**CHILD INTAKE**

**TODAY’S DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE: \_\_\_\_\_\_\_\_\_\_ SEX ASSIGNED AT BIRTH: \_\_\_\_\_\_\_\_\_\_\_ GENDER IDENTITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT(S)/GUARDIAN(S):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE PARENTS MARRIED? Yes \_\_\_\_ No \_\_\_\_ IF NO, IS THERE A CUSTODY AGREEMENT? Yes \_\_\_\_ No \_\_\_\_

HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECONDARY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CAN WE LEAVE A MESSAGE/VOICEMAIL? Yes \_\_\_\_\_ No \_\_\_\_\_ BEST TIME TO CALL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT ARE YOUR PRIMARY CONCERNS AT THIS TIME? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**DEVELOPMENTAL HISTORY:**

PREGNANCY: Full Term\_\_\_\_\_\_\_\_ Premature/# weeks \_\_\_\_\_\_\_\_\_ Birth Weight\_\_\_\_\_\_\_\_\_\_\_\_

COMPLICATIONS DURING PREGNANCY? \_\_\_\_\_Accidents \_\_\_\_\_Infection

\_\_\_\_\_Medication Use \_\_\_\_\_Cigarette Use \_\_\_\_\_Alcohol Use \_\_\_\_\_Drug Use

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMPLICATIONS AFTER BIRTH? \_\_\_\_\_Fetal Distress \_\_\_\_\_Jaundice \_\_\_\_\_Feeding

DEVELOPMENTAL MILESTONES: Age (months) when…

Sat without support \_\_\_\_\_\_\_\_\_ Crawled \_\_\_\_\_\_\_\_\_\_\_\_\_ Walked Alone \_\_\_\_\_\_\_\_\_\_\_

Spoke First Word\_\_\_\_\_\_\_\_\_\_ Used Phrases \_\_\_\_\_\_\_\_\_\_ Conversations\_\_\_\_\_\_\_\_\_\_\_\_

Toilet Trained Day \_\_\_\_\_\_\_\_\_\_\_\_ Toilet Trained Night \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH A MEDICAL CONDITION? Y N

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS YOUR CHILD HAD ANY HOSPITAL VISITS? Y N

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS VISION BEEN ASSESSED? Y N Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS HEARING BEEN ASSESSED? Y N Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY CURRENT MEDICATIONS (Include dosage and reason for taking medication):

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

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

INDICATE HISTORY (“H”) OR CURRENT (“C”) CONCERNS WITH ANY OF THE FOLLOWING:

\_\_\_\_Headache \_\_\_\_Stomach ache \_\_\_\_Wetting/Soiling \_\_\_\_Staring Spells

\_\_\_\_Seizures \_\_\_\_Ear Infections \_\_\_\_Overweight \_\_\_\_Underweight

\_\_\_\_Poor Growth \_\_\_\_Acne \_\_\_\_Depression \_\_\_\_Anxiety

\_\_\_\_Sexual Abuse \_\_\_\_Physical Abuse \_\_\_\_Emotional Abuse \_\_\_\_Neglect

\_\_\_\_Sleeping \_\_\_\_Self Harm \_\_\_\_Unusual Movements \_\_\_\_Allergies

\_\_\_\_Alcohol Use \_\_\_\_Cigarette Use \_\_\_\_Drug Use Other:

**FAMILY HISTORY**

HOUSEHOLD MEMBERS: (for more space, please write on the back side)

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | AGE | SEX | RELATIONSHIP TO CHILD |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

FAMILY PSYCHOLOGICAL HISTORY: Please list any members with any of the following

|  |  |  |  |
| --- | --- | --- | --- |
|  | SIBLINGS | MOTHER’S FAMILY | FATHER’S FAMILY |
| Developmental Delays |  |  |  |
| Learning Difficulty |  |  |  |
| Intellectually Disabled |  |  |  |
| ADHD (Hyperactivity) |  |  |  |
| Seizures |  |  |  |
| Tics/Tourette’s |  |  |  |
| Autism or PDD |  |  |  |
| Depression |  |  |  |
| Anxiety |  |  |  |
| Bipolar Disorder |  |  |  |
| Schizophrenia |  |  |  |
| Substance Use/Abuse |  |  |  |
| Suicide Attempt |  |  |  |

