CLIENT INFORMATION SHEET (CHILD/ADOLESCENT)

Name of child/adolescent: _____ Referred by: _____

Date of Birth: ____/____/_____ Age: _____ Insurance CO: _____

Address: _____ Insurance ID: _____

_____ Insurance CO. phone #: _____

City Zip Family Doctor: _____

Home phone: (_____) _____ Address: _____

E-mail: _____ _____

Cell phone: (_____) _____ _____

Parent's employer: _____ Medications taken: _____

Office phone: (____) _____ Medication allergies: _____

Parent's marital status: _____ _____

Names of parents: _____ Medical conditions: _____

Name of legal guardian: _____ Previous therapy: _____

Names and ages of siblings: _____

Names of others living in the home & relationship: _____

Reason for seeking therapy at this time: _____

lease read and sign: Each individual and family session is 45 to 55 minutes. Co-payments are due each visit. You are ltimately responsible for all fees for services if your carrier does not pay a claim. If you must cancel an appointment, lease provide at least 48 hour notice- because this time is reserved for you. A session that you did not attend, cannot e charged to the insurance company for reimbursement. There is a fee of $40 for appointments that were not ancelled 48+ hours in advance. Please be aware that this does not apply for group sessions. You are responsible for all roup sessions whether you are able to attend or not. The fee for a missed group session is also $40.

elease of Information: I hereby give permission for Grunblatt Psychology and Counseling Offices, P.C. and my surance carrier and the primary care physician to share information regarding my child's treatment. I permit a copy this to be used in place of the original.

_____ _____/_____/20_____

Signature Date

ıereby give permission for Grunblatt Psychology and Counseling Offices, P.C. and _____

) share information regarding my child's academics, behavior and treatment. (Name of school)

_____ _____/_____/20_____

Signature Date

CONSENT FOR PSYCHOLOGICAL SERVICES FOR MINOR

Name of Person Giving Consent: _____

Your Relationship to Child (check one):

☐ Parent ☐ Stepparent ☐ Grandparent

☐ Guardian ☐ Other: _____

Name of Child: _____ Date of Birth: _____

I, _____ consent to the following psychological services for the child named above:

Check and Initial All That Apply

☐ Clinical Interview/Evaluation
☐ Counseling/Psychotherapy
☐ Other: _____

_____ _____

Signature of person giving consent Date

_____ _____

Signature of person giving consent Date

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We, Grunblatt Psychology and Counseling Offices, P.C. assume that we may contact you by telephone at your home, cell and at your workplace, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

I wish to be contacted as follows (check all that apply):

☐ At my home telephone number: _____
____ You can leave messages with detailed information
____ Leave message with call-back number only
____ Call only at specified times of day: _____

☐ At my work telephone number: _____
____ You can leave messages with detailed information
____ Leave message with call-back number only
____ Call only at specified times of day: _____

☐ At my cell phone number: _____
____ You can leave messages with detailed information
____ Leave message with call-back number only
____ Call only at specified times of day: _____

☐ SEND APPOINTMENT REMINDER E-MAILS/TEXTS: _____

☐ In writing at:

____ My home address
____ My work address
☐ Other (Specify): _____

_____ _____
Signature of patient Date

_____
Print Name

GRUNBLATT PSYCHOLOGY AND COUNSELING OFFICES, P.C.

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INFORMED CONSENT AND AGREEMENT FOR PSYCHOLOGICAL SERVICES

As we begin psychotherapy we would like to inform you about the type of work we expect we will be doing together. There are many different forms of psychotherapy. We utilize a practice we call "eclectic", which draws from a variety of procedures that have been effective in helping people deal with their emotional and social life.

While benefits can be expected from this treatment, no particular outcome can be guaranteed. We will work together to establish goals for therapy. The psychotherapeutic process can sometimes bring up upsetting feelings and, on occasion, a client may feel worse before feeling better. You will need to participate in a periodic review of your progress and goals.

As your therapists, we place a high value on the confidentiality of the information you share with us. State law and professional ethics also require psychologists, social workers, and mental health counselors to maintain confidentiality and not to release information about you without your written consent. Most of the provisions explaining when the law requires disclosure were described to you in the accompanying Notice of Privacy Practices. There are a few possible exceptions to confidentiality.

