Harry Dudley, Psy.D.

7600 NE 41st Street, Suite 310
Vancouver, WA 98662

phone (360) 571-2045
fax (360) 253-3196

Consent to Use or Disclose Clinical Information

I authorize Harry Dudley, Psy.D. to use and disclose the health care information for the purpose of ***Treatment*** (such as coordinating your care with your primary physician or other health care professionals), ***Payment*** (such as billing your insurance company and determining eligibility of your health benefits) and routine ***Health Care Operations*** (such as scheduling appointments or calling to remind you of an appointment).

This consent form is being provided to you with an attached ***Notice of Privacy Practices.*** Please review this ***Notice of Privacy Practices*** for additional information about the uses and disclosures of protected health care information described in this Consent prior to signing this Consent.

A summary of the ***Notice of Privacy Practices*** will be posted in my office indicating the effective date of the current copy of this document. As more fully explained in the Notice of Privacy Practices, you have the right to request restrictions on how your health care information may be used for treatment, payment, and routine health care operations. You also have the right to request a review of your records or to amend your records; this is more fully explained in the Notice of Privacy Practices.

Please verify that you received the ***Notice of Privacy Practices*** by initialing here: _____

I understand that I have the right to revoke this Consent, provided that I do so in writing, except to the extent that this office has already used or disclosed information prior to my decision to revoke consent.

_____ _____
Signature of Client Date

_____ _____
Signature of legal guardian (if client is a minor) Date

_____
Relationship to client (if client is a minor)

Harry Dudley, Psy.D.
7600 NE 41st Street, Suite 310 phone (360) 571-2045
Vancouver, WA 98662 fax (360) 253-3196

Notice of Privacy Practices

This document describes how clinical and health care information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice describes the privacy policies followed by this office and any practitioner who might provide "on-call" coverage for me, and applies to the information I have about your health and the services you receive from this office. If you have any questions or requests concerning this notice, please contact me.

I am required by current federal law, effective April 14, 2003, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) to give you this notice. It will tell you about the ways in which I may use and disclose protected health information about you and describe your rights and my obligations regarding the uses and disclosure of that information.

How I may Use and Disclose Protected Health Information (PHI):

By State law and the ethics of the mental health profession, I must have your written and signed consent to use and disclose health care information for the following purposes:
For Treatment: I may disclose health care information in order to provide better clinical services, i.e.; discussing your case with your primary physician or another practitioner for consultation purposes.
For Payment: I may use and disclose health information so that services may be billed and paid by you, your insurance company or a third party. It is my policy to release only demographics, diagnosis, date and type of service when I bill third party payers. If more information is required by a payer, I will request your written consent for that disclosure.
For Routine Health Care Operations: I may use health information about you in order to run my practice, i.e., appointment reminders. I may contact you as a reminder that you have an appointment. Please notify me if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contacts.

You may revoke your Consent at any time by giving written notice. Your revocation will be effective when I receive it, but will not apply to any uses and disclosures that occurred prior to that time.

If you are receiving substance abuse treatment, federal and state law require your written Authorization each time I release information. The Authorization will specify who is to receive the information, the purpose of the release of information, and a time period after which the Authorization will terminate. You may modify or revoke an authorization at any time.

Special Situations:
I may use or disclose health information about you without your permission for the follow purposes, subject to all applicable legal requirements and limitations:
To Avert a Serious Threat to Health or Safety: Based on professional judgment, I may use and disclose information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
Required by Law: Based on professional judgment, I may disclose health care information about you when required by federal, state or local law.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court order or subpoena, and I will use my professional judgment about the information to be disclosed.
Law Enforcement: I may release health information if required to do so in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
Family and Friends: In situations where you might not be capable of giving authorization, because you are not present or due to your incapacity or medical emergency, I may determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only information relevant to the person's involvement in your care.

Additional disclosures are permitted under HIPAA regulation. These will not be made without your authorization and consent. Once information leaves my office and becomes part of any data resource beyond my control, HIPAA permits disclosure in the following circumstances:
Research: Health information about you may be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address, or other information that reveals who you are.
Military, National Security, and Intelligence: If you are a member of the armed forces, or part of the national security or intelligence communities, military command, or other government authorities may require the release of health information about you. HIPAA also permits the release of information about foreign military personnel to the appropriate foreign military authority.

Workers Compensation: Health information may be released for workers compensation or similar programs. These programs provide benefits for work-related injuries.
Public Health Risks: Health information may be released in order to prevent or control disease, injury or disability; report births, deaths, suspected abuse or neglect, non-accidental injury, reactions to medications or problems with products.
Health Oversight Activities: Health information may be disclosed to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
Information Not Personally Identifiable: Health information may be disclosed in a way that does not personally identify you or reveal who you are.