**SCHOOL/INTERVENTION HISTORY:**

NAME OF SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE: \_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CHECK ALL SCHOOL CONCERNS THAT APPLY:

\_\_\_\_\_Declining Grades \_\_\_\_\_Behavior Problems \_\_\_\_\_Homework

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS CHILD EVER BEEN RETAINED (HELD BACK)? Y N If Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DID YOUR CHILD START KINDERGATEN AT AGE 5 OR 6? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF SERVICES:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Did your child receive this service? (Y/N) | Name of Provider or Facility | What year or grade did this service first start? | Is this service still in place? (Y/N) |
| Early Intervention (or DART) |  |  |  |  |
| Speech Therapy |  |  |  |  |
| Occupational Therapy |  |  |  |  |
| IEP or 504 Plan |  |  |  |  |
| Title 1 Services |  |  |  |  |
| Private Tutoring |  |  |  |  |
| Outpatient Counseling/Psychotherapy |  |  |  |  |
| PCIT |  |  |  |  |
| Wraparound/Family Based |  |  |  |  |
| Psychiatry (Medication) |  |  |  |  |

**Authorization to Release Information**

The purpose of this document is to consent and authorize AIBDT to coordinate care with another provider. Coordination of care may include written or verbal communication between providers.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize AIBDT and/or its contractors, to release to and/or obtain the following diagnostic or treatment information in my records:

\_\_\_\_\_ Psychological Evaluation Report \_\_\_\_\_\_Psychiatric Records

\_\_\_\_\_ Psychotherapy Records \_\_\_\_\_\_Medical Records

\_\_\_\_\_ Educational Records \_\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release of information, as specified above, is authorized to the following provider or organization:

**PROVIDER OR PRACTICE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROVIDER/PRACTICE PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROVIDER/PRACTICE FAX NUMBER, IF KNOWN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIRECT CONTACT PERSON, IF APPLICABLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. The Consent will expire automatically one year from the date on which it is signed. I understand I may revoke this authorization, in writing, at any time by sending such written notification to my clinician.

Signature of Patient, if 14 years or older: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian, if patient is under 14 years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coordination of care between mental health and primary care providers is generally a requirement of health insurance companies. Patients have the right to opt out of PCP/mental health coordination of care; if you would like to opt out of coordination of care, please inform your clinician.

|  |
| --- |
| **Notice of Privacy Practices (HIPAA)** |

I am required by law and committed to protecting your private personal information, which may be personal information collected from you, information about health care we provide to you, or payment of healthcare provided for you.  I will only use and disclose your personal information as necessary to provide you with behavioral healthcare. I am also required by law to provide you with this Notice of Privacy Practices explaining my legal duties and privacy practices with respect to information.  I am legally required to follow the terms of this notice. The terms of this notice may change in the future, as allowed by law.  If this notice is changed, the new privacy practices will apply to your information that I already possess, as well as, future information.  If changes are made to the notice, I will post the new notice in our reception area and will have copies available upon request.  
  
**Uses and Disclosure of Protected Health Care Operations**I routinely use your health information inside my office in order to provide behavioral healthcare and to obtain payment for that healthcare. For example: I may use and disclose medical information about you to obtain payment for behavioral health care service.  This may incorporate releasing your protected health information to submit for payment of claims delivered to you to your insurance carrier. Or, I may use and disclose protected personal information, such as your name, contact information, and amount due, to collection agencies in efforts to collect payment on delinquent accounts.

**Required by Law/Public Health Activities**

I may use and disclose medical information about you to the full extent that public health activities are permitted by law. For example, I may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

**Abuse or Neglect/Harm of Self or Others**

I may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse or neglect, as I may be obligated by law to make such reports. Or, I may disclose your protected health information if I believe that the disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public or harm to oneself.

**Legal Proceedings**

I may disclose your protected health information in the course of any judicial proceeding, in response to an order of a court tribunal, and in response to a subpoena or other lawful process.

**Abuse or Neglect**

I may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse or neglect, as I may be obligated by law to make such reports.

