Welcome to Regina Caeli Clinical Services (RCCS). This document contains important information about the services you and/or your child will receive. Please read it carefully, and ask your therapist any questions that you may have.

**Did you know?**
Psychotherapy has benefits and risks.
- Risks may include recalling unpleasant aspects of your personal history or feeling uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, and/or helplessness. Psychotherapy may intensify difficulties before alleviating them.
- Benefits may include better relationships and quality of life, more effective communication, resolutions of specific problems, and a significant reduction of distress.

**How long is each session?**
Typically 45-50 minutes.

**How often will I/my child meet with a therapist?**
You/Your child and the therapist will decide what frequency is appropriate for your/your child’s needs. To make the most progress, you and/or your child will need to work during and in between the sessions.

**How long will I/my child be in therapy?**
At the end of the initial sessions, you and/or your child can discuss this with the therapist. Duration can range from a few sessions to many sessions spanning months or years.

**My/Our reasons for seeking therapy are very personal. Do I/we have to share them with the therapist right away?**
It may take some time before you/your child feel comfortable sharing the more personal details about your life. However, in order to best help you/your child, the therapist needs accurate information about your/your child’s situation. If you are uncomfortable talking about something, please tell the therapist, and the therapist and you and/or your child can discuss the best manner to proceed.

**If I am a minor, will my parents know what I say in therapy? If I am a parent, will I be able to know what my child shares in therapy?**
When working with children and adolescents, it is often helpful for them to be able to share their thoughts and feelings without the worry that they will be shared with their parents. Therefore, depending on your/your child’s age, the details of these interactions may not be routinely discussed with parents unless the parents need to know in order to prevent harm to their child or others.

**Why did I receive all these forms?**
These forms inform you of your/your child’s rights and responsibilities, including privacy rights. The Client Information Questionnaire helps you and/or your child and your therapist to monitor your/your child’s progress and plan treatment. You may be asked to complete these and other forms again in the future. Please take the time to read and complete the forms carefully, correctly, and completely.

**What if I have an emergency? Who should I call?**
For life-threatening emergencies, call 911, or go directly to the nearest emergency room. For non-life-threatening emergencies, please try to contact your therapist through the clinic phone number (720-377-1359). Your therapist will return your call by the next business day.

**How do I schedule or change appointments?**
To cancel, change, or make appointments, please call the regular clinic line at 720-377-1359. Please note: RCCS requires at least 24 hours advance notice of cancellations for scheduled appointments. Please consult Page 2 of the Client Services Agreement for our “Late Cancellation” and “No Show” policies under the heading “Scheduling or Cancelling Appointments.”
WELCOME to Regina Caeli Clinical Services (RCCS). RCCS is a comprehensive, community-based psychological service ministry. The name refers to Our Mother Mary, Queen of Heaven (in Latin, Regina Caeli). RCCS is a ministry of Catholic Charities created to serve individuals, parishes, and schools in the Archdiocese of Denver, Colorado. Although services are available to anyone regardless of religious affiliation, all RCCS therapists will abide by Catholic doctrine and Catholic moral teaching in their professional practice.

CLIENT SERVICES AGREEMENT
When you receive mental health services from a therapist, you enter into a therapeutic contract. This Client Services Agreement is designed to make that contract explicit. This document also contains important information about RCCS’ professional services and business policies, including certain statements required by the State of Colorado denoted by DS for “Disclosure Statement.” Information about the Health Insurance Portability and Accountability Act (HIPAA) may be found in the Notice of Privacy Practices (hereafter referred to as “the Notice”) that you received with this booklet.

Please read this Agreement and the Notice carefully and discuss any questions you may have with your therapist. You will be asked to sign the “Acknowledgement of the Client Services Agreement” indicating that you have received this Agreement and that you agree to its terms. You may revoke this agreement in writing at any time.

ABOUT THE RCCS STAFF AND UNIQUE CIRCUMSTANCES AS A TRAINING CLINIC
Regina Caeli Clinical Services is a training clinic. This means that some of the therapists who offer services at RCCS are not licensed but are working towards full licensure under the supervision of a licensed psychologist. Here is an explanation of titles you may hear at our clinic.

1. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Registered Psychotherapists and the Board of Psychologists Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado, 80202, (303) 894-7800.

As to the regulatory requirements applicable to mental health professionals:

a. Registered psychotherapist is a psychotherapist listed in the State’s database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

b. Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.

c. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
Furthermore, the following terms are used at our clinic:

a. **Extern/Practicum Student**: This is a person who is still taking classes in his/her academic program. Externs/Practicum Students at RCCS may include:
   i. Clinical Psychology Doctoral Externs (referred to as Doctoral Externs)
   ii. School Psychology Doctoral Externs (referred to as Doctoral Externs)
   iii. Licensed Professional Counseling Externs (referred to as Counseling Externs).

b. **Intern**: An intern has finished all coursework but has not yet graduated from his/her academic program. Interns at RCCS may include:
   i. Clinical Psychology Doctoral Interns (referred to as Doctoral Interns)
   ii. School Psychology Doctoral Interns (referred to as Doctoral Interns)
   iii. Licensed Professional Counseling Interns (referred to as Counseling Interns).

You will receive a form that includes your provider’s name and credentials at your first appointment after receiving this booklet.

**Confidentiality at RCCS:**

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client’s consent. There are exceptions to this confidentiality, some of which are listed in Section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

However, as mentioned above, RCCS is a training clinic. As such, we seek to provide the best possible care through individual and group supervision on all of the work done by all Externs (Doctoral and Counseling), Interns (Doctoral and Counseling), and Psychologist Candidates. *Due to this fact, and in order to broaden their training and experience, the above-described confidentiality is held within the Regina Caeli Clinical Services staff as a whole, not just between you and your therapist, even if you are meeting with an individual who is licensed, registered, or certified.*

Supervision and consultation are most effective when the Counseling and Doctoral Interns and Externs are able to listen to their sessions and play portions of the sessions for their supervisor. For this reason, we ask that you give your consent to record your sessions by auditory or visual means. **Your signature of the “Audio and/or Video Recording Consent and Release Form” provides this consent.** Recordings are secured in locked file cabinets and typically destroyed at the end of each academic year. Recordings will not be kept beyond this time without your prior written consent.

Close supervision of the work of the Interns (Doctoral and Counseling), Externs (Doctoral and Counseling), and Psychologist Candidates is imperative. Therefore, if you do not wish to consent to any of the unique circumstances of being a training clinic we would be happy to refer you to another clinic.

At your first appointment, please initial here to indicate you’ve read the section entitled “ABOUT THE RCCS STAFF AND UNIQUE CIRCUMSTANCES AS A TRAINING CLINIC”:

**CONTACTING YOUR THERAPIST**

You are welcome to call 720-377-1359 and ask to speak with your therapist. If he/she is unavailable, you may leave a message and your call will be returned as soon as possible. RCCS staff will not leave messages on your voicemail without your explicit permission. This permission is provided verbally in the message you leave and/or when you answer the related question in the “Client Information Questionnaire” (this question is typically on Page 1). We do not correspond with clients via email. **If a life-threatening emergency arises, please call 911 or go to the nearest emergency room.**
SCHEDULING OR CANCELLING APPOINTMENTS
To cancel, change, or schedule an appointment, please call RCCS at 720-377-1359. RCCS requires at least 24 hours advance notice of cancellations for scheduled appointments. Our "late cancellation" and "no show" policies are as follows:
- Appointments cancelled with less than an 8 hour notice are considered late cancellations and will be charged $20. After the third late cancellation within a six (6) month period, RCCS may close the client’s file for 45 days. Referrals will be provided.

If a client does not attend a scheduled appointment without notification beforehand to cancel or reschedule, it is considered a “no show” and a $20 dollar fee will be charged to the client’s next session fee. After two “no shows” within a six (6) month period, RCCS may close the client’s file for 45 days. Referrals will be provided.

- Clients that arrive 15 minutes late to their appointment will not be able to see their therapists and will be rescheduled.

