



CHILD INFORMATION FORM

CONTACT INFORMATION

Today's date: _____

Child/Adolescent complete name: _____ Date of birth: _____ Grade: _____

Nicknames or aliases: _____ Age: _____ Social Security # _____ - _____ - _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Mother's name: _____

Cell phone: (____) _____ Home/evening phone: (____) _____ Work phone: (____) _____

Calls will be discreet, but please indicate any restrictions: _____

Father's name: _____

Cell phone: (____) _____ Home/evening phone: (____) _____ Work phone: (____) _____

Calls will be discreet, but please indicate any restrictions: _____

Who is the child's Legal Guardian?: _____

Child's school: _____

Pediatrician: _____

School address: _____

Pediatrician's address: _____

School's phone #: _____

Pediatrician's phone #: _____

School's fax #: _____

Pediatrician's fax #: _____

Primary Teacher: _____

Guidance Counselor: _____

REASONS FOR SEEKING TREATMENT AT THIS TIME?

Child/Adolescent's symptoms include (check all that apply)

- | | | | | | |
|---|--|---|---|---|--|
| <input type="checkbox"/> Inattention | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Divorce | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Crying spells | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> No pleasure | <input type="checkbox"/> No energy |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Pain | <input type="checkbox"/> Can't sit still | <input type="checkbox"/> Can't concentrate | <input type="checkbox"/> Eating too little | <input type="checkbox"/> Eating too much |
| <input type="checkbox"/> Sleeps too much | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Worries too much | <input type="checkbox"/> Weight loss / gain | <input type="checkbox"/> Distrustful | <input type="checkbox"/> Self harm |
| <input type="checkbox"/> Sleeps too little | <input type="checkbox"/> Steals | <input type="checkbox"/> Lies | <input type="checkbox"/> Fearful | <input type="checkbox"/> Explosive outbursts | <input type="checkbox"/> Past abuse |
| <input type="checkbox"/> Oppositional behaviors | <input type="checkbox"/> Difficulty with transition(s) | <input type="checkbox"/> School / learning difficulties | <input type="checkbox"/> Fighting | <input type="checkbox"/> Obsessive / compulsive | <input type="checkbox"/> Thoughts to harm others |

Others: _____

How long have these difficulties been present? _____

What are your goals for treatment? _____

WHOM MAY WE THANK FOR THIS REFERRAL?

Name: _____ Phone: _____

Internet website (which?): _____ Seminar _____ Other: _____

MENTAL HEALTH HISTORY

Previous Mental Health Treatment:

Date(s)	Therapist/Facility	Reason for seeking treatment	Was treatment helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Psychological and/or Educational Testing

Date(s)	Assessor/Facility	Reason for seeking testing	Results of testing?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is the child currently prescribed any psychiatric medications?

Date(s)	Medication	Reason for prescription	Is medication helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has the child been prescribed any psychiatric medications in the past?

Date(s)	Medication	Reason for prescription	Reason stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY INFORMATION

Mother

Name: _____

Date of Birth / Age _____

Education _____

Employer _____

Occupation _____

Marital Status _____

Length of Marriage _____

Father

Name: _____

Date of Birth / Age _____

Education _____

Employer _____

Occupation _____

Marital Status _____

Length of Marriage _____

If parents are divorced, what is the custody arrangement? _____

If parents are divorced, has either parent remarried? Yes No

Do both parents agree to this treatment/evaluation? Yes No (If not, please explain): _____

Please list the child's siblings

Name	Age	Sex	Living at home? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there anyone else living at home?: _____

Family Relationships:

What is your child's relationship like with:

Mother: _____ Father: _____

Sister(s) _____ Brother(s): _____

Stepparent (if applicable): _____

Parent's marital relationship: _____

Type of discipline in home: _____

Has your child ever experienced any traumatic event (accident, death of a loved one): No Yes: If yes, please describe: _____

History of physical or sexual abuse, family violence or neglect?: No Yes, If yes, please describe: _____

FAMILY BACKGROUND INFORMATION

History of psychiatric/psychological disorders in family: _____

History of substance abuse in family: _____

History of suicide in the family? (if yes, please describe) _____

History of violence in the family: _____

History of sexual abuse in the family: _____

DEVELOPMENTAL HISTORY

Please fill in any information you have on the areas listed below.

