CHILD'S APPLICATION

Child's Name: _____ D.O.B: _____ Age: ___ Sex: ___ Race: _____

Street address: _____ City: _____ State: ____ Zip: _____

Phone Number: _____ School: _____ Grade: ____ Teacher: _____

Child's Social Security #: _____ How were you referred to this office?: _____

If not referred, how did you find out about this office? _____ Family Physician: _____

Would you like your provider to coordinate treatment with your physician? ☐Yes ☐No

Parent/Guardian	Parent/Guardian
Check One:	Check One:
☐ Natural ☐ Step ☐ Adoptive ☐ Foster	☐ Natural ☐ Step ☐ Adoptive ☐ Foster
Name: _____	Name: _____
Street address: _____	Street address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Primary Phone: _____ ☐Home ☐Cell	Primary Phone:_____ ☐Home ☐Cell
Secondary Phone: _____ ☐Home ☐Cell	Secondary Phone: _____ ☐Home ☐Cell
E-Mail Address: _____	E-Mail Address: _____
Social Security #: _____	Social Security #: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Work Phone: _____	Work Phone: _____

Who does the child live with? ☐ Mother ☐ Father ☐ Relative ☐ Foster Home

☐ Guardian (If related list the relationship) _____ ☐ Other (Please explain) _____

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Living together ☐ Other _____

If parents are divorced or separated please bring a copy of the most recent court order regarding custody. Unless there is a court order restricting a parent's contact with a child, in most custody agreements both parents retain a right to know about and participate in the child's treatment.

If parents are divorced or separated what is the current parenting plan: _____

_____

_____

List all other household members:

NAME	AGE	Living At Home	Relationship to child
		☐YES ☐NO	
		☐YES ☐NO	
		☐YES ☐NO	
		☐YES ☐NO	
		☐YES ☐NO	
		☐YES ☐NO	
		☐YES ☐NO	

CONCERNS ABOUT CHILD (Check all that apply):

☐Sad/Depressed	☐Physical Abuse	☐Bedwetting	☐Temper Tantrums
☐Anxiety	☐Sexual Abuse	☐Anger	☐Suicidal thoughts
☐Panic attacks	☐Neglect	☐Truancy	☐Self-harming
☐Separation anxiety	☐Nightmares	☐Low Self-Esteem	☐Running away
☐Defiance	☐Drug Abuse	☐Alcohol Abuse	☐Physically aggressive
☐ADHD	☐Lying	☐Poor grades	☐Poor appetite
☐Stealing	☐Bullies/intimidates	☐Eating disorder	☐Legal issues
☐Argues a lot	☐Difficulty with peers	☐Withdrawn/Shy	☐Poor hygiene
☐Academic problems	☐Difficulty sleeping	☐Isolation	☐Destroys property

Any other concerns: _____

_____

From what persons/agencies have you sought help in the past (Please list and give dates of contacts):

_____

_____

Does the child have any illness, allergies, or current medication? If Yes, please list below: ☐YES ☐NO

_____

INSURANCE INFORMATION

Name of Insurance Company: _____

Policy Holder: _____ Policy ID #: _____

Policy Holder D.O.B.: _____ Group Number/Name: _____

Please Note: Ultimate responsibility for payment is to the person who requests treatment for the child. This is true whether or not that person is designated as the responsible party.

RESPONSIBLE PARTY

Name: _____

Street address: _____ City: _____ State: _____ Zip: _____

Name of person requesting treatment: _____

CONSENT TO TREAT: I hereby grant permission for _____ to provide me with mental health services that are professionally appropriate. I certify that no guarantee has been made regarding the outcome of those services.

RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary to process insurance claims. If applicable, I authorize my provider to release appropriate clinical information required by a managed care network to obtain authorization for treatment.

ASSIGNMENT OF INSURANCE BENEFITS & AGREEMENT TO PAY: I authorize insurance benefits to be paid directly to the provider rendering my services. I understand that charges incurred are ultimately my responsibility and I agree to pay for all charges.

PLEASE NOTE:

Any appointments not cancelled 24 hours in advance are subject to be charged.

If psychological testing is being done for a custody evaluation and/or is court ordered, total charges are your responsibility. No insurance will be filed. No exceptions.