**Others Involved in Your Healthcare**

I may disclose your protected health information to a designated friend, family member or guardian (parents/guardian for minors) if previously agreed that the individual is involved in your healthcare.

**Right to Access**

You have the right to look at or get copies of your protected health information, which generally includes medical and billing records as well as decision made about your healthcare. However, you may not be able to inspect or copy any psychotherapy or case file notes. If desired, a typed summary of case notes can be provided to you upon special arrangement and agreement with the provider.

**Right to Restriction**

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or other healthcare operations. I will abide by the agreement unless the information is needed to provide emergency treatment to you. Any agreement of restrictions will be in writing.

**Information I Collect**

I collect information about the patient, parent or guardian either directly or through a chosen party or administrator. This information includes personal data provided on intake questionnaires or behavior symptom questionnaires that may include such information as your name, social security number, date of birth, marital status, dependent and employment/school information. It may also include other healthcare or school information submitted to me by other agencies/institutions upon your request. Information may also include payment claims submitted, a diagnosis code and services provided, charges, and amounts paid.

**How Information is Protected**

Protected Health Information is available only to the providing clinician, consultants or other healthcare providers involved in the treatment, and third party billing agents. I maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard personal financial information from unauthorized access, use, and disclosure.

**Grievances**If you think that I have not properly respected the privacy of your information, you are free to submit a grievance to this clinician or the U.S. Department of Health and Human Services, Office for Civil Rights.  I will not retaliate against you if you make a complaint.



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

Associates in Behavioral Diagnostics and Treatment

**Receipt of Privacy Practices (HIPAA)**

*My signature indicates that I (client and parent/guardian) have reviewed and understand the above information, including confidentiality, and consent for treatment.*

**Patient (Guardian) Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_**

**OUTPATIENT SERVICES CONTRACT**  
**INTRODUCTION TO SERVICES**  
Welcome to the practice. This document contains important information about our professional services and business policies. Please read it carefully and ask any questions you may have. When you sign this document, it will represent an agreement between you and the company.  
  
**If you are coming to the practice for Psychological Testing/Neuropsychological Testing:**  
There are a variety of tests and assessment procedures utilized for psychological testing. The types of measures and duration of testing depend upon such things as the presenting concern, age of patient, as well as history of prior testing. These might include IQ testing or personality, language, attention, visual motor, or memory assessment, for example. Prior to testing being conducted, you will meet with the psychologist for a Diagnostic Interview, during which time a full history will be taken and determination for testing needs will be made. Most insurance companies require pre-authorization, which will be obtained by the psychologist after the initial diagnostic interview. You will also be given a feedback session, to review testing results, and a written report of results following the testing. Your signed permission will be obtained to release these results to other professionals as needed, such as the PCP. Psychological testing often leads to better understanding of diagnosis, functional impairment, or reasons for distress or unwanted behaviors. But there are no guarantees of results.  
  
**If you are coming to the practice for Psychotherapy/Counseling:**  
Psychotherapy and Behavioral/Educational Consultation are not easily described in general statements. It varies depending on the personalities of the psychologist/counselor and the patient, as well as the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy or Behavioral/Educational Consultation, unlike a medical doctor visit, 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. In general, the providers from the practice work within a framework called Cognitive Behavioral Therapy, which is a therapeutic approach that is well researched and supported for many psychological and behavioral conditions. Other counseling approaches, such as interpersonal therapy or client centered therapy, may be integrated within the treatment approach.  
  
Psychotherapy and Behavioral/Educational Consultation can have benefits and risks. Since 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 or Behavioral/Educational Consultation often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress or unwanted behaviors. But there are no guarantees of what you will experience.  
  
The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your clinician 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 of whether you feel comfortable working with your therapist. Therapy and Behavioral/Educational Consultation 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 the procedures, they should be discussed whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.  
  
**MEETINGS**  
If you are here for psychological testing or neuropsychological testing services, there have been three individual sessions pre-arranged to complete this service. For psychotherapy and Behavioral/Educational Consultation, you will have a weekly or biweekly appointment scheduled, depending on your needs. Each regular session lasts 50-minute, although some sessions may be longer or more frequent as needed. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation or unless you and the psychologist/counselor both agree that you were unable to attend due to circumstances beyond your control. In that event, we will try to find another time to reschedule the appointment, if possible.  
  
