Anchor Psychology Group, PLLC

1402 S. Custer Road, Suite 803
McKinney, TX 75072
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THERAPY INTAKE PACKET (Child or Adolescent)

Included in this Packet:

(1) Information & Consent Form (pp. 2-7)
(2) Consent to Treatment (p. 8)
(3) Notice of Privacy Practices (pp. 9-10)
(4) Acknowledgment of Receipt of NPP (p. 11)
(5) Fee Agreement (pp. 12-13)
(6) Assent Agreement for Minors (p. 14)
(7) Intake Questionnaire (pp. 15-20)
(8) Credit Card Authorization Form (p. 21)

Instructions:

Before your child's Appointment:

(1) Read, Sign and Date the ***APG Office Copy*** of the **Information & Consent Form**
(Keep the *Client Copy* that is printed for you)
(2) Complete the **Intake Questionnaire**
(3) Review the **Notice of Privacy Practices (NPP)**
(4) Sign/Date the **Acknowledgment of Receipt of NPP**

Bring to your child's Appointment:

(1) The signed ***APG Office Copy*** of the **Information & Consent Form**
(2) The signed **Acknowledgment of Receipt of NPP**.
(3) Copy of Custody Agreement, if needed.

Therapy Information and Consent Form (Minor)

[Client Copy – Retain for your records]

I understand that if my child has parents that are divorced and/or part of a joint custody arrangement I must furnish the clinician with a copy of the divorce decree and most current child custody arrangement and/or provide any updates and changes before work can begin per Texas state law.

Services Provided

Anchor Psychology Group (APG) offers a variety of therapy and assessment services provided by psychologists, counselors, psychology post-doctoral and pre-doctoral interns, licensed professional counselor interns, and psychology and counseling graduate students.

Psychotherapy

Psychotherapy can have both risks and benefits. The therapy process may include discussions of personal challenges and difficulties which can elicit uncomfortable feelings such as sadness, guilt, irritability and frustration. However, psychotherapy has also been shown to have many benefits. It can often lead to better interpersonal relationships, improved academic performance, solutions to specific problems, and reduction in feelings of distress. But, there is no assurance of these benefits.

Telehealth Services

Telehealth is the delivery of therapeutic services through technology and includes, but may not be limited to, video, phone (call or txt), and e-mail. Telehealth supports continued therapeutic work if/when those services are unable to completed physically face-to-face. Privacy and confidently laws that protect medical/psychological information also pertain to Telehealth. I can decline to engage in Telehealth and resume/seek face-to-face psychological services without jeopardizing future services or benefits at any time. Doxy.Me, a free, HIPAA compliant platform, will be used in order to increase privacy of confidential information shared during telehealth sessions. The risks of Telehealth include, but are not limited to, theft of personal information, breach of confidentiality, and interruption of service. In the event of technical difficulty (e.g. loss of power shutting down internet), sessions may continue via telephone or rescheduled depending on the circumstances and nature of the session. Despite safety measures, it is possible, though unlikely, for systems to be breached and for the privacy and confidentiality to be compromised. If/when APG is aware of such a breach, it understood that the Client will be notified. The need for Telehealth will be reassessed to make sure this means of services is appropriate. The Client may not record any portion of telehealth session without the written consent of APG. APG will both notified of the possibility of a third party hearing/seeing any part of the session prior to the beginning of the session. It is the responsibility of the Client to establish and maintain the technology and equipment necessary to participate in Telehealth sessions. I will notify APG in advance if the Client will be in a different state during our regularly scheduled Telehealth session. It is the responsibility of the Client to log into the virtual meeting prior to the start of the previously schedule teletherapy session (the meeting link will be given prior to the session).

Fees for Service

Anchor Psychology's clinicians are individually contracted with insurance companies. Not all clinicians take insurance, and some take only certain panels. If we are in-network with your insurance, we will attempt to verify benefits before your first session and file claims accordingly. Please note that we are only able to provide you with an estimate of benefits and the insurance company reserves the right for the final approval. You will be responsible for charges which are not covered or contracted by insurance. If we are not in-network, we will provide you with a Superbill, upon request, so that you may file with your insurance company.

There will be a fee of **$150** should you chose to request medical records that are 50 pages or less. There will be an additional fee of **$1** per page for records 51 pages or more. Medical records sent to another provider of services will not incur a fee.

Financial Responsibility

Payment is due at the time of service unless other arrangements are made in advance with the APG director or Office Manager. For my ongoing psychotherapy, I agree to pay **$**_____ per session. I understand that APG does not accept all insurance panels; however, they will provide the necessary information allowing me to file the claim myself. **I understand that it is my responsibility to contact my insurance company to clarify benefits and reimbursement for psychological services.**

I understand that this regular fee will be charged for any additional professional services rendered at my request, such as phone calls over 10 minutes, consults with other professionals, preparation of special forms, summaries, letters, etc. that are not related to my direct treatment. This includes paperwork for disability and legal matters.