Therapist cancellations and RCCS Closures: If your therapist needs to cancel an appointment, or if RCCS will be closed for any reason, we will notify you as soon as possible. In cases of inclement weather, please call our office at 720-377-1359 and choose extension 0 to learn of any appointment cancellations or office closures.

CLIENT RIGHTS
Your first few therapy sessions are spent assessing your individual situation. At the end of the assessment, you and your therapist will develop a treatment plan. This plan will often include homework, which is a key component of successful counseling.

D  You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

We do request, however, that you discuss terminating therapy with your therapist before doing so. You may also request a referral or refuse specific services.

D  Sexual intimacy with your therapist is never appropriate and should be reported to the Division of Professions and Occupations.

You are encouraged to discuss with your therapist any questions or concerns you may have about your rights, your therapy, or your therapist. If your questions or concerns remain unaddressed, you may contact the Clinic Director, Dr. Kathryn Benes, at 720-377-1359, and an appropriate consultation or referral will be provided.
KEEPING OF CLIENT RECORDS
Your records are confidentially maintained at RCCS during treatment and for 10 years following termination of therapy for adults. Records of minors are kept for 10 years after the person reaches the age of majority. The purpose of the case documentation is to support the therapeutic treatment of the individual(s) named in the chart and will not be released outside the clinic for other purposes other than the exceptions and limits to confidentiality already mentioned in this document and in the Notice.

Pursuant to HIPAA, your Protected Health Information (PHI) is separated in two sets of professional records: your Clinical Record and Psychotherapy Notes.

Clinical Records typically include:

- Reasons for seeking therapy
- ways in which your problem impacts your life
- diagnosis
- treatment goals
- progress towards goals
- medical, social and treatment history
- reports of professional consultations
- billing records
- past treatment records received from other providers
- reports sent to anyone, including reports to your insurance carrier

Except in the unusual circumstance that disclosure is reasonably likely to endanger you, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in the presence of your therapist, or have them forwarded by our office to another mental health professional so you can discuss the contents with him or her. If RCCS refuses your request for access to your Clinical Record, you have a right of review, which will be discussed with you upon request.

Psychotherapy Notes typically include:

- Contents of psychotherapy sessions
- Analysis of psychotherapy
- Psychotherapy progress
- Sensitive information not included in your Clinical Record

Psychotherapy Notes are designed to assist your therapist in providing you with the best treatment possible. Psychotherapy Notes are kept in a separate section of your file apart from your Clinical Record. You may examine and/or receive a copy of your Psychotherapy Notes unless it is determined that such disclosure is not in your best interest. There is no appeal of that decision.

MINOR CLIENTS & THEIR PARENTS
Clients under 18 years of age who are not emancipated from their parents should be aware that the law allows parents to examine their child’s treatment records. Privacy in psychotherapy is often crucial to successful progress, particularly with teenagers. For this reason, RCCS employs a confidentiality agreement. With this confidentiality agreement, the parent(s), minor, and therapist determine what kind of information may be shared with the parents. After this agreement has been signed, parents will be provided only with general information about the progress of the child’s treatment and his/her attendance at scheduled sessions. Parents will also be provided with a summary of their child’s treatment when it is completed. If the child is a danger to him/herself or someone else, the parents will be notified immediately.
BRINGING CHILDREN TO YOUR APPOINTMENT

Children While You’re In Session: We understand that obtaining quality and affordable childcare for your children during your sessions may be difficult at times. However, in order to make the best use of your time in therapy, we ask that you not bring children to your appointments. RCCS does not provide childcare during therapy sessions.

Children In the Waiting Room: Unless otherwise agreed upon, all children age twelve and under who spend time in the waiting room (for example, while another sibling is in session) must be accompanied by an adult at all times and are expected to be on good behavior. This includes using a quiet voice, refraining from running, and keeping feet off of furniture. RCCS may in no way be held responsible for the words, actions, or whereabouts of children left unattended by parents/guardians in the waiting room.

BILLING AND PAYMENTS

Fees are to be paid in full by the client at the time of service unless other billing arrangements (e.g., payment plan, charitable grant, etc.) are approved by the Clinic Director in advance. We reserve the right to postpone or defer providing additional services or to discontinue providing services if billed amounts are not paid when due. Referrals will be provided. If a client discontinues services at RCCS, he/she remains liable for payment of all services previously rendered. If your check is returned by the bank, you will be charged $20 for each returned check in addition to the session fee.

