NOTICE AND FINANCIAL AGREEMENT FOR PSYCHOLOGICAL SERVICES

Welcome to my practice. This document contains important information about my professional services and business policies. HIPAA, the Healthcare Portability Act, which I will explain elsewhere, provides you with additional rights. 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.

Although I may share office space with other therapists at 4046 Wetherburn Way, Suite 7, Peachtree Corners, GA 30092, we are each independent practitioners and not responsible or liable for one another's practices or procedures. This document consists of my office policies, your rights to confidentiality and records under the law, your permission to treat you and/or your child(ren) and our financial agreement.

PSYCHOLOGICAL SERVICES

I specialize in the assessment, diagnosis and treatment of learning, relationship, psychological, and some neuropsychological disorders. By signing this agreement, you are giving consent for yourself or your child/adolescent to undergo psychological evaluation and/or treatment. As a licensed psychologist, I will be performing this 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, diagnosis of a mental illness, 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, insight into one's emotional and/or behavioral problems, and "processing" or making sense of troubling, confusing, and traumatic events in one's past. 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 Dr. Kovner the client works to improve their 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 physical health.

Consultation and Court Room Testimony

Dr. Kovner provides consultation to teachers, school personnel, lawyers and other professional, as well as testifying in court.

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 are 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 my private practice.

However, 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 emergency needs will be seen within (6) hours or directed to emergency care. Clients with urgent care needs will receive care within 24 hours.

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 of $0.10 per page (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.

Please note that in some cases our 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. The written notice of these HIPAA rights are framed on the wall of the waiting room and a copy can by provided to you if you request it. 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. For a detailed description of your rights under HIPAA, go to the Health and Human Services web page below.

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html.

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.

Children and Adolescent Clinical Records

With regards to your child or adolescent, the review of the clinical record would violate your child's privacy. Without privacy, most children and adolescents will not talk or disclose matters of true concern and therapy would

be ineffective. There may be a general discussion with you about the goals, progress and effectiveness of therapy, but this would be at Dr. Kovner's discretion.

If during the course of treatment, I were to become concerned that your child was being physically or sexually abused, I am mandated by law to contact the State Agency charged with child-protection (DFCS). DFCS will investigate whether there are grounds for Therefore, before I would agree to treat your child (or adolescent) I request that you consent to waive your right to have a copy, or review the details, of the clinical record by signing in the space below. Your printed name will reporesent your signature if you are unalbel to sign, so please type your name in both the printed and signature fields.

I, _____, the parent or legal guardian of _____
(Print Parent's or Legal Guardian's Name) *(Print Child's or Adolescent's Name)*

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

_____ _____
(Parent's or Legal Guardian's Signature) *(Parent's or Legal Guardian's Signature)*

Date:_____ *Date:_____*

Please note that in some cases our 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.

INSURANCE & CONFIDENTIALITY

You should be aware that most insurance companies require you to authorize your treating psychologist to provide them with a clinical diagnosis and, sometimes, detailed clinical records. In that case, we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we 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 data bank. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit our disclosure to what is necessary.

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.

Recording of Sessions

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

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.

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

- *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 keep voices down to a whisper if you talk on your cell phone or step outside.*
- *We use the radio to provide the Office Manager with privacy. She has limited time. Please respect her time and privacy. All clinical information is to be presented* ***in therapy sessions by appointment****.*

FINANCIAL AGREEMENT

Dr. Kovner's usual and customary fee is $175.00 per hour. He charges this amount for other professional services you may need. Other services include:

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

If you become involved in legal proceedings through the court system or hire me to support your child in an IEP meeting, Board Meeting, or Tribunal Hearing through the school system, you will be charged $200.00 per hour for travel, wait time, preparation and attendance. I require a $1,600.00 retainer before work is begun.

If you plan to use your health care insurance, you are expected to contact them and be informed of your Mental Health benefits. We cannot be responsible for interpreting your insurance benefits. Unless your insurance company has contracted directly with the Kovner Center, this office cannot call, contact or negotiate for you with your insurance company. However, we will print out statements for you to submit for reimbursement. Any special arrangements must be discussed in advanced with the office manager. Missed appointments are generally not insurance reimbursable.

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.

LATE FEES AND NON-PAYMENT ACTIONS

Customer agrees to be responsible 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.