Litigation Policy

Active litigation, such as custody disputes, is often detrimental to the therapeutic relationship and can hinder a clinician's ability to treat a patient, namely due to the fact it often involves full disclosure of matters of a confidential nature. As such, it is agreed that, should there be legal proceedings, you (the parent/legal guardian presenting this child for treatment), your attorneys, or anyone acting on your behalf will NOT subpoena APG records, or any APG clinician or employee to provide a deposition, testify in court, or engage in any other legal process or proceeding. If any APG employee is subpoenaed to provide records or testimony in violation of this agreement, you agree to pay any and all fees accrued for document preparation and professional time, even if said records or testimony is requested by another party. Should this occur, which is again in violation of this agreement, APG reserves the right to terminate treatment of the child patient and/or his/her family immediately. Referrals to other mental health professionals will be provided.

By signing this Consent to Services, you hereby agree to this Litigation Policy in its entirety. You also acknowledge the applicable fees outlined below represent reasonable compensation for the expertise of our clinicians, and are hence considered liquidated damages in the event this agreement is violated, regardless of which party issues the subpoena. These fees are to be paid in full at least five (5) business days prior to preparation of requested documents or appearance at any legal proceeding:

- $200.00 – One (1) copy of mental health records and other pertinent documentation.
- $1500.00 – Availability of the treating licensed clinician from 8:00 am to 12:00 pm or 1:00 pm to 5:00 pm (half day) within 50 miles of the APG office.
- $2000.00 – Availability of the treating licensed clinician from 8:00 am to 5:00 pm (full day) within 50 miles of the APG office.
- $3000.00 – Availability of the treating licensed clinician for any amount of time between 8:00 am to 5:00 pm beyond 50 miles of the APG office.
- $2000.00 – Availability of the treating clinician, who provides services under the required supervision of Dr. Davis or Dr. Ballinger from 8:00 am to 12:00 pm or 1:00 pm to 5:00 pm (half day) within 50 miles of the APG office.
- $3500.00 – Availability of the treating clinician, who provides services under the required supervision of Drs. Davis or Ballinger, and the supervising psychologist from 8:00 am to 5:00 pm (full day) within 50 miles of the APG office.

$4500.00 – Availability of the treating clinician, who provides services under the required supervision of Drs. Davis or Ballinger, and the supervising psychologist for any amount of time between 8:00 am to 5:00 pm beyond 50 miles of the APG office.

Confidentiality

In keeping with professional ethical standards and state and federal law, all services provided by the staff of APG are kept confidential except as noted below and in the accompanying *Notice of Privacy Practices*. We consult as needed within the staff of APG about the best way to provide the assistance that you might need. As required by psychological practice guidelines and current standards of care, we keep records of all therapy sessions. These records are stored securely in a manner consistent with federal and professional security standards for medical records. All requests for records should be done in writing, with a Release of Information form. Please be advised, a succession plan is in place if your clinician should become seriously ill, impaired in some capacity, or pass away unexpectedly.

APG professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself, or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults, or the elderly, when the client lacks the capacity to care for him or herself, or when there is a valid court order for the disclosure of client files. Fortunately, these situations are infrequent.

By signing this form you also give APG permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. If you are suing someone or being sued, or if you are charged with a crime and you tell the court that you are client at APG, APG or your therapist may then be ordered to show the court your records. Please note, as of 2015 in the state of Texas, psychologists (and any clinician in training) are not permitted to provide statements in court regarding appropriate custody of a minor, parental fitness (i.e. which parent is a psychologically better fit to raise the child), and/ or parental alienation unless they have had specialized training in this area (usually referred to as Forensic Psychologists). Please consult with your clinician regarding their training in this area and with your lawyer should you believe these issues may arise. Please consult with your therapist if you have any questions about confidentiality. There are additional fees associated with the clinician's involvement with legal matters such as testifying in court, consult with law professionals, and preparation of legal documents.

Policies

In general, you may review your child's records in APG's files at any time. There are some limitations regarding raw testing data, but for the most part, you have access to your information. You may add to this information or correct this information, and you may have copies of the records. However, you may not examine records created by anyone else and sent to APG. In some very rare situations, parts of your child's records may be temporarily removed before you see them. This would happen if it is determined that the information would be harmful to you; nevertheless, the therapist or appropriate APG staff shall discuss this with you if it becomes an issue.