CLINICAL FEES

RCCS does not currently contract with any insurance companies. The fees are as seen below:

<table>
<thead>
<tr>
<th></th>
<th>Initial Interview (75-80 minutes)</th>
<th>Clinical Hour (45-50 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Psychologists</td>
<td>$210.00</td>
<td>$140.00</td>
</tr>
<tr>
<td>Licensed Master’s Level Therapists; Psychologist Candidates; Registered Psychotherapists; Doctoral Interns</td>
<td>$150.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>Doctoral and Counseling Externs</td>
<td>$120.00</td>
<td>$80.00</td>
</tr>
</tbody>
</table>

The fee for psychological evaluation and testing is based on the same hourly rate as therapy sessions. This fee includes interview meetings, test sessions, report writing, and feedback sessions.

GRANTS

Grants may be available to those clients who cannot afford the full clinical fees. Grants are based upon three factors: the client’s household income, the number of dependents, and the assigned therapist’s grant availability. We typically require your most recent tax return as verification of your financial situation. Please speak to the Office Manager to learn of other forms of acceptable verification. You must provide verification at or before your first appointment. You will be responsible for the full fee until this verification is received. Fee reductions will not be applied retroactively.

Please discuss any financial concerns with your therapist or the Office Manager.

We reserve the right to postpone or defer providing additional services or to discontinue providing services for any reason.

YOUR SIGNATURE ON THE “ACKNOWLEDGMENT OF THE RECEIPT OF THE CLIENT SERVICES AGREEMENT” FORM INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY
The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule is a federal regulation implemented to ensure privacy protections and patient rights with regard to the use and disclosure of Protected Health Information (PHI). The Privacy Rule went into effect on April 14, 2003. In compliance with HIPAA, Regina Caeli Clinical Services (RCCS) has developed a Client Services Agreement and Notice Form which outline your rights and responsibilities. The law requires that you sign an acknowledgment that you have been provided with this information.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
Regina Caeli Clinical Services (hereafter RCCS) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- **PHI** refers to information in your health record that could identify you.
- **“Treatment, Payment, and Health Care Operations”**
  - **Treatment** is when your psychologist/counselor provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your psychologist/counselor consults with another health care provider. However, RCCS requires a separate authorization to disclose your PHI outside of our clinic for the purpose of treatment.
  - **Payment** is when RCCS obtains reimbursement for your healthcare. Examples of payment are when your PHI is disclosed to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - **Health Care Operations** are activities that relate to the performance and operation of RCCS. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- **Use** applies only to activities within RCCS such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **Disclosure** applies to activities outside the RCCS such as releasing, transferring, or providing access to information about you to other parties.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION
RCCS may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. For example, your psychologist/counselor may want to consult with another health care provider outside of RCCS, such as your family physician or another psychologist/counselor. In those instances when your psychologist/counselor is asked for information for purposes outside of treatment, payment or health care operations, they will obtain an authorization from you before releasing this information. They will also need to obtain an authorization before releasing your psychotherapy notes.

- **Psychotherapy notes** are notes about conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

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

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION
RCCS is required or permitted to use or disclose your PHI without your consent or authorization in the following circumstances (as permitted by the HIPAA Privacy Regulation):

- **Child Abuse** – When there is reasonable cause to believe that a child has been subjected to abuse or neglect, or if your psychologist/counselor observes a child being subjected to conditions which would reasonably result in abuse or neglect, RCCS must report this to the proper law enforcement agency or to the Denver County Department of Human Services.
There may be additional disclosures of PHI that RCCS is required or permitted by law to make without your consent or authorization, however, the disclosures listed above are the most common.