CANCELLATION POLICY AND RESCHEDULING APPOINTMENTS

In order to accommodate you we offer flexible appointment hours, including after-school and evening hours. When you schedule an appointment, that time is yours and you pay for that time whether you use it and attend your appointment or you fail to show up or fail to cancel your appointment ***at least two days prior. We charge a $50.00 fee for not canceling your appointment 2 days (48 hours) in advance.*** *We refer to this as the* ***Cancellation Fee****. The fee may be waived at Dr. Kovner's discretion when you were unable to attend due to circumstances beyond your control.*

Individuals who miss two consecutive appointments without advanced notification will be taken off the calendar. There may be situations when I agree that you were unable to attend due to circumstances beyond your control. Under these circumstances, the fee will be waived at Dr. Kovner's discretion and you will be able to schedule your next appointment.

INTENT TO USE MEDICAL INSURANCE

Please indicate below your intention to use health insurance.

☐ *I do not have mental health insurance.*

☐ *I have decided not to utilize my health insurance to cover the cost of these services.*

☐ *I have decided to use my health insurance to cover the cost of these services. My signature on this agreement verifies that I understand that a pre-authorization from my insurance company is not a guarantee that your insurance company will pay for these services and that if your insurance company chooses not to pay, or to pay only partially for this service, you agree to pay the balance on your account in full.*

Please check your coverage carefully prior to your first session. You can call the number on your insurance card and ask the following questions:

1. *Do I have benefits for outpatient mental health services?* **Yes** ☐ **No** ☐
2. *Do I have coverage when I see an Out of Network provider?* **Yes** ☐ **No** ☐
3. *Will my insurance offer a "single case agreement" to allow payment for an Out of Network provider?* **Yes** ☐ **No** ☐
4. *What is the maximum dollar amount or number of sessions per year covered by and what dates does it start over?* **Yes** ☐ **No** ☐
5. *How much is my deductible and has it been met this year?* **Yes** ☐ **No** ☐
6. *Is there a separate deductible for mental health services?* **Yes** ☐ **No** ☐
7. *What is my co-pay for mental health services?*

If you have medical insurance that covers outpatient psychotherapy, you will only need to pay the portion of your fee not covered by insurance. Insurance claims will be submitted for you. If I, or your insurance company, determine that your psychotherapy is not "medically necessary" according to the guidelines of the insurance industry, you will be responsible for the fee, as insurance covers only such "medically necessary" services. If your insurance company has not paid your account in full within 90 days, the balance will be billed to you or transferred to your credit card.

CREDIT CARD AND AUTHORIZATION FORM

Credit Card Holder:		***Expirations Date***	/	***Security Code***	
Credit Card Number:		***The services rendered are checked below.***			
Zip Code:		( ) *Diagnostic Interview*	( ) *Psychotherapy 50-60 Min.*		
		( ) *Psychological Evaluation*	( ) *Court Testimony*		
		( ) *Two-Day Couples Retreat*	( ) *Written Correspondence*		
_____ ***Authorizing Signature*** ***Your typed name will represent your signature if you cannot sign.***	_____ ***Date***	( ) *Test Results Feedback*	( ) *School Board, IEP or Tribunal Hearing*		
		( ) *Phone Consultations greater than 10 minutes*			

ACKNOWLEDGMENT OF REVIEW OF OUR OFFICE, FINANCIAL AND CANCELLATION POLICIES & AGREEMENTS, AND PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with, understand and accept the policies in the "HIPAA Notice of Privacy Practices" as well as Dr. Kovner's "Office Policies, Cancellation Requirements" and Financial Obligations. Therefore, I have been advised of how health information about me may be used and disclosed by Dr. Kovner, how I may obtain access to and control this information and my responsibilities to pay all fees not covered by insurance and the costs associated with late fees and collection services.

*X*_____ _____

Signature of Patient or Personal Representative (Type Your Name if You Cannot SIgn) *DATE*

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

Name	*Relationship to Client*	*Phone Number*
Name	*Relationship to Client*	*Phone Number*
Name	*Relationship to Client*	*Phone Number*

2. May we leave a message on your answering machine? YES ☐ *NO* ☐

3. Preferred method of contacting you:

*Home #*_____*Cell #*_____*Work #*_____

THIS SECTION WILL BE COMPLETED IF THE WRITTEN ACKNOWLEDGMENT IS NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgment, but the acknowledgment was not obtained for the following reason(s):

☐ *The individual refuses to sign and/or did not return his or her receipt of the Acknowledgment.*

☐ ***Other:***

Date:

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*