**PROFESSIONAL FEES AND PAYMENTS**  
The fees for services will vary depending on the services requests and the type of provider you see. In general, the hourly fee for a Psychologist is $200 for an initial appointment and $100-150 per session, either individual or family session, after that. The fee for a Professional Counselor or Social Worker is $150 for the first session and $75-125 per hour, either individual or family, after that. If your clinician is contracted with your behavioral insurance provider, (s)he will agree to accept the contracted reimbursement amount specified by your insurance provider if less than the above stated amount. The fee for private pay psychological testing of school age children is $1000.00, neuropsychological testing for school age is $1500.00. Pre-K psychological testing private pay rate is $450.00, and pre-K neuropsychological testing is $600.00. Stand-alone Achievement testing is $400.00. You may request a Fee Schedule for other services as needed. You will be expected to pay for each session, or co-pay/deductible/co-insurance, determined by your insurance provider, at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, the psychologist/counselor may be willing to negotiate a fee adjustment or payment installment plan.] There will be an additional fee of $35 for each returned check.  
  
If you go more than two appointments without making payments, you will have to contact the office to arrange scheduling of any future appointments, as there will no longer be a standing appointment for you. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the company has 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 information released includes the patient’s name, the nature of services provided, and the amount due.  
  
All payments can be made by cash, credit card (Visa, Master, or Discover), or check in the name of “Associates in Behavioral Diagnostics and Treatment" or "AIBDT").  
  
**INSURANCE REIMBURSEMENT**  
If you have a health insurance policy, it will usually provide some coverage for mental health treatment. The clinician will assist in this process to help you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers, if any. This includes determining if your mental health coverage has been carved out to another company or provider. You should also be aware deductibles that you may have to meet as well as any authorization that may be required. The clinician will obtain the authorizations as needed. This process may include releasing the diagnosis as well as additional clinical information, such as treatment plans or summaries, or copies of the entire record in some 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, your clinician, and AIBDT, LLC, 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 report I submit, if you request it. For services not covered by your insurance, we will discuss and sign additional consent for agreement of out of pocket expenses.

Please note that most AIBDT providers do not participate with Pennsylvania Medical Assistance (PA MA) program. If you have or obtain PA MA at any point during treatment, you will be responsible for payment if your provider is non-participating.

\*My signature on this document represents my authorization to release information to my insurance company in order to submit claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me. In consideration of the services provided to me, I assign all benefits to AIBDT if accepted, and I authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Associates in Behavioral Diagnostics and Treatment and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary. If I don't have insurance or choose not to use my insurance, I will inform my clinician.  
  
**CONTACT INFORMATION**  
You will be given the individual contact information for your psychologist/counselor. Generally, this is a cell phone number. You may also call the main office number at 412-329-7778. Your therapist may not be immediately available by telephone, although telephone messages are checked regularly between 9 AM and 5 PM. We 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 your clinician of some times when you will be available. If you are unable to reach your clinician and feel that you cannot wait for a return phone call, contact your primary care physician or the nearest emergency room and ask for the psychiatrist on call. You can also contact Allegheny County Mental Health Crisis Line at 1-888-424-2287. If your clinician will be unavailable for an extended time, you will be provided with the name of a colleague here in the office to contact, if necessary.  
  
**PROFESSIONAL RECORDS**  
The laws and standards of Psychology and Professional Counseling require that treatment records be kept. You are entitled to review your therapy health records, or your clinician can prepare a summary for you instead. However, you may not photocopy any psychotherapy notes or other documents in the mental health file. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them with your psychologist/counselor together, so that you can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.  
  
**MINORS**  
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. If your parents agree to give up rights to access your records, the clinician will provide them only with general information about our treatment, unless there is concern with high risk that you will seriously harm yourself or someone else. In this case, your clinician is required by law to release information to them and possibly to protection agencies. Before giving your parents any information, the clinician will discuss the matter with you, if possible, and do his/her best to handle any objections you may have. It is also noted that PA State Low allows minutes 14 years and older the right to consent for mental health treatment.  
  