IV. PATIENT'S RIGHTS AND PSYCHOLOGIST/COUNSELOR'S DUTIES

Patient's Rights:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information. This request must be in writing. (However, RCCS is not required to agree to a restriction you request).
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. This request must be in writing. (For example, you may not want a family member to know that you are being seen by our psychologist/counselor. At your request, your bills will be sent to another address).
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. This request must be in writing. (You may be denied access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. There is no right of review of the denial of access to psychotherapy notes. At your request, your psychologist/counselor will discuss with you the details of the request and denial process.)
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request may be denied. This request must be in writing. (At your request, your psychologist/counselor will discuss with you the details of the amendment process).
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). This request must be in writing. At your request, your psychologist/counselor will discuss with you the details of the accounting process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of this Notice upon request, even if you have agreed to receive the Notice electronically.

Psychologist/Counselor’s Duties:

- RCCS is regulated by the Division of Professions and Occupations of the Department of Regulatory Agencies. You may contact the Division of Professions and Occupations at 1360 Broadway, Suite 1350, Denver, CO 80202 or by phone at (303) 894-7800 or by fax at (303) 894-7693.
- If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law. RCCS will not release information without a court order or without the written authorization from you or your personal or legally appointed representative. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

V. QUESTIONS AND COMPLAINTS

- If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may contact Kathryn Benes, Ph.D., Clinic Director, at (720) 377-1359 or toll free at (855) 377-1359.
- RCCS is regulated by the Division of Professions and Occupations of the Department of Regulatory Agencies. You may contact the Division of Professions and Occupations at 1360 Broadway, Suite 1350, Denver, CO 80202 or by phone at (303) 894-7800 or by fax at (303) 894-7693.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Clinic Director can provide you with the appropriate address upon request.
- We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us, with DORA, or with the U.S. Department of Health and Human Services.
- Revised 2/15/14
The purpose of this questionnaire is to obtain a comprehensive picture of your child’s background, enabling us to design a treatment program tailored to his/her specific needs. Please complete these questions as fully and accurately as possible. When you have completed this form, please return it to Regina Caeli Clinical Services. It is understandable that you may be concerned about what happens to this information, since much or all of it is highly personal. Case records are strictly confidential. **ONLY SELECT OFFICE PERSONNEL IS PERMITTED TO SEE YOUR CASE RECORD WITHOUT YOUR WRITTEN PERMISSION.**

**Date:** ________/_______/_______  **Form Completed By:** ____________________________

**Circle One: Parent / Guardian / Other:** ______________

**Child’s Name:** ____________________________________  **Age:** ____  **DOB:** ____ / ____ / ____

**Address:** ____________________________________________

**Street Number**  **City**  **County**  **State**  **ZIP**

**Ethnic Origin:**  Caucasian ☐  Black ☐  Hispanic ☐  Native Amer. ☐  Asian ☐  Other: _____________

**School Attending:** ____________________________________  **Grade:** _______

**Child’s Medical Information**

**Name of Physician:** ________________________________  **Ph#:** __________  **Date of last exam:** ________

**Major Health Problems:** ______________________________

**Medications Presently Taking:** __________________________

**Allergies:** _________________________________________

**Date of last hearing screening:** ____ / ____  Results: __________________________

**Date of last vision screening:** ____ / ____  Results: __________________________

**Were there any complications during your child’s birth? If so, please describe.** __________________________

**At what age did your child reach the following milestones?**

**Crawling:** _________  **Walking:** _________  **First Word:** _________

**Talking in Sentences:** _________  **Toilet Training:** _________

**Do you now, or did you ever, have concerns about your child’s development? Yes / No**

**If so, please describe your concern:** __________________________

**Please describe any accident, injuries, or significant illnesses your child has suffered including head injury or loss of consciousness and provide dates.** __________________________
Has your child ever expressed suicidal thoughts or attempted suicide? Yes / No
If so, when, and what was the response to the suicidal thought or attempt?