Other Uses and Disclosures of Health Information:
This office will not disclose your health information for any purpose other than those identified in the previous sections without your specific written Authorization. You may also revoke your Authorization in writing, at any time. If you revoke your Authorization, I will not disclose any further information, but I cannot take back any disclosures already made with your permission. A separate written authorization is required for the release of information regarding HIV or substance abuse treatment. In order to disclose these types of records, I will provide a separate written release that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Protected Health Information:
Right to Review Records: You have the right to review your clinical, medical and billing records. You must submit a written request to me, the designated privacy officer, in order to inspect your health information. If you request a copy of the records, I may charge a fee for the costs of copying and/or mailing the records. I may deny your request to inspect, review or copy records in certain limited circumstances, such as when I believe exposure to this information may be detrimental to your mental health. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, I will select a licensed mental health care professional to review your request and my denial. The person who conducts this review will not be the person who denied the request, and I will comply with the outcome of the review. You do not have the right to review or copy private psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative proceeding.
Right to Amend: If you believe the health records about you are incomplete or incorrect, you may ask me to amend the information. You have the right to request an amendment when the information is kept by this office. To request an amendment, you must submit a clear statement of the requested amendment to the designated privacy contact. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask to amend information that:
- I did not create.
- Is not part of the health information that I keep.
- You would not be permitted to review, inspect, or copy.
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures I have made of clinical information about you for purposes other than treatment, payment, and routine health care operations. To obtain this list, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). I may charge you for the costs associated with providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions: You have the right to request a restriction or limitation on the health care information disclosed about you for treatment, payment or health care operations. You have the right to request limits on disclosures, such as asking that I not call you at your office, or that I not communicate with family members.
Right to Request Confidential Communications: You have the right to request that I communicate with you about clinical matters in a confidential way, such as asking that I only contact you at home.
Right to a Paper Copy of this Notice: You have the right to a paper copy of this privacy notice. Even if you agreed to receive it electronically, you are entitled to a paper copy.

Changes to this Notice:
I reserve the right to change this privacy notice, and to make the revised notice effective for any medical or clinical information I receive in the future. I will post a summary of the current privacy notice, including its effectiveness date, in my office. You are always entitled to a copy of the notice currently in effect.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

HARRY C. DUDLEY, PSY.D.
Consulting & Clinical Psychology

7600 NE 41st Street, Suite 310
Vancouver, WA 98662
360-253-6425 – 360-253-3196 Fax

DISCLOSURE STATEMENT

I am a licensed psychologist in the State of Washington (PY1794). I have been in private practice as a solo practitioner since 1993 as one of the number of independent mental health practitioners at 7600 NE 41st Street, Suite 310, Vancouver, Washington 98662. I obtained a Bachelor of Arts in Psychology from Syracuse University in 1982 and a Masters of Arts Degree in Psychology from Yeshiva University in 1985. I was awarded the Doctor of Psychology (Psy.D.) Degree from Yeshiva University in 1988. While attending university, I was employed in a number of clinical and research settings. After receiving the doctorate, I was a staff psychologist for two years at a day treatment school for children with neuro-developmental disorders (1988-1990). For three years I was a senior psychologist at a family court based forensic mental health services clinic in Manhattan, New York (1990-1993) while simultaneously maintaining a part-time psychotherapy practice.

My practice focuses onpsychological evaluations of children, adolescents and adults, and psychotherapy. I have expertise in a variety of treatment modalities, including but not limited to Cognitive Behavioral Therapy (CBT), Compassion Focused Therapy (CFT), Acceptance and Commitment Therapy (ACT), Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Behavioral Therapy for Insomnia (CBT-I), Integrative Restoration Yoga Nidra Meditation (iRest), various forms of mindfulness based interventions (MBI), and somatic psychotherapy. I also provide meditation training to students from a non-dual perspective.

PSYCHOTHERAPY & EVALUATION APPOINTMENTS

Psychotherapy appointments begin with a one hour initial interview assessment session and are followed with weekly or bi-weekly psychotherapy appointments of 45 minutes duration. 48-hour notice during business days (Monday through Friday, not including weekends and holidays) are required to cancel an appointment, otherwisethe full fee will be billed to you. Insurance will be billed as applicable for services provided.