1. PREGNANCY AND DELIVERY

Prenatal medical illnesses and health care: _____

Mother's age when child was born: _____ Was the child premature? No Yes Birth weight: _____

Any birth complications or problems? _____

2. FIRST FEW MONTHS OF LIFE

Any medical conditions/allergies? _____

Sleep patterns or problems: _____

Child's personality as a baby: _____

3. MILESTONES: At what age did your child do the following?

Sat up: _____ Crawled: _____ Walked: _____ Toilet Trained: _____

First Word: _____ Talked in sentence: _____

Any current bedwetting/toileting concerns?: _____

Any speech, hearing, or language difficulties? _____

Child's primary language at home: _____ Other language(s) spoken: _____

MEDICAL HISTORY

Date of child's last physical exam: _____

At any time has your child had the following?

Condition	NO	YES	If yes, please describe:
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy or seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart or blood pressure problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head injury with loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lengthy hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech or language problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fine motor/handwriting problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gross motor difficulties/clumsiness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soiling problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wetting problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other (please describe): _____

Therapist use only: If medical condition, was a referral provided? N/A NO YES: to _____

Current medications (non psychiatric):

Date(s)	Medication	Reason for prescription
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ACADEMIC INFORMATION

School(s) (Name, district, address, phone)	Grade(s)	Age	Dates attended
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What kind of grades does your child usually earn?: A B C D F other: _____
 Child's scores on most recent standardized test (FCAT, SAT, etc.): _____
 Present attitude toward school: _____
 Grade(s) repeated: _____ Reason: _____
 Does your child have an IEP (Individualized Educational Plan)?: YES NO
 Placement in special classes?: _____
 Describe school behavioral problems: _____
 Describe relationship with teachers: _____
 Describe relationship with peers: _____
 Please list your child's Extracurricular activities: _____
 List hobbies, sports; recreational, TV, and toy preferences; etc.: _____

LEGAL HISTORY

Has your child had any type of legal involvement? No Yes, If yes, please describe: _____

OTHER

Please list some of your child's strengths: _____

 Please list some of your child's weaknesses: _____

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

My signature below indicates that I have voluntarily and accurately completed the Delta Psychological Group Child Information Form. A photocopy of this agreement will be considered as valid as an original.

_____	X	_____
<i>Client name</i>	<i>Signature of Client/Parent or Guardian</i>	<i>Date</i>
_____	_____	_____
<i>Therapist name</i>	<i>Signature of Therapist</i>	<i>Date</i>

CONSENT FOR TREATMENT

I do hereby seek and consent to take part in the treatment and/or Psychological Evaluation with _____, an
(clinician's name)

Independent Contractor at Delta Psychological Group. If the patient is a minor, I hereby give my consent as a parent/legal guardian for my child to participate in Psychotherapy and/or complete Psychological Evaluation by the above named clinician. I understand that it is my sole responsibility to notify my child's other parent of these Psychological Services. I also understand that no promises have been made to me as to the results of treatment, evaluation or of any other procedures provided by this clinician, as treatment benefits, while likely, cannot be guaranteed. I understand that services provided to me, and any future implications or consequences, are the sole responsibility of the Independent Contractor. Delta Psychological Group and any other Independent Contractors will not be held vicariously liable for any damages, liabilities, claims, lawsuits, settlements, judgments, costs, penalties that arise out of the acts or omissions of Independent Contractor or Independent Contractor's agent or representative in the rendering of the below services.

I have the right to inquire fully about the credentials, education, and experience of my clinician or my child's clinician and to have my questions answered to my satisfaction. At Delta Psychological Group, therapy and evaluation are provided either by a licensed member of a mental health profession (psychology, psychiatry, social work, or counseling) or by an unlicensed professional with training allowing him or her to practice under the supervision of a licensed professional. If my clinician or my child's clinician is an unlicensed professional, I will receive an explanation of the supervision arrangement and the name and phone number of the supervisor. I have the right to discuss my service or my child's services with the supervisor at any time.