PARENT/GUARDIAN INFORMATION

Phone Number (Primary): (       )      (Alt): (       )
Permission to Contact at:   Primary: Yes / No     Alt: Yes / No
Permission to Leave Messages at:     Primary: Yes / No     Alt: Yes / No

Referral by:

Marital Status:      Single Engaged Married Separated Divorced Widowed
Remarried (number of times ______ ) Living with Someone ___________________________

Religion:    ______________________________ Parish/Church: ____________________________

Name of person(s) to be contacted in case of emergency:
Name      Relationship    Phone Number

Person Responsible for Payment:

Name: ____________________________ Relationship: __________ SS#: __________________
Address: ____________________________ City: _______ State: ____ ZIP: _________
Phone Number (H): (       )       (W): (       )

Anticipated Method of Payment: Full-fee Self-pay:    ☐    Grant-reduced Self-pay: ☐
If it were an available option, I would use my insurance:    ☐    Insurance Carrier: __________________

ANALYSIS OF CURRENT PROBLEMS:

What is the biggest concern you have regarding your child right now?.

On the scale below, please estimate the severity of this problem(s):

Mildly Upsetting                      Moderately Upsetting                          Very Severe                           Extremely Severe                      Totally Incapacitating

When did the problems begin? (give dates):

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of your child’s problems:

What would be an acceptable alternative behavior related to the problem? What would you like to see your child do instead?

Has your child ever been in therapy before or received any prior professional assistance for his/her problems?
If so, please give name(s), professional titles(s), dates of treatments, and results:
**EXPECTATIONS REGARDING SERVICES:**
In a few words, what do you hope to gain for your child from therapy/services? ____________________________________________________________________________________________

**SOCIAL DYNAMICS:**
Who are the most important people in your child’s life? ____________________________________________________________________________________________

Does he/she make friends easily? _______ Does he/she keep them? __________________________________________
Who does your child feel most comfortable talking to? __________________________________________________
How would you describe your child’s personality: ____________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

What does your child do well? _________________________________________________________________

What strengths do you see in him/her that might help address the problem? ____________________________________________________________________________________________

List the schools your child attended and what his/her experience was like at each (i.e. friendships, sports, clubs/organizations, honors, etc.).
Grade School: ____________________________________________ Grades ____________________________
Junior High: ___________________________________________ Grades ____________________________
High School: __________________________________________ Grades ____________________________

Please list academic strengths: ____________________________________________________________________________________________

Any behavioral or academic difficulties? ____________________________________________________________________________________________

Has your child ever been retained/held back a grade? Y / N If yes, what grade? _______
For what reason? ____________________________________________________________________________________________

Does your child date? Y  /  N
Has he/she ever been in trouble with the law/police? Y / N
Does your child smoke or use tobacco? Y / N
Has your child ever drunk alcohol? Y / N Have they been drunk? Y / N
Has your child ever used drugs or been high on drugs? Y / N
Has your child ever witnessed or experienced any kind of abuse? Yes / No
☐ Sexual    ☐ Verbal     ☐ Physical     ☐ Emotional (e.g., extreme mind games or guilting)

**FAMILY DYNAMICS:**
What is the primary language spoken at home? ____________________________
What other languages are spoken at home? ____________________________
Is your child adopted?  Yes ____ No ____ If yes, at what age? ____________________________
Has your child always lived with you?  Y / N
If not, who has he/she lived with and at what ages? ____________________________
Was your child ever in childcare? Y / N At what age? _________ For how long each day? ________________
Who cared for him/her in childcare? ____________________________
In what ways is your child disciplined? __________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
What are the rules and expectations about behavior in your child’s home? ____________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
What happens when your child does something good or special? ________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
If your child has a step-parent(s), how old was he/she when the parent remarried. __________________
Indicate any significant life events for the family. ______________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Please list any family strengths: ______________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Does any member of your family suffer from any of the following? (if so, please indicate relation and duration):
Alcoholism or drug abuse? ________________________________________________________________
__________________________________________________________________________________________
Anxiety or depression? ________________________________________________________________
__________________________________________________________________________________________
Mental illness? ________________________________________________________________
__________________________________________________________________________________________
Has any relative attempted or committed suicide? ____________________________________________
Have you or any relatives had serious criminal problems? ______________________________________
__________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>M/F</th>
<th>Age/DOB</th>
<th>Occupation</th>
<th>Quality of relationship with your child</th>
<th>Living in your child’s home (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling(s) continue on back if needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stepparent(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other’s in your home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>