Appointments for psychological evaluations can vary considerably with respect to how they are structured and the length of the appointments, and this will be discussed with you prior to scheduling. Clinical evaluations, including evaluations

for neuro-developmental disorders and learning disabilities, begin with a one hour appointment and maybe billed to insurance depending upon the referral question.

CONFIDENTIALITY

All issues discussed in the course of psychotherapy are considered confidential. By law, information concerning treatment or evaluation may be released only with written consent of the person treated or the patient's parent or guardian. There are limits to confidentiality, however, in which the law requires release of confidential information under the following four situations:

1. Suspected child, elder, or dependent adult abuse,

2. Potential suicidal behavior or inability to care for oneself,

3. Threatened harm to another, and

4. Under certain circumstances your records may be subject to a court subpoena. Washington law also indicates that you maybe also waving certain rights to privilege if you make your psychotherapy or mental health status part of a court proceeding. Your insurance company might also require periodic reports of your treatment.

FEES

I bill for my time at the rate of $200 per clock hour. The usual and customary fees for specific procedures and appointments are as follows:

- Initial psychotherapy assessment appointment - $200
- Individual or family psychotherapy - $150.
- Charges for review of records are billed at the rate of $200 per hour.
- Individual test charges vary from $100.00 to $200.00 depending on the measure administered.

Significantly past due accounts beyond 90 days will be subject to collections.

TESTIMONY

Regardless of whether you have been evaluated as part of a clinical evaluation, or you have been seen for psychotherapy, I require a retainer for court appearances and depositions to be provided at least 72 hours in advance of the scheduled testimony or deposition. Retainers for testimony range from $1,000 to $4,000 depending on the scope of testimony and the anticipated time for preparation. I require 48-hour notice during business days (Monday through Friday, not including weekends and holidays) for cancellation, otherwise a portion of the retainer will be kept to cover time spent preparing and for time reserved.

EMERGENCY CALLS

Our office includes a medical office manager who answers the telephone during normal business hours (9am to 5pm, Monday through Friday) and you will have access to my voicemail. If you are calling after hours I will attempt to return your call in a timely manner. I also selectively provide my email for scheduling and contact purposes. If you are experiencing an emergency and need assistance you are directed to call 911 or go to your local emergency room.

PRACTICE OF PSYCHOLOGY

During your initial appointments we will explore your reasons for seeking out services and I will discuss my approach to treatment. It is possible that we may mutually determine that a different provider or approach may be of greater benefit to you. It is your right to continue or discontinue therapy as you see fit, and termination can also occur at my request or determination as well. If you have questions about the laws pertaining to the practice of psychology in Washington State as well as ethical questions, you may contact the State Examining Board of Psychology at (360) 753-1392.

I understand and agree to the aforementioned policies and procedures.

_____ Date: _____
Signature

_____ Date: _____
Parent/Guardian

Harry C. Dudley, Psy.D.
Licensed Psychologist

PATIENT COPY

HARRY C. DUDLEY, PSY.D.
Consulting & Clinical Psychology

7600 NE 41st Street, Suite 310
Vancouver, WA 98662
360-253-6425 – 360-253-3196 Fax

DISCLOSURE STATEMENT

I am a licensed psychologist in the State of Washington (PY1794). I have been in private practice as a solo practitioner since 1993 as one of the number of independent mental health practitioners at 7600 NE 41st Street, Suite 310, Vancouver, Washington 98662. I obtained a Bachelor of Arts in Psychology from Syracuse University in 1982 and a Masters of Arts Degree in Psychology from Yeshiva University in 1985. I was awarded the Doctor of Psychology (Psy.D.) Degree from Yeshiva University in 1988. While attending university, I was employed in a number of clinical and research settings. After receiving the doctorate, I was a staff psychologist for two years at a day treatment school for children with neuro-developmental disorders (1988-1990). For three years I was a senior psychologist at a family court based forensic mental health services clinic in Manhattan, New York (1990-1993) while simultaneously maintaining a part-time psychotherapy practice.

My practice focuses onpsychological evaluations of children, adolescents and adults, and psychotherapy. I have expertise in a variety of treatment modalities, including but not limited to Cognitive Behavioral Therapy (CBT), Compassion Focused Therapy (CFT), Acceptance and Commitment Therapy (ACT), Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Behavioral Therapy for Insomnia (CBT-I), Integrative Restoration Yoga Nidra Meditation (iRest), various forms of mindfulness based interventions (MBI), and somatic psychotherapy. I also provide meditation training to students from a non-dual perspective.