I am aware that I may discontinue services with this clinician at any time. My only obligation will be to pay all outstanding fees for the services I have already received. I understand that under certain circumstances I may lose other services or may face other consequences if I stop treatment (for example, if my treatment has been Court-ordered, my discontinuing treatment may have an adverse effect on the outcome of the Court proceeding). I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show for my appointment, I will be charged the agreed upon fee for that service. I understand that if I do not pay for the services I receive, those services may be discontinued.

The initial appointment for Psychotherapy is a diagnostic intake session with a fee of \$ _____. The standard fee for Psychotherapy is \$_____ for a full 45 minute session, which will be billed at the conclusion of each session. Due to financial hardship, reduced fees may be available for 20-30 minute sessions. I understand that my treatment and/or treatment of a minor will not be compromised due to my financial situation. I agree to be responsible for a reduced rate of \$ _____ per session. Fees for therapeutic groups are \$ _____ per person per session or as otherwise agreed between myself and my treatment provider.

I understand that the fee for Psychological Testing is \$_____ per hour, which will be billed at the conclusion of each testing session and following the completion of the Psychological Report; or a flat-rate of \$_____. This flat-rate is payable in two parts: a deposit of \$_____ payable before the start of this (these) services, and a second payment of the balance due on the completion and delivery of any report (or, for depositions, testimony, or other services, at the time these services take place). Additional fees may be charged for tests requiring computer scoring. If completing Psychological Testing, I understand that these services may include direct, face-to-face contact, interviewing, and/or testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, and any other activities to support these services.

I am aware that the procedures utilized for selecting and implementing therapeutic interventions; selecting, giving, and scoring psychological tests; interpreting and storing testing results; and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations. All interventions and assessment measures that are chosen will be suitable for the purposes described above (in psychological terms, their reliability and validity for these purposes and population have been established in relevant scientific and psychological research). All service-related documents, psychological tests and test results will be kept in a secure place.

Historically, mental health services have been associated with absolute confidentiality between the family and clinician. Currently, Federal and Florida laws and regulations and professional ethics require clinicians to maintain complete confidentiality of information and communications revealed in the course of treatment. In these cases, the clinician cannot release any information about my family without my expressed and informed permission. There are some exceptional circumstances where clinicians are required or permitted to communicate information about mental health services to persons outside the family. I am aware that an

agent of my insurance company, billing service or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. Other exceptions include the following situations:

- The client presents a clear and present danger to himself or herself and refuses to accept appropriate treatment.
- The client communicates to the clinician an imminent threat of physical violence against a clearly identified or reasonably identifiable victim, or the clinician has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
- The client introduces his or her mental condition as a defense in a legal proceeding.
- In child custody or adoption cases, the judge determines that the clinician has information bearing significantly on the client's ability to provide suitable care or custody and this information bears significantly on the welfare of the child.
- The client initiates legal action against the clinician, and client information is necessary or relevant to the clinician's defense.
- The clinician has grounds to believe a child under the age of 18, an elderly person (over age 60), or a handicapped adult, has been or is at risk of being abused or neglected.
- A Judge orders a clinician to release client information.

With a properly signed Release of Information, I understand that Treatment Summary letters may be provided in lieu of releasing the complete psychological records to a requesting party.

I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members for all psychological services rendered; including psychotherapy, psychological testing, and other psychological services. I understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed. I understand that I am responsible to meet my insurance deductible and co-payments, in addition to payment for any services not covered by my insurance carrier. If my insurance carrier refuses to make payment, I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family. Independent Contractors reserve the right to release necessary and relevant information to a collection agency regarding overdue balances or fees owed for services provided.

If an emergency arises after working hours and in the event that I cannot contact my clinician or the clinician on call, I will call 911 or go to the nearest emergency room if I believe I am a danger to myself or others or my child may be a danger to him/herself or others.

My signature below shows that I have read, understand and agree with all of the statements within this Consent for Treatment. A photocopy of this agreement will be considered valid as an original.