_____ **- Initial**

1. As your therapist we are required by law to report any suspected child abuse or neglect. This law is designed to protect children from harm.
2. If we learn information that could result in danger, injury or harm to you, to your personal property, or to others or to their property, then we have a duty to notify some other organizations, officials, or person who in our judgment can reduce that risk of danger.
3. If you are or become involved in litigation, the court may request a report, an evaluation, or your entire mental health record. If you are requested to sign a release for your psychotherapy records, you should consult your attorney.
4. If an insurance carrier or a managed care company is paying for your treatment, then your treatment records are available to them upon request and they are likely to put your treatment information into a central database that could be accessed by others.
5. We may consult with the therapists in the practice or professional colleagues about our work together. However, your name and other identifying information will not be revealed without your express consent.
6. If we are away or unavailable, and another therapist of the practice is covering, it may be necessary to share some information about our work together in order for the covering therapist to help you in an emergency.
7. Please be aware that if you use email or texting that those methods are not confidential, therefore please try to limit communication via email and texting to mainly scheduling issues.

We will try to discuss each situation with you before any confidential information is disclosed and we will reveal the least amount of information necessary. _____ **- Initial**

The psychotherapy session will be 45 minutes in length. If you have a **Deductible** that has not been met and/or no insurance coverage we will require a deposit of our regular charge of **$225** per intake session and **$175** for a regular individual session. Longer sessions will be pro-rated. There will be a **charge for telephone** contacts beyond 5 minutes in length. Generally, Insurance companies do not pay for phone contacts or phone sessions, thus you are responsible for those charges. Likewise, meetings outside the office related to your treatment including travel time will be billed accordingly. Should you need financial hardship consideration please let the office know ahead of time.

All copays are due at the time of service. _____-Initial

If you have a minor attending therapy you as the guardian are required to make proper payment arrangements.

_____ - Initial

You are required to give at least **48 hour notice** if an appointment must be changed or cancelled. If you give us less than 48 hour notice or no notice, you will be billed for the missed appointment. The flat fee for **a missed appointment** is **$40**. We will reschedule your appointment whenever possible. Insurance companies do not pay for broken or missed sessions.

_____ - Initial

Grunblatt Psychology and Counseling Offices, P.C. may participate in **training** clinicians who provide individual, family or couple therapy or who help run groups, or provide testing under supervision of our seasoned clinicians. This is to teach clinicians to become more experienced. Confidentiality agreements apply to everyone observing services being provided or providing services at Grunblatt Psychology and Counseling Offices, P.C.

_____ - Initial

For **Testing,** Insurance companies generally only pay for face to face contact. The time to score the tests and to write up a report will not be paid by Insurance, so you will be responsible for those charges. Usually, we request that you pay an initial retainer for testing services in the amount of $750. This retainer is based on our fee of $200 per 45 minutes for scoring or report writing. Should it take us less time or should the Insurance Company pay for such services we will gladly reimburse you for any remaining amount.

_____ - Initial

For **Therapeutic Visitation or court ordered services,** Insurance companies generally do not pay, because they are not based on medical necessity. Our fee for therapeutic visitations is $250 per 45 minute session. This fee will be applied in increments of 5 minutes to any contact in person, on the telephone, or in writing that we make with you, your attorneys, the court, or other involved parties.

_____ - Initial

For **Mental Health Evaluations**, we charge a flat fee of $3000. This fee will be applied to time spent for testing, report write ups, contact with lawyers, courts, or other entities involved.

_____ - Initial

If we are required to **testify in court**, we charge $1250 for a half day or $2500 for a full day. A retainer of $1000 is required before services begin. An additional retainer of $1500 is required if testifying in court is required, at least three weeks prior to court performance. Please also be aware that should you request us to testify in court you wave confidentiality of the content of our sessions together. We do not guarantee any outcome of our court involvement.

_____ - Initial

We are engaged to provide **psychotherapeutic treatment**, not "expert testimony" for court. As our client you agree not to require us to provide "expert testimony" in any litigation. Should we be subpoenaed or be required by a court to participate in a deposition, give testimony, records, or other information to attorneys or Court, you agree to pay us $250 per 45 minutes. (Please review section on **therapeutic visitation or court ordered services** for a more detailed explanation).

_____ - Initial

You are making **the choice to begin psychotherapy**. You have the right to end your treatment at any time. If you decide to leave treatment, you are encouraged to speak with us before leaving so we can end our work appropriately and we can assist you with making plans for future treatment if necessary. Missing three consecutive scheduled appointments without explanation or notification will constitute voluntary termination by you.

_____ - Initial

By signing below you indicate that you have read and understood this agreement and give consent to treatment.

Client's Name(s):
(Printed)_____

Signature(s):_____ Date_____/_____/20_____

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Authorization Form (HIPAA)

Authorization for Disclosure of Protected Health Information

Name of Patient: _____

1. I authorize the Healthcare practitioner Grunblatt Psychology and Counseling Offices, P.C., 124 Green Street, Kingston, New York 12401 (the 'Practitioner') and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information, as specified below to: _____
_____(name and address of person/entity to receive information)

2. I am hereby authorizing the disclosure of the following protected health information:
_____
_____
(Specifically describe the protected health information to be disclosed such as date of service, type of service, and level of detail to be released.)