PSYCHOTHERAPY & EVALUATION APPOINTMENTS

Psychotherapy appointments begin with a one hour initial interview assessment session and are followed with weekly or bi-weekly psychotherapy appointments of 45 minutes duration. 48-hour notice during business days (Monday through Friday, not including weekends and holidays) are required to cancel an appointment, otherwisethe full fee will be billed to you. Insurance will be billed as applicable for services provided.

Appointments for psychological evaluations can vary considerably with respect to how they are structured and the length of the appointments, and this will be discussed with you prior to scheduling. Clinical evaluations, including evaluations

for neuro-developmental disorders and learning disabilities, begin with a one hour appointment and maybe billed to insurance depending upon the referral question.

CONFIDENTIALITY

All issues discussed in the course of psychotherapy are considered confidential. By law, information concerning treatment or evaluation may be released only with written consent of the person treated or the patient's parent or guardian. There are limits to confidentiality, however, in which the law requires release of confidential information under the following four situations:

1. Suspected child, elder, or dependent adult abuse,

2. Potential suicidal behavior or inability to care for oneself,

3. Threatened harm to another, and

4. Under certain circumstances your records may be subject to a court subpoena. Washington law also indicates that you maybe also waving certain rights to privilege if you make your psychotherapy or mental health status part of a court proceeding. Your insurance company might also require periodic reports of your treatment.

FEES

I bill for my time at the rate of $200 per clock hour. The usual and customary fees for specific procedures and appointments are as follows:

- Initial psychotherapy assessment appointment - $200
- Individual or family psychotherapy - $150.
- Charges for review of records are billed at the rate of $200 per hour.
- Individual test charges vary from $100.00 to $200.00 depending on the measure administered.

Significantly past due accounts beyond 90 days will be subject to collections.

TESTIMONY

Regardless of whether you have been evaluated as part of a clinical evaluation, or you have been seen for psychotherapy, I require a retainer for court appearances and depositions to be provided at least 72 hours in advance of the scheduled testimony or deposition. Retainers for testimony range from $1,000 to $4,000 depending on the scope of testimony and the anticipated time for preparation. I require 48-hour notice during business days (Monday through Friday, not including weekends and holidays) for cancellation, otherwise a portion of the retainer will be kept to cover time spent preparing and for time reserved.

EMERGENCY CALLS

Our office includes a medical office manager who answers the telephone during normal business hours (9am to 5pm, Monday through Friday) and you will have access to my voicemail. If you are calling after hours I will attempt to return your call in a timely manner. I also selectively provide my email for scheduling and contact purposes. If you are experiencing an emergency and need assistance you are directed to call 911 or go to your local emergency room.

PRACTICE OF PSYCHOLOGY

During your initial appointments we will explore your reasons for seeking out services and I will discuss my approach to treatment. It is possible that we may mutually determine that a different provider or approach may be of greater benefit to you. It is your right to continue or discontinue therapy as you see fit, and termination can also occur at my request or determination as well. If you have questions about the laws pertaining to the practice of psychology in Washington State as well as ethical questions, you may contact the State Examining Board of Psychology at (360) 753-1392.

I understand and agree to the aforementioned policies and procedures.

_____ Date: _____
Signature

_____ Date: _____
Parent/Guardian

Harry C. Dudley, Psy.D.
Licensed Psychologist

HARRY C. DUDLEY, PsyD, C-iRest
Licensed Psychologist
Certified iRest Meditation Teacher

7600 NE 41st Street, Suite 310
Vancouver, WA 98662
360-253-6425 – 360-253-3196 Fax
PSYDHCD@aol.com

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

I have a preferred telehealth platform which will be used. At this point in time, I prefer to use Zoom, but I may use other platforms or services on a case by case basis.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. 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 or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of

electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover

electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____
Client

_____
Date

INTAKE EVALUATION (CHILD)

To be completed by parent

Child's name: _____ Today's Date: _____

Gender (M/F): ___ Age: ____ Date of Birth: ____/_____/_____

Custodial parent(s) name: _____

Address: _____ City, State, ZIP: _____

Telephone: _____ _____ E-Mail:
home May we leave messages? Y/N

_____ _____ _____
Mother cell, work (please indicate) May we leave messages? Y/N

_____ _____
Father cell, work (please indicate) May we leave messages? Y/N

Grade in school: _____ School: _____

Others living in the home (name, birth date, relationship to client):

_____ ___/____/____ _____, _____ ____/____/____ _____

_____ ___/____/____ _____, _____ ____/____/____ _____

_____ ___/____/____ _____, _____ ____/____/____ _____

Immediate family living outside the home (name, birth date, relationship to client):