Signature of Client *Date*

Signature of Parent or Guardian *Date*

My signature below shows that I have received the Notice of Privacy Practices regarding the use and disclosure of my Protected Health Information from Delta Psychological Group and that I consent to the use and disclosure of my Protected Health Information for the purposes of Treatment, Payment, and Health Care Operation on this date:

Signature of Client/Parent or Guardian *Date*

As the treating and/or testing clinician, my observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent. As an Independent Contractor of Delta Psychological Group, I understand that all services rendered by me and any future implications or consequences of these services are my sole responsibility.

Signature of Clinician *Date*

WITHIN PRACTICE RELEASE OF INFORMATION AUTHORIZATION FORM

Client Name: _____ Date of Birth: ____/____/____ Age: _____

I, _____ hereby authorize Delta Psychological Group to share any and all information with all Independent Contractors and Employees within the practice for the purpose of clinical case review, clinical coverage, and/or independent consultation.

I have been informed that I may revoke this authorization at any time and for any reason by written communication to Delta Psychological Group. In the event that I do not revoke this consent in writing, this release will expire when the purpose for which the consent was given has been accomplished. A photocopy of this Release of Information will be considered as valid as the original.

_____	<input checked="" type="checkbox"/>	_____	_____
<i>Client name</i>		<i>Signature of Client/Parent or Guardian</i>	<i>Date</i>
_____		_____	_____
<i>Clinician name</i>		<i>Signature of Clinician</i>	<i>Date</i>

RELEASE OF INFORMATION AUTHORIZATION FORM

Client Name: _____ Date of Birth: ___/___/_____ Age: _____

I, _____ hereby authorize Delta Psychological Group to:
Client/Legal Guardian

Release Protected Health Information to:

Receive Protected Health Information from:

Share Protected Health Information with:

Name of Facility/Individual

Address

(_____) _____ (_____) _____
Phone Number Fax Number

Purpose of this disclosure:

To facilitate treatment and/or evaluation of myself or a family member

Other: _____

This authorization shall expire:

When the purpose for which this consent was given has been accomplished

Once treatment has been terminated

Date: _____

I have been informed that I may revoke this authorization at any time and for any reason by written communication to Delta Psychological Group. In order for the revocation of this authorization to be effective, it must include: Client’s name, address, phone number, and date of birth; Effective date of the revocation of the Authorization to Release Protected Health Information; Client and/or Legal Guardian’s signature. All requests must be sent to Delta Psychological Group and are not effective until received. I understand that only information obtained or produced by Delta Psychological Group is subject to release. I certify that this form has been fully explained to me and that I understand its contents. A photocopy of this Release of Information will be considered as valid as the original.

I understand that information sent, released, or disclosed pursuant to this Release of Information Authorization form may be subject to additional disclosure by the recipient of your information and is no longer protected by HIPAA Privacy Laws.

Client name

Signature of Client/Parent or Guardian

Date

Clinician name

Signature of Clinician

Date

CANCELLATION / NO-SHOW POLICY

At Delta Psychological Group, we are committed to providing you with the most ethical and effective treatment possible. Therefore, we value every appointment that we schedule and will reserve that day and time for you. This reservation, however, also preserves your clinician’s time and precludes your clinician from scheduling other clients. Therefore, if you are unable to attend your session we require that you call your clinician to cancel your session with a minimum of 24 hours notice. If the appointment is not cancelled within 24 hours, you will be charged a late cancellation fee of \$50. If you do not attend your scheduled appointment and you do not call to cancel, you will be charged our full and customary fee. We at Delta Psychological Group understand that extenuating circumstances may arise over which you have no control, and for these isolated incidents, there will be no charge. In any event, please call our office as soon as possible to inform us that you will not be able to attend your scheduled session. Thank you for your cooperation and understanding.

I understand that if I do not attend my scheduled session or do not call to cancel within 24 hours, Delta Psychological Group may charge my credit card.

Credit Card Information

Please Check One:

Visa Mastercard

Name on Credit Card Account Number Expiration Date

I have read, understand, and agree with the entire contents of this form:

Client name *Signature of Client/Parent or Guardian* *Date*

Clinician name *Signature of Clinician* *Date*