3. This protected health information is being used or disclosed for the following purposes: At the request of the individual or _____ (enter specific reason)

4. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

7. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient — Date

_____ _____
Print Name of Patient, Parent of Minor Patient or Personal Representative of Patient — (If a Personal Representative state relationship to patient.)

I received a copy of this Authorization form _____ (please initial)

[redacted]

Student Name: _____ DOB: _____

Address: _____ Telephone: _____

Informant: _____ Relationship: _____

Date of Interview: _____ Interviewer: _____

Referral Source: _____

Reason for Referral: _____

_____

I. Family Composition

	Parent's Name	Birth Date	Birth Place	Education	Occupation
Father					
Mother					

	Children in order of birth	Sex	School attended	Grade
1				
2				
3				
4				
5				
6				
7				
8				

	Others in household	Relationship	Age	Occupation
1				
2				

Age of Parents at birth of child: Mother _____ Father _____

II. Prenatal (pregnancy)

1. Is there a known blood incompatibility between parents? Yes ☐ No ☐
2. Did the mother have any serious health problems or injuries during pregnancy (e.g. hepatitis, German Measles, toxemia, anemia, uterine bleeding, an accident or fall)? Yes ☐ No ☐
If yes, please identify problem _____

_____

Were x-rays taken? Yes ☐ No ☐
Was mother under medication? Yes ☐ No ☐

3. Length of pregnancy was _____ months.

III. Perinatal (birth)

1. Labor was: uncomplicated ☐ induced ☐ prolonged ☐ difficult ☐
Comments: _____

2. Delivery was: uncomplicated ☐ by forceps ☐ Caesarean ☐
Comments: _____

3. Birth weight was: _____

4. Immediately after birth the baby: did not cry spontaneously ☐;
was jaundiced ☐; was given oxygen ☐; was given a transfusion ☐;
was placed in an incubator ☐.
Comments: _____

III. Developmental Milestones

1. Would you consider the child as having been "late" in any of the following areas? (answer yes if appropriate)
lifting head ☐ sitting up ☐ standing alone ☐ walking ☐
making speech noises ☐ talking ☐

2. At present the child is self-sufficient for: feeding ☐; toilet care ☐;
dressing ☐; bathing ☐

3. The child is right or left handed (circle one which is correct)

V. Medical Health History

1. Has the child had a convulsion or seizure? YES ☐ NO ☐
If yes, please indicate: date of onset _____; frequency _____; date of last seizure _____; probable cause _____;
characteristics of seizure _____

2. Has the child had any evidence of ear/hearing problems? YES ☐ NO ☐
If yes, please state problem _____
and treatment _____

3. Has the child had any evidence of eye/vision problems? YES ☐ NO ☐
If yes, please state problem _____
and treatment _____

4. In addition to those previously mentioned, has the child been hospitalized for illness or surgery? YES ☐ NO ☐
If yes, please explain: _____

5. Has the child experienced any changes in behavior as a result of illness or injury? YES ☐ NO ☐
If yes, please explain: _____

6. Does the child have problems with any of the following (please check if appropriate)?

Constipation	☐	Skin itching	☐	Headaches	☐
Diarrhea	☐	Nose bleed	☐	Dizziness	☐
Nausea/vomiting	☐	Bedwetting	☐	Insomnia	☐
Poor appetite	☐	Nail biting	☐	Fatigue	☐
Underweight	☐	Nervousness	☐	Coordination	☐
Overweight	☐	colds	☐		

7. In addition to the above, does the child have any, chronic health concerns such as allergies, anemias, asthma, diabetes, skin problems, heart condition, orthopedic problems, etc.? YES ☐ NO ☐, if yes, please indicate:
a) Problem _____
b) date of onset _____
c) severity of condition _____
d) treatment _____

8. Is child presently under medication? YES ☐ NO ☐ If yes, please list:
a) Name of medication(s) _____
b) How often it is given _____

c) Physician ordering medication: _____

9. Has the child had a severe or unusual illness? (these would include encephalitis, meningitis, etc.) YES ☐ NO ☐
If yes, please state illness and date(s): _____

10. Has the child had a severe injury/ (broken bones, head injury, etc.) ?
YES ☐ NO ☐
If yes, please state date and nature of injury _____
Did child lose consciousness? YES ☐ NO ☐

11. Please list the names of all professionals who have examined the child such a pediatrician, neurologist, optometrist, dentist, psychiatrist, psychologist, speech pathologist, educational specialist, audiologist, etc., and give month/year date of the most current evaluation.