_____ _____

Signature Date

ASSOCIATES IN PSYCHOLOGICAL AND FAMILY SERVICES

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

This form is an agreement between you, _____ and me/us_____. When we use the word "you" below it can mean you, your child, a relative or other person if you have written his/her name here _____.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign the consent form.

By signing below you also acknowledge having received a copy of our Notice of Privacy Practices.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our office.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to your Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his/her personal representative Date

_____ _____

Printed name of client or his/her personal representative Date

_____

Signature of authorized representative of this office or practice

Date of NPP _____ given to the client/parent/personal representative.

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how mental health and medical information about you can be used and disclosed and how you can get access to this information. Please review it carefully.

1. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATION

I may use or disclose your protected health information (PHI) for treatment, payment and health operation purposes with your consent. To help clarify these terms here are some definitions:

PHI refers to information in your health record that could identify you.

TREATMENT is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I (with your consent) consult with another health care provider, such as your family physician or another mental health provider.

PAYMENT is when I obtain reimbursement for your health care or to determine eligibility or coverage.

USE applies only to activities with my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

DISCLOSURE applies to activities outside my office such as releasing, transferring, or providing access to information about you to others.

2. USES AND DISCLOSURES REQUIRING AUTHORIZATION

I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond your general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during private, joint, or family counseling sessions, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time provided each revocation is in writing. You may not revoke an authorization to the extent that I (1) have relied on that authorization; (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

I will also obtain an authorization from you before using or disclosing: PHI in a way that is not described in this Notice.

3. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report within 48 hours to the Department for Children and Families or to any local or state law enforcement agency.

Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department for Children and Families.

Health Oversight: If a complaint is filed against me with the Behavioral Sciences Regulatory Board they have the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment, such information is privileged under state law, and I will not release information without written authorization from you or your personal or legally appointed representatives, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat or Harm to Safety: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical and/or law enforcement personnel.

Workers Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

Use of disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits and national security and intelligence.

4. PATIENT RIGHTS AND MENTAL HEALTH PROVIDER'S DUTIES

Patient's Rights:

Right to Request Restrictions: You have the right to request restrictions to certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communication by Alternative Means at Alternative Locations: For example, you may not want a family member to know you are seeing me.

Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny access to PHI under certain circumstances, but in some cases you may have to have this decision reviewed.

Right to Amend: You have the right to amend your PHI for as long as the PHI is maintained in the record. I may deny your request.

Right to Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section 3 of the above).

Right to Restrict Disclosures When You Have Paid for Your Care Out-Of-Pocket: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI: You have the right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

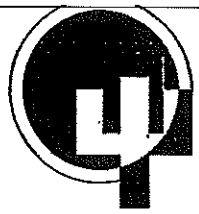
Mental Health Provider's Duties

I am required by law to maintain the privacy of PHI and to provide you with a copy of these rules.

I reserve the right to change my privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect.

5. Complaints

If you are concerned that I have violated your privacy rights, you have the right to file a complaint in writing to the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.



NEW CLIENT INFORMATION

Enclosed is some information to acquaint you with our professional services and business policies. Please read through it carefully so you can raise any questions or concerns at your next session.

Associates in Psychological and Family Services is a group of independent mental health professionals. Each of us is responsible for providing his/her own clinical services. Professional records are separately kept for each therapist and no one has access to them without the client's written permission.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personality and orientation of the therapist and the particular problem the client has. While there are no guarantees therapy will be successful, the more active clients are in addressing their problems, the higher the likelihood of a positive outcome.

Psychotherapy has both benefits and risks. Benefits can include resolving problems and achieving increased feelings of well-being. Risks include experiencing uncomfortable feelings like sadness, anger, and helplessness. After one or more sessions you will be provided some initial impressions of what our work will involve as well as an estimate of how long it may take to realistically reach our objective. The relationship between therapist and client is crucial in arriving at agreed upon objectives. In that sense, psychotherapy is a collaborative effort. It is essential you determine your level of comfort working with your therapist. If you have questions or concerns, you are encouraged to raise them as they come up. If you decide you are not benefiting from psychotherapy, this should be discussed with the therapist and a decision can be made whether to refer to another mental health professional.