**CONFIDENTIALITY**  
In general, the privacy of all communication between a patient and a provider is protected by law, and the Psychologist/Counselor 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 proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order the Psychologist or Counselor to testify if he/she determines that the issues demand it.  
  
There are some situations in which the Psychologist and Counselors are legally obligated to take action to protect others from harm, even if this involves revealing information about a patient’s treatment. For example, if the clinician believes that a child [elderly person, or disabled person] is being abused, (s)he must [may be required to] file a report with the appropriate state agency.  
  
If the clinician believes that a patient is threatening serious bodily harm to another, (h)she 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, the clinician may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.  
  
While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have at your next meeting. Your Psychologist/Counselor will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex.

*My signature indicates that I (client and parent/guardian) have reviewed and understand the above information, including confidentiality, and consent for treatment.*

Client Name and DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature (Minors) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Provider’s Signature (Witness) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Parents who are Separated/Divorced**

***My signature below indicates that I have sole legal custody of my child and am not required by court order or legal arrangement to obtain the consent of any other parent or guardian prior to seeking treatment for my child.***

**Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider’s Signature (Witness) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AIBDT Psychological services**

**Informed Consent for Telepsychology**

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the Internet. Please review this information carefully and let your therapist know if you have any questions.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, which is offered through a HIPAA-approved videoconferencing platform. Telepsychology allows therapists and clients to engage in services outside of the office when needed. Telepsychology requires that both the therapist and the client have the computer skills and resources to make it work. This requires that you have an electronic device that allows for video streaming, such as your computer, smartphone, or tablet.

**Differences in Telepsychology from In-Person Therapy:**

Confidentiality concerns. Depending upon your environment, there may be the potential for other people to overhear sessions if you are not in a private place during the session. It is important for you to make sure you find a private place for your video appointment and that you will not be interrupted. You should be in a room that is private, where other people are not present and cannot overhear the conversations. Your therapist will be in a private, secure setting as well, either at an AIBDT office or a home office. The therapist will conduct the sessions through TherapyNotes PatientPortal, which is a HIPAA approved (encrypted connection), web-based platform, on a computer, phone or tablet. Your sessions will be live-streamed and will not be recorded in any way. If TherapyNotes portal is unavailable for any reason, an alternate HIPAA-compliant method of communication will be offered.

Technology concerns. There are ways that technology issues might impact telepsychology. The main concern is if one of us has a computer or connection problem during the appointment. If we are unable to re-establish the connection, the appointment may have to be rescheduled. You will not be billed for time if we are unable to establish a connection.

Safety/Crisis concerns. Usually, our therapists will not engage in telepsychology with people who are in crisis, and who may require a high level of support and help. Before starting video appointments, your therapist will discuss procedures for managing a mental health crisis, should one arise. This may include but not be limited to arranging an in-office appointment for assessment and intervention.

Effectiveness concerns. You may wonder whether video appointments are less helpful than in-person ones. In fact, research on this question consistently finds that most people find it to be as helpful as in-person appointments, and some even find it to be more helpful! Even so, some people do find it less helpful. If you find that Telepsychology is not a good match for you, please let your therapist know. The therapist may also determine that you may not be a good candidate for Telepsychology services. In these events, in-person appointments can be arranged.

Equipment: You are solely responsible for any cost to you to obtain any necessary equipment to take part in video appointments, which would include a device able to live-stream from the internet. This includes phone, tablet, or computer with internet streaming capabilities.

Documentation: Your therapist will maintain a written record of your video appointments in the same way that records of in-person appointments are maintained.

Fees

Not all insurance policies in PA cover Teletherapy; although, many do. Upon scheduling, our office will help determine if your plan covers this service. If your insurance policy does cover the service, the same copays and deductibles that you have for in-person appointments will apply. The reimbursement rates are the same for in-person and Telepsychology services. If your policy does not cover Telepsychology or if we are not in-network with your policy, then a private pay fee will be charged.

Informed Consent Summary

This agreement is a supplement to our standard Informed Consent for services at AIBDT and does not amend or replace any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions listed above.

My signature indicates that I (client and/or parent/guardian) have reviewed and understand the above information, including confidentiality, and consent for treatment.

Client Name and DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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