APG is not an emergency or crisis intervention facility. In the event of an emergency or crisis between scheduled appointments, go to the nearest emergency room or seek help by calling the Suicide Crisis Center 24-Hour Line at 214-828-1000 (all ages), or call 911 if it is a life-threatening situation.

Cancellation Policy

APG clinicians look forward to working with you (and your child). Our therapy sessions are approximately 45-55 minutes long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary, your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. If you are more than 15 minutes late, we will have no choice but to reschedule your appointment and you will be responsible for the fees of a no show. In order to avoid paying no

show fees, we require at least twenty-four (24) hours' notice for all cancellations, unless your appointment is on Monday, in which case the cancellation needs to be before 3pm on the prior Friday. **Insurance companies will not pay for "No Shows or Late Cancellations," therefore you will be responsible for the $75 fee for a missed appointment (no show or late cancellation).** After the third no show or late cancellation, you may not be able to schedule another appointment and/or may be referred to another provider.

Use of electronic mail/text features/social media
Please be aware that e-mail may not be private or confidential and may not be read by the recipient in a timely fashion. With regards to any client of APG (adult or minor), your clinician will not communicate therapeutic information via email. Your clinician will not provide updates on your or any minor's symptoms, presenting issues, or treatment feedback via email, regardless of your choice to communicate such information to the clinician. **Additionally, not all clinicians have work phones with text features; however, if this feature is available only scheduling information should be discussed.** Please ask your clinician if texting is an option. Clinicians work to protect your privacy, thus will not accept requests for connecting or messaging on social media sites.

Search Engines
It is not a regular part of our practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If we have reason to suspect you are a danger to yourself or others and have exhausted all other reasonable means to contact you and/or your emergency contact, then we may use a search engine for information to ensure your welfare. If this ever occurs, it will be fully documented and discussed with you at your next session.

Location-Based Services
Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending sessions at the office. The office is not a check-in location on various sites such as Facebook, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at the office location.

Failure to Comply
Please be aware that if you violate these policies and/or the spirit and intention behind them, it may result in termination of your child's services.

Defamation
By signing this intake and consent form below, you agree that you or your child will not make defamatory comments about your counselor, APG, or any staff members to others or post defamatory commentary about them on any website or social media site. In the event that defamatory remarks about them are made by you or your child, or others acting in concert with you, you further consent by signing below to allowing your counselor, APG, or any staff member to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Psychiatric consults and medication
APG does not retain a psychiatrist on staff, nor do we prescribe or dispense psychiatric medications. APG can provide you with a psychiatric referral if deemed necessary. You may sign a release to enable APG to consult with your Psychiatrist.

APG is a training and research site for psychologists and counselors
APG is a training and research facility. Thus, the care you receive may be with a graduate clinical psychology or counseling student, licensed professional counselor intern, pre-doctoral intern, post-doctoral fellow, licensed psychologist, or licensed professional counselor. All clinicians in training will inform you of their trainee status as well as the name of their supervising psychologist or counselor who can be contacted through our office. In order to adequately supervise trainees, a supervisor may ask that therapy sessions be audio or video recorded. Staff

psychologists may also wish to record sessions for the purpose of training others. Any and all video sessions will **not** be a part of your formal record as they will be erased regularly. You have the right to review these tapes at any time and can request this through your therapist. You may choose not to have your sessions recorded. Please talk with your therapist if you have questions about audio and video recording.

APG utilizes psychological test data in archival research and the training of graduate students in mental health. Archival research is the study of past psychological test scores from your records to investigate scientific questions that arise in the future. This scientific investigation is generally aimed at improving treatment outcomes and increase our understanding of psychiatric conditions. This data will be collected and scored without you being identified and without any personal information from which you may be identified. By signing this form you agree to allow the use of this data for research with the understanding that you will receive no financial benefit from the use of the archival data.

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APG professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself, or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults, or the elderly, when the client lacks the capacity to care for him or herself, or when there is a valid court order for the disclosure of client files. Fortunately, these situations are infrequent.

By signing this form you also give APG permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. If you are suing someone or being sued, or if you are charged with a crime and you tell the court that you are client at APG, APG or your therapist may then be ordered to show the court your records. Please note, as of 2015 in the state of Texas, psychologists (and any clinician in training) are not permitted to provide statements in court regarding appropriate custody of a minor, parental fitness (i.e. which parent is a psychologically better fit to raise the child), and/ or parental alienation unless they have had specialized training in this area (usually referred to as Forensic Psychologists). Please consult with your clinician regarding their training in this area and with your lawyer should you believe these issues may arise. Please consult with your therapist if you have any questions about confidentiality. There are additional fees associated with the clinician's involvement with legal matters such as testifying in court, consult with law professionals, and preparation of legal documents.