Sessions are usually scheduled for either 45 or 55 minutes. Most often these are scheduled weekly but a more or less frequent interval may be used depending on the problem. It is our policy to charge for appointments that are not canceled 24 hours in advance and for appointments that are not kept. Emergency situations or circumstances beyond your control will be taken into consideration. Insurance does not pay for missed appointments. Our answering service provides 24 hour, seven day a week access to us.

PROFESSIONAL FEES AND BILLING

Our initial Intake Interview is $185.00. Our rates are $135.00 for each 45 minute session and $175.00 for each 55 minute session. Our family therapy rate is $145.00 for a 45-50 minute session. In addition, we charge on a prorated basis for other professional services you require like phone conversations beyond ten minutes, writing letters, or consulting with other professionals at your

request. Fees for preparation for legal proceedings and attendance in court or depositions are determined by each therapist.

Although the client is ultimately responsible for all charges, we will file any necessary insurance forms for you. The portion of fees not covered by insurance will be due at the time of service. If you have questions about this please discuss them with your therapist. It is very important for you to look into what mental health services your insurance policy covers. We will assist you in any way we can. If your account is delinquent and suitable arrangements have not been made to pay on the account we have the option of utilizing a collection agency to collect on your account. In such cases, only the client's name, the amount due, and service rendered are disclosed.

With children of divorce, it is our policy to bill the parent bringing in the child(ren), and that parent is responsible for payment regardless of court-ordered arrangements.

Managed care plans often require advance approval before they will authorize reimbursement for mental health services. Such plans are often oriented toward short-term treatment designed to resolve specific problems. It is often necessary to seek additional approval after the initial sessions. While much can be accomplished in short-term therapy, sometimes a longer term approach is needed. It is important to discuss this in detail with your therapist. Most plans require a clinical diagnosis and sometimes a treatment plan or summary is requested. We will have you sign an appropriate release of information to provide your plan with the necessary information. In most cases, your therapist will discuss creating a treatment plan with you. We will provide an assignment of benefits and release of information form for you to sign initially, and this will be updated yearly or as needed.

OFFICE HOURS AND EMERGENCIES

Office hours vary by therapist. However, there is generally someone in the office from 8:00 a.m. to 7:00 p.m., Monday through Thursday. For after hours, our answering service is available at (316) 263-2351. In an emergency, call this number and the answering service will attempt to locate your therapist. If your therapist is unavailable, the answering service will contact one of the other therapists. You may also call your family physician or emergency room at the nearest hospital. For questions regarding billing information, call between 8:00 a.m. and 5:00 p.m., Monday through Thursday.

PROFESSIONAL RECORDS

Both the standards of our profession and the law require keeping appropriate treatment records. If you have questions about or wish to review your records, you are encouraged to discuss this with your therapist.

MINORS

If you are under 18 years of age, your parents are entitled to receive some feedback about your treatment. Usually we provide parents of older children only general information unless there is a significant risk of harm to yourself or others. Any sensitive information that needs to be shared with your parents will be discussed with you first.

CONFIDENTIALITY

The law protects the confidentiality of all communications between a client and a mental health provider. Information about your treatment can only be revealed with a few exceptions, with your written permission. There are situations, such as child custody hearings, where a judge may order treatment records to be released to the court, and your confidentiality may not be able to be protected. In cases where a child, elderly person, or disabled person is suspected of being abused, we are required by state law to file a report with the appropriate agency. If a client is threatening bodily harm to another, we are required to take protective actions, including notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm himself/herself, we are also required to seek hospitalization or appropriate protective treatment as well as contact family members who can help.

In certain cases we find it helpful to consult one another. Your identity will remain confidential in these situations.

Your signature below indicates you have read this information and agree it is your responsibility to seek clarification if you have questions.

_____ _____

Client/Parent Signature Date

_____ _____

Witness Date

Appointment Reminders

You can receive an appointment reminder to your e-mail address, your cell phone (via a text message), or your home phone (via a computer generated message) the day before your scheduled appointments.

Your name: _____

Client name (If minor):_____

Your e-mail address:_____

Your cell phone number:_____

Your home phone number(if applicable):_____

Where would you like to receive an appointment reminder? (**CHECK ONLY ONE**)

____Via a text message on my cell phone (normal text message rates will apply)

____Via an e-mail message to the address listed above

____Via an automated telephone message to my home phone

____None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to the "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Signature Date