_____

_____

_____

_____

12. Current pediatrician or health care provider, please give name, address and telephone number: _____

_____

VI. SOCIAL HISTORY

1. How does the child get along with his/her brothers/sisters?

☐ doesn't have any
☐ better than average
☐ average
☐ worse than average

2. How easily does the child make friends

☐ easier than average
☐ average
☐ worse than average
☐ dk

3. How does the child get along with teachers and others?

☐ easier than average
☐ average
☐ worse than average
☐ dk

4. What strategies have been implemented to address these problems (check which have been successful)

- ☐ verbal reprimands
- ☐ time out (isolation)
- ☐ removal of privileges
- ☐ rewards
- ☐ physical punishment
- ☐ acquiescence to child
- ☐ avoidance of child

5. On the average, what percentage of the time does your child comply with initial commands?

- ☐ 0-20%
- ☐ 20-40%
- ☐ 40-60%
- ☐ 60-80%
- ☐ 80-100%

6. To what extent are you and your spouse consistent with respect to disciplinary strategies?

- ☐ most of the time
- ☐ some of the time
- ☐ none of the time

VII. DIAGNOSTIC CRITERIA

1. Which of the following are considered to be significant problems at the present time

- ☐ fidgets
- ☐ difficulty remaining seated
- ☐ easily distracted
- ☐ often blurts out answers to questions before they have been completed
- ☐ difficulty following instructions
- ☐ difficulty sustaining attention
- ☐ shifts from one activity to another
- ☐ difficulty playing quietly
- ☐ often talks excessively
- ☐ often interrupts or intrudes on others
- ☐ often does not listen
- ☐ often loses things
- ☐ often engages in physically dangerous activities

2. Which of the following are considered to be a significant problem at the present time.

___ often loses temper
___ often argues with adults
___ often actively defies or refuses adult requests or rules
☐ often deliberately does things that annoy other people
☐ often blames others for own mistakes
☐ is often touchy or easily annoyed by others
☐ is often angry or resentful

3. Which of the following are considered to be a significant problem at the present time?

☐ unrealistic and persistent worry about possible harm to attachment figure
☐ unrealistic and persistent worry that a calamitous event will separate the child from attachment figure
___ persistent refusal to sleep alone
___ persistent avoidance of being alone
___ repeated nightmares re: separation
___ somatic complaints
☐ excessive distress in anticipation of separation from attachment figure
___ excessive distress when separated from home or attachment figure

4. Which of the following are considered to be a significant problem at the present time?

___ unrealistic worry about future events
☐ unrealistic concern about appropriateness of past behavior
___ unrealistic concern about competence
___ somatic complaints
☐ marked self-consciousness
☐ excessive need for reassurance
☐ marked inability to relax

5. Which of the following are considered to be significant problem at the present time?

- ☐ depressed or irritable mood of day, nearly every day
- ☐ diminished pleasure in activities
- ☐ decrease or increase in appetite assoc. with possible failure to make weigh gain
- ☐ insomnia or hypersomnia nearly every day
- ☐ psychomotor agitation or retardation
- ☐ fatigue or loss of energy
- ☐ feelings of worthlessness or excessive inappropriate guilt
- ☐ diminished ability to concentrate

6. Which of the following are considered to be a significant problem at the present time?

- ☐ depressed or irritable mood for most of day for the last year
- ☐ poor appetite or overeating
- ☐ insomnia or hypersomnia
- ☐ low energy or fatigue
- ☐ low self-esteem
- ☐ poor concentration or difficulty making decisions
- ☐ feelings of hopelessness
- ☐ never without symptoms for > 2 mos over a 1-year period

7. Has the child exhibited any symptoms of

- ☐ excessive lability w/o reference to the environment
- ☐ explosive temper with minimal provocation
- ☐ excessive clinging, attachment, or dependence on adults
- ☐ unusual fears
- ☐ strange aversions
- ☐ panic attacks
- ☐ excessively constricted or bland affect
- ☐ situationally inappropriate emotions

1 = Siblings 2 = Maternal Relatives 3 = Paternal Relatives

	Self	Mother	Father	Brother	Sister	Total
Problems with aggressiveness, Defiance, & oppositional behavior as a child						
Problems with attention, activity, & impulse control as a child						
Learning disabilities						
Failed to graduate from high school						
Mental retardation						
Psychosis or schizophrenia						
Depression for greater than 2 weeks						
Anxiety disorder that impaired adjustment						
Tics or Tourette's						
Alcohol abuse						
Substance abuse						
Antisocial behavior (assaults, thefts, etc.)						
Arrests						
Physical abuse						
Sexual abuse						