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APG clinicians look forward to working with you (and your child). Our therapy sessions are approximately 45-55 minutes long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary, your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. If you are more than 15 minutes late, we will have no choice but to reschedule your appointment and you will be responsible for the fees of a no show. In order to avoid paying no

show fees, we require at least twenty-four (24) hours' notice for all cancellations, unless your appointment is on Monday, in which case the cancellation needs to be before 3pm on the prior Friday. **Insurance companies will not pay for "No Shows or Late Cancellations," therefore you will be responsible for the $75 fee for a missed appointment (no show or late cancellation).** After the third no show or late cancellation, you may not be able to schedule another appointment and/or may be referred to another provider.

Use of electronic mail/text features/social media
Please be aware that e-mail may not be private or confidential and may not be read by the recipient in a timely fashion. With regards to any client of APG (adult or minor), your clinician will not communicate therapeutic information via email. Your clinician will not provide updates on your or any minor's symptoms, presenting issues, or treatment feedback via email, regardless of your choice to communicate such information to the clinician. **Additionally, not all clinicians have work phones with text features; however, if this feature is available only scheduling information should be discussed.** Please ask your clinician if texting is an option. Clinicians work to protect your privacy, thus will not accept requests for connecting or messaging on social media sites.

Search Engines
It is not a regular part of our practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If we have reason to suspect you are a danger to yourself or others and have exhausted all other reasonable means to contact you and/or your emergency contact, then we may use a search engine for information to ensure your welfare. If this ever occurs, it will be fully documented and discussed with you at your next session.

Location-Based Services
Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending sessions at the office. The office is not a check-in location on various sites such as Facebook, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at the office location.

Failure to Comply
Please be aware that if you violate these policies and/or the spirit and intention behind them, it may result in termination of your child's services.

Defamation
By signing this intake and consent form below, you agree that you or your child will not make defamatory comments about your counselor, APG, or any staff members to others or post defamatory commentary about them on any website or social media site. In the event that defamatory remarks about them are made by you or your child, or others acting in concert with you, you further consent by signing below to allowing your counselor, APG, or any staff member to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Psychiatric consults and medication
APG does not retain a psychiatrist on staff, nor do we prescribe or dispense psychiatric medications. APG can provide you with a psychiatric referral if deemed necessary. You may sign a release to enable APG to consult with your Psychiatrist.

APG is a training and research site for psychologists and counselors
APG is a training and research facility. Thus, the care you receive may be with a graduate clinical psychology or counseling student, licensed professional counselor intern, pre-doctoral intern, post-doctoral fellow, licensed psychologist, or licensed professional counselor. All clinicians in training will inform you of their trainee status as well as the name of their supervising psychologist or counselor who can be contacted through our office. In order to adequately supervise trainees, a supervisor may ask that therapy sessions be audio or video recorded. Staff

psychologists may also wish to record sessions for the purpose of training others. Any and all video sessions will **not** be a part of your formal record as they will be erased regularly. You have the right to review these tapes at any time and can request this through your therapist. You may choose not to have your sessions recorded. Please talk with your therapist if you have questions about audio and video recording.

APG utilizes psychological test data in archival research and the training of graduate students in mental health. Archival research is the study of past psychological test scores from your records to investigate scientific questions that arise in the future. This scientific investigation is generally aimed at improving treatment outcomes and increase our understanding of psychiatric conditions. This data will be collected and scored without you being identified and without any personal information from which you may be identified. By signing this form you agree to allow the use of this data for research with the understanding that you will receive no financial benefit from the use of the archival data.

Consent to Treatment

By signing below, I agree to allow my child to enter psychotherapy with a qualified APG therapist. I understand I have the right **not** to sign this form. My signature below indicates I have read and discussed this agreement; it **does not** indicate that I am waiving any of my or my child's rights. I understand I can choose to discuss my concerns with the therapist before my child begins therapy. I understand that after therapy begins I have the right to withdraw my consent to my child's psychotherapy at any time, for any reason. However, I will make every effort to discuss my concerns with the therapist before ending the treatment.

I understand that no specific promises have been made to me by the therapist or APG staff about the results of my child's psychotherapy.

Information obtained during my child's treatment will be confidential and privileged except for the limitations noted above.

I, _____, parent and / or managing conservator (guardian) for
(Parent/Guardian's Printed Name)

_____, agree to allow my child to enter into psychotherapy at
(Child's Printed Name)

Anchor Psychology Group (APG) in accord with the policies outlined above.

_____	_____	_____
Parent/Guardian's Printed Name	Signature	Date
_____	_____	_____
Clinician's Printed Name	Signature	Date

Notice of Privacy Practices (NPP), Minor

[Client Copy – Retain for your records]

This notice describes how mental health information about your child may be used and disclosed and how you may obtain access to this information. Please review it carefully.