_____ ___/____/____ _____, _____ ____/____/____ _____

_____ ___/____/____ _____, _____ ____/____/____ _____

Emergency contact: _____ Telephone: _____

Referred by: _____

Insurance Information

Name of Insured: _____ Insured date of birth: _____
Address of Insured: _____ City, State, ZIP: _____
Relationship of client to Insured: _____ Employer of Insured: _____
Primary insurance company: _____ Phone: _____
Insurance company address: _____ City, State, ZIP: _____
Insurance identification number: _____ Group number: _____

Secondary insurance company: _____ Phone: _____
Name of secondary insured: _____ Date of birth: _____
Secondary insurance address: _____ City, State, ZIP: _____
Secondary identification number: _____ Group number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____ Date: _____

Child's Name: _____

Presenting Problem

Describe the child's problem(s) that brought you here today:

Check any of these symptoms that the child has been having:

___ Depressed mood
___ Extreme sadness
___ Trouble concentrating
___ Change in sleeping habits
___ Security blanket or object
___ Bedwetting
___ Change in eating habits
___ Problems getting along with family
___ Doesn't seem to enjoy usual activities
___ Trouble doing schoolwork
___ Feeling stressed
___ Low self esteem
___ Perfectionistic
___ Worries
___ Feeling fearful
___ Physical complaints of pain
___ Anger outbursts
___ Running away
___ Has hurt or cut on themself
___ Thoughts of killing self
___ Feels hopeless
___ Tearful / crying spells
___ Memory problems
___ Lack of energy
___ Stuttering
___ Thumbsucking
___ Weight / appetite changes
___ Problems getting along with friends
___ Feelings of extreme happiness
___ Truancy
___ Irritability
___ Isolation / withdrawal
___ Expresses feelings of guilt
___ Seems nervous
___ Sudden feelings of panic
___ Tense / uptight
___ Acting violently
___ Harm to animals
___ Firesetting
___ Thoughts of killing others

This space reserved for additional comments by clinician:

Child's Name: _____

Have you worked with the child's teacher or school counselor? Yes ___ No ___
If so, please describe it below.

Name of teacher or counselor: _____ Date(s): _____
Explain what happened:

Has the child ever been in counseling before? Yes ___ No ___
If so, please describe it below. Start with the most recent time first.

When (dates): _____ Who did you see? _____
Explain what happened:

When (dates): _____ Who did you see? _____
Explain what happened:

Has the child been prescribed any psychiatric medications? Yes ___ No ___
If yes, please describe:

Substance use history (if applicable)	Current	Suspected	Past	No
Does the child use tobacco (any form)?	___	___	___	___
Does the child use alcohol?	___	___	___	___
Does the child use caffeine (any form, including cola drinks)?	___	___	___	___
Does the child use recreational drugs?	___	___	___	___

Child's Name: _____

Medical information

Has the child seen a doctor within the last year? Yes ___ No ___
What was that for?

Who is the child's doctor? _____ Phone: _____

Is the child taking any medications, prescription or over-the-counter? Yes: ___ No: ___
Please list any medications the child is taking:

Please list any major medical problems the child has had, such as chronic illness, serious illness, operations, injuries or trauma to the head, etc.:

Does the child have allergies to anything? Yes ___ No ___
Describe any allergy problems the child has:

Does the child have any problems with sleeping? Yes ___ No ___
Does the child have any problems with eating? Yes ___ No ___
Does the child have any problems with toileting? Yes ___ No ___
Describe the problem(s):

Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss or experiencing abuse (physical, sexual, or emotional)? Yes ___ No ___
Please describe the relevant issue(s):

Child's Name: _____

Developmental history

	Yes	No
Were there any problems with the pregnancy or delivery of the child?	___	___
Any problems with eating, sleeping, or crying spells (colic, nightmares, etc.)?	___	___
Any difficulties or delays in walking, talking, toilet training?	___	___
Have there been any family crises such as marital separation or divorce?	___	___
Have there been any mental health problems in the family of origin?	___	___
Have there been any substance use or abuse issues in the family?	___	___

Briefly describe the child's relationship to parents:

Briefly describe the child's relationship to siblings:

Briefly describe the child's temperament:

School history

When did the child start school?

Were there any problems when the child started school? Yes ___ No ___

What problems have come up during the school years?

What grades is the child getting?

Describe any changes in the child's school performance:

How does the child get along with his or her teachers?

How does the child get along with his or her friends or peers in school?

What are the child's favorite subjects or school activities?

What subjects or activities does the child have problems with?