Anchor Psychology Group is a teaching and research clinic. Graduate counseling and clinical psychology students, psychology pre-doctoral interns and post-doctoral fellows, and licensed professional counselor interns may participate in your child's care as a part of their mental health training programs. All care is overseen and supervised by a licensed mental health professional. All information describing your child's mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information that you and your child disclose to us. We are required by law to maintain the confidentiality of information that identifies your child and the care he or she receives. When we disclose information to other persons and companies to perform services for us, we require them to protect you and your child's privacy, too. This Notice also applies to your psychologist, counselor, psychiatrist and other health care professionals who provide care to you or your child. We must also provide certain protections for information related to your child's medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, you and your child's rights, and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

- For Treatment. For example, we may give information about your child's psychological condition and functioning to other health care providers, such as your child's pediatrician or another psychologist, to facilitate your child's treatment, referrals, or consultations.
- For Payment. For example, a health care provider may contact your insurer to verify what benefits your child is eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.
- For Healthcare Operations For example, we may give information to University or professional mental health and training organizations to review the quality of care provided, for performance improvement, or for the training of health professionals. Other examples could include audits and administrative services, and case management and care coordination.
- For Appointments and Services to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.
- To Individuals Involved in a Child's Care. For example, parents or guardians of a minor receiving treatment or evaluation.
- With your written authorization w*e* may use or disclose mental health information for purposes not described in this Notice.

WE MAY USE YOUR CHILD'S MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATON:

- As Required by Law when required or authorized by other laws, such as the reporting of child abuse, elder abuse, disabled or dependent adult abuse.
- For health oversight activities to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.
- In Judicial Proceedings in response to court/administrative orders, subpoenas, discovery requests or other legal process. If APG and/or your child's assessor is subpoenaed to appear in court and provide testimony regarding our knowledge and experience of your child and our assessment, we will assert privilege on your behalf. Nevertheless, if the judge insists we testify, we will testify truthfully and honestly to our thoughts and professional opinion

- To Public Health Authorities to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.
- To Law Enforcement for example, to assist in an involuntary hospitalization process.
- To the State Legislative Senate or Assembly Rules Committees for legislative investigations.
- For Research Purposes subject to a special review process, and the confidentiality requirements of state and federal law.
- To Prevent a Serious Threat to Health or Safety of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.
- To Protect Certain Elective Officers including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

- To Receive a Copy of this Notice when you obtain services for your child.
- To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about your child for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.
- To Inspect and Request a Copy of Your Child's Mental Health Record except in limited circumstances. A fee will be charged to copy your child's record. You must put your request for a copy of your records in writing. If you are denied access to your child's mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
- To Request an Amendment and/or Addendum to Your Child's Mental Health Record**.** If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason for the request. We may deny your request or an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your child's records.
- To Receive an Accounting of Certain Disclosures we have made of your child's mental health information. You must put your request for an accounting in writing.
- To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests

CHANGES TO THIS NOTICE: Anchor Psychology Group reserves the right to change or revise this Notice. If a revision is made to our policies and procedures, a revised copy will be posted in the office and a copy will be provided to you upon request.

CONTACT INFORMATION: If you have any questions about this Notice, please contact the office manager at Anchor Psychology Group, 1402 S. Custer Road, Suite 803, McKinney, Texas, 75072, or by telephone at 469-619-7622.If you believe your privacy rights have been violated, you may contact the Texas Board of Examiners of Psychologists at 1-800-821-3205 or the Texas Board of Examiners of Professional Counselors at 1-800-942-5540. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Effective Date: May 1, 2012

Acknowledgment of Notice of Privacy Practices

[APG Office Copy]

The Anchor Psychology Group Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child.

In addition to the copy we will provide you, copies of the current notice may be obtained through the office manager at APG.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Client or Client's Legal Representative *Date*

_____

Print Name

Interpreter (if applicable) _____*Relationship to Client* _____

Therapy Fee Agreement (Minor)

[Client Copy- Retain for Your Records]

Financial Responsibility

Payment is due at the time of service unless other arrangements are made in advance with the APG director or Office Manager. For my child's ongoing psychotherapy, I agree to pay **$**_____ per session. I understand that APG does not accept all insurance panels; however, they will provide the necessary information allowing me to file the claim myself. **I understand that it is my responsibility to contact my insurance company to clarify benefits and reimbursement for psychological services.**

I understand that this regular fee will be charged for any additional professional services rendered for my child at my request, such as phone contacts with me or my child over 10 minutes, consults with other professionals, preparation of special forms, summaries, letters, etc. that are not related to my direct treatment. This includes paperwork for disability and legal matters.

_____ _____

Child's Printed Name *Parent or Guardian's Printed Name*

_____ _____

Signature of Parent or Guardian *Date*

Therapy Fee Agreement (Minor)

[APG Copy to be kept In Client File]

Financial Responsibility

Payment is due at the time of service unless other arrangements are made in advance with the APG director or Office Manager. For my child's ongoing psychotherapy, I agree to pay **$**_____ per session. I understand that APG does not accept all insurance panels; however, they will provide the necessary information allowing me to file the claim myself. **I understand that it is my responsibility to contact my insurance company to clarify benefits and reimbursement for psychological services.**

I understand that this regular fee will be charged for any additional professional services rendered for my child at my request, such as phone contacts with me or my child over 10 minutes, consults with other professionals, preparation of special forms, summaries, letters, etc. that are not related to my direct treatment. This includes paperwork for disability and legal matters.

_____ _____

Child's Printed Name *Parent or Guardian's Printed Name*

_____ _____

Signature of Parent or Guardian *Date*

Minor Assent / Agreement for Meeting with My Counselor

I _____ agree to meet with my counselor. Our meetings will last 45- 55 minutes. When we meet, we will mostly likely just talk, but we may also draw pictures, play games, or do other things to help this counselor get to know me better and understand my problems, thoughts, and goals.

I understand that my parent (or parents) or my guardian has a right to know how I am doing in counseling. I agree that this counselor may talk with my parent/guardian to discuss how I am doing. They may also talk about concerns and worries they may have about me. Or they may talk about things the counselor and I decide my parent/guardian needs to know about. Sometimes this counselor may meet with my parent/guardian without me. At other times we may all meet together.

The specific things I talk about in my meetings with the counselor are private. I understand this counselor will not tell others about the specific things I tell him or her. My counselor will not repeat these things to my parent/guardian, my teachers, the police, probation officers, or agency employees. But there are two exceptions. First, because of the law, the counselor will tell others what I have said if I talk about seriously hurting myself or someone else. The counselor will have to tell someone who can help protect me or the person I have talked about hurting. Second, if I am being seriously hurt emotionally, physically or sexually by anyone, this counselor has to tell someone for my protection.

I understand that I may not feel good about some things we may talk about in our meetings. I may feel uncomfortable talking to this counselor because I don't yet know him or her very well. I may feel embarrassed talking about myself. Some of the things we talk about may make me feel angry or sad. Sometimes coming to meetings may interfere with doing other things I enjoy more. But I also understand that coming to counseling should help me feel better in the long run. I may find that I will trust this counselor and can talk about things that have been hard to talk to anyone else about. I may learn some new, important, and helpful things about myself and others. I may learn some new and better ways of handling my feelings or problems. I may feel less worried or afraid and come to feel better about myself.

Any time I have questions or am worried about my counseling, I know I can ask this counselor. My counselor will try to explain things to me in ways that I can understand. I also know that if my parent/guardian has any questions, the counselor will try to answer them. I understand that my parent/guardian can stop my coming to counseling if he or she thinks that is best. If I decide counseling is not helping me and I want to stop, this counselor will discuss my feelings with me and with my parent/guardian. I understand that the final decision about stopping is up to my parent/guardian.

Our signatures below mean that we have read this agreement, or have had it read to us, and agree to act according to it.

_____ _____

Signature of Child Date

_____ _____

Signature of Parent Date

I, the clinician, have discussed the issues above with the minor client and his or her parent/guardian. My observations of their behavior and responses give me no reason, in my professional judgment, to believe that these persons are not fully competent to give informed and willing consent and assent.

_____ _____

Signature of Clinician Date

Today's Date: _____ / _____ / _____
Month Day Year

INTAKE QUESTIONNAIRE:

Section A: Parent/Guardian Information

(A1) Contact information:

Parent/Guardian's Full Name _____

Relationship to Client _____ **D.O.B.** _____
Occupation _____
Place of Employment _____
Street Address _____
City/State _____ **Zip** _____
☐ **OK to forward communications to this address**
Cell Phone _____
☐ OK to Phone ☐ OK to Text ☐ OK to Leave Message
Home or Other Phone _____
☐ OK to Phone ☐ OK to Text ☐ OK to Leave Message
Preferred E-mail address: (Please be aware that email might not be confidential.)
_____
☐ OK to email regarding your child's appointment

Second Parent/Guardian's Full Name _____

Relationship to Client _____ **D.O.B.** _____
Occupation _____
Place of Employment _____
Street Address _____
City/State _____ **Zip** _____
☐ **OK to forward communications to this address**
Cell Phone _____
☐ OK to Phone ☐ OK to Text ☐ OK to Leave Message
Home or Other Phone _____
☐ OK to Phone ☐ OK to Text ☐ OK to Leave Message
Preferred E-mail address: (Please be aware that email might not be confidential.)
_____
☐ OK to email regarding your child's appointment

Additional Parent/Guardian's Full Name _____

Relationship to Client _____ **D.O.B.** _____
Occupation _____
Place of Employment _____
Street Address _____
City/State _____ **Zip** _____
☐ **OK to forward communications to this address**
Cell Phone _____
☐ OK to Phone ☐ OK to Text ☐ OK to Leave Message
Home or Other Phone _____
☐ OK to Phone ☐ OK to Text ☐ OK to Leave Message
Preferred E-mail address: (Please be aware that email might not be confidential.)
_____
☐ OK to email regarding your child's appointment

Section A: Parent/Guardian Information (Cont.)

(A2) Preferred Method of Contact:

☐ Cell Phone ☐ Home Phone ☐ E-mail ☐ Mail
☐ Other (specify) _____

(A3) Referred to Anchor Psychology Group by: (check all that apply)

☐ Self (see below) ☐ Friend ☐ Family Member ☐ School Hospital ☐ Clergy/Religious Leader
☐ Medical Provider ☐ Mental Health Provider ☐ Disability Services or Social Security Admin
If referred by physician or mental health provider, please provide their name and contact information:
_____

If Self, how did you hear about our services?
☐ APG Website ☐ Other Website ☐ Internet Search ☐ Brochure ☐ Presentation/Lecture/Workshop
☐ Other (specify) _____

(A4) Emergency Contact:

Name _____

Relationship to you _____ Phone _____

Address _____

(A5) Parent / Guardian's Current Relationship Status:
☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Other (specify) _____
If applicable, how long have you been / were you in this relationship? _____

(A6) Do you as parent / guardian have full custody of this child? ☐ Yes ☐ No (specify below)
If no, please describe the custody arrangement and bring a copy to the office:
_____
_____
_____
_____

☐ **If no, I attest that I have the independent right to provide services for the minor child and I have provided the most recent court orders/custody agreement to that effect.**

Section B: Child Information

(B1) Child's Legal Name: _____ _____ _____
First Name MI Last Name

Preferred Name/Nickname: _____

(B2) Child's Birth Date: _____ / _____ / _____ **Current Age:** _____
Month Day Year

(B3) Child's Educational Information:

Current Grade: _____

Schools Attended/Attending (School Name and City): _____
_____
_____

Any special services or accommodations received: _____
_____
_____
_____

(B4) Child's Gender:

☐ Female ☐ Male ☐ Transgender ☐ Other _____

(B5) Child's Ethnicity: _____

☐ Prefer Not to Answer

(B6) Child's Sexual Orientation:

☐ Bisexual ☐ Heterosexual ☐ Lesbian/Gay ☐ Questioning

☐ Other (specify) _____

(B7) Please list the members of your child's family (e.g., parents, siblings, relatives with whom your child is close:
Name, Relationship to child, Living or Deceased, Age (or age at time of death), Occupation
(e.g., Sally, sister, living, 12, student)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(B8) Is there a family history of mental illness, substance abuse, or learning difficulties?

☐ Yes (specify below) ☐ No

If yes, please provide a brief explanation: _____
_____
_____
_____

Section B: Child Information (cont.)

(B9) Is there a history of physical, sexual, or emotional abuse of the client? ☐ Yes ☐ No

Has CPS ever been involved with the family and/or client? ☐ Yes ☐ No

Is CPS currently involved with the family and/or client? ☐ Yes ☐ No

Are there any legal or criminal issues which affect the client (either their own or in the family)? ☐ Yes ☐ No

Does the client have a history of substance use/abuse in any capacity? ☐ Yes ☐ No

(Clinician will ask about any, "Yes," answers during the clinical interview.**)**

Section C: Child's Health History

(C1) Child's Pediatrician/Physician Information: (list name, address, and phone number)

_____
_____
_____
_____

(C2) When was your child's last physical exam/well-visit? _____

(C3) Currently, how is your child's physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

(C4) Has your child had any serious accidents or injuries? ☐ Yes (specify below) ☐ No

If yes, please describe: _____
_____
_____
_____

(C5) Please describe any medical issues or hospitalizations your child has or had: _____
_____
_____
_____
_____

(C6) Please list any other persistent physical symptoms or health concerns _____
_____
_____

(C7) Does your child regularly take any prescribed medications, over-the-counter drugs, supplements, or alternative remedies to treat a medical condition? ☐ Yes ☐ No

If yes, please list any medications you are <u>currently</u> taking, the condition for which the medication is taken, and the prescribing physician (if applicable):

(e.g. Albuterol 5 mg/mL (nebulizer) as needed for asthma, Family Doctor)

_____
_____
_____
_____

Psychiatric medications? ☐ Yes ☐ No

_____
_____
_____

Section C: Child's Health History (cont.)

(C8) Is your child having any problems with sleep habits?

☐ No problems ☐ Sleeping too much ☐ Sleeping too little
☐ Poor quality of sleep ☐ Nightmares / Sleep Terrors
☐ Other (please describe) _____

(C9) How many times per week does your child engage in physical activity? (e.g., running, swimming, sports, active play, etc.) ☐ One or less ☐ Two to four ☐ Five or more

(C10) Is your child currently having difficulty with appetite or eating habits? Check all that apply.

☐ No difficulty ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting
☐ Significant weight change (gain or loss)

Please describe the nature of these eating habits or weight change: (e.g., frequency of eating patterns, how much weight lost and time frame, etc.) _____
_____
_____

(C11) Has your child received counseling or psychotherapy services in the past?

☐ Yes (specify below) ☐ No
If yes, please explain, including when and with whom: _____
_____
_____
_____
_____

(C12) Is your child a returning client to Anchor Psychology Group?

☐ Yes (specify below) ☐ No
If yes, when did your child receive services and who was the mental health provider/clinician:
_____

(C13) Is your child currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ☐ Yes (specify below) ☐ No

If yes, please provide the mental health provider's name and phone number:
(e.g., Dr. Smith, 214-555-5555) _____

(Our license requires a release of information form to have your clinician share information with this provider.)

(C14) Has your child ever been assessed for psychological or learning issues (e.g., anxiety disorder, mood disorder, learning disorder, post-traumatic stress disorder, eating disorder, personality disorder, etc.) by a therapist, school counselor, or other provider? ☐ Yes (specify below) ☐ No

If yes, please explain, including when, by whom, and the findings/diagnosis: _____
_____
_____
_____
_____
_____
_____

Section C: Child's Health History (cont.)

(C15) Does your child have (or have they had) an IEP or 504 in place at school and what was the reason?

_____
_____
_____
_____
_____

(C16) Has your child been prescribed psychiatric medication in the past?

☐ Yes (specify below) ☐ No

If yes, please list what medications, dosage, and when taken:
(e.g., Prozac, 20 mg, 2012-2014) _____
_____
_____

Were the medications helpful? ☐ Yes ☐ No

(C17) Has your child ever seen a psychiatrist or been hospitalized for psychiatric reasons?

☐ Yes (specify below) ☐ No

If yes, please specify who, when, and why: _____
_____
_____
_____
_____

Was the hospitalization helpful? ☐ Yes ☐ No

Section D: Presenting Concerns

(D1) Briefly describe what brings you and your child to Anchor Psychology Group: _____
_____
_____
_____
_____
_____
_____
_____
_____

(D1 cont.) Is there any additional information about your child, your child's current difficulties, special circumstances or challenges within your family or in your child's world that would be helpful for us to know?

_____
_____
_____
_____
_____
_____

(D2) Approximately how long have these concerns been bothering you and/or your child?

☐ A couple days ☐ A week ☐ A month ☐ Several months ☐ A year ☐ Several years

Thank you for completing the Intake Questionnaire.

Credit Card Authorization Form For Ongoing Therapy Sessions

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.
All information will remain confidential.

I, _____, give Anchor Psychology Group permission to charge the following credit card, debit card, flexible spending card, or health savings account:

Name on card:_____
Card Number: _____ Exp. Date: _____
Billing Zip Code: _____ Security Code: _____
Applicable charges include: Counseling Sessions Report/Paperwork Requests Records Requests Late Cancellations/No Show Group Sessions

Please initial the following:

_____ I understand that this release is limited to what I have agreed to above. If I would like to change the card information in the future, I will need to alert my counselor.

_____ I understand that should an account become overdrawn, I am responsible for any incurred fees.

_____ I understand that all credit cards are subject to a $3 convenience fee. I understand that this fee will be applied to each transaction on my card.

** If, for any reason, multiple "charges" are processed as one single transaction – e.g., accrued charges/past due balances, multiple family members paying for individual sessions in a lump sum payment – one (1) $3 convenience fee would be applied for the transaction.*

_____ I agree that I will pay for services in accordance with the issuing bank cardholder agreement.

_____ I understand that this release is valid when I sign it, and that I may withdraw my consent to this release at any time, either verbally or in writing.

Card holder: Print Name, Sign, and Date below:

Printed Name: _____

Signature: _____ Date: _____