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 the examiner any questions that you may have.

Did you know?
Taking a psychoeducational assessment has benefits and risks.
- Risks may include discovering troubling elements of your or your child’s cognitive abilities and academic strengths and weaknesses.
- Benefits often include being provided important information pertaining to one’s cognitive functioning and learning style in hopes of identifying barriers to learning.

How many and what kind of assessment will be given?
You and your examiner and/or the party requesting the assessment will decide which evaluations are needed.

How long will the assessment take?
The lengths of evaluations are determined by the presenting questions and which assessments are being done. Assessments vary in length from 15 minutes to three hours. A total of 8 to 12 direct assessment hours over the course of two to three days is common. After that, results typically take three to four weeks to process.

How can one prepare for the assessment?
The goal of a psychoeducational assessment is to help you and any third parties requesting the assessment (if applicable) to better understand your or your child’s cognitive and academic functioning. Therefore it is important for you and/or your child to give your best effort and be honest and open in your answers.

What happens after taking the assessment?
Following the assessment sessions, an RCCS staff member will score and summarize the information obtained. This information may be provided to the referral source (with your signed permission). A follow-up appointment is scheduled to provide you with feedback regarding evaluation results.

What is the cost for the assessment?
Psychoeducational assessment fees typically range between $1000 - $2200.

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 assists in providing relevant background information pertaining to areas of concern. 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 the examiner through the clinic phone number (720-377-1359).

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.
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.

2. 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:
Clinical Psychology Doctoral Interns (referred to as Doctoral Interns)
School Psychology Doctoral Interns (referred to as Doctoral Interns)
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 Statues, 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 $25. 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. Please note, your therapist may accept new clients during the 45 day waiting period. Should your therapist become fully booked you may be placed on a wait list once the 45 day period has expired.
* If a client does not attend a scheduled appointment without notification beforehand to cancel or reschedule, it is considered a “no show” and a $25 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. Please note, your therapist may accept new clients during the 45 day waiting period. Should your therapist become fully booked you may be placed on a wait list once the 45 day period has expired.
• 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.

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.

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 Executive Director, Dr. Linda Montagna, at 720-377-1359, and an appropriate consultation or referral will be provided.

**KEEPING OF CLIENT RECORDS Are these timelines correct? 10 years after reaching majority?**
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 Executive 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 $25 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 a predetermined schedule based on needed assessments. This fee is comprehensive including the initial interview meetings, test sessions, report writing, and feedback sessions. Insert the fees for assessments.
GRANTS
Grants may be available for counseling fees to those clients who cannot afford the full clinical fees. Grants are not available for assessments as these rates are set based on a discounted market price. 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 and three months of current pay stubs as verification of your financial situation. Please speak to the Director of Operations to learn of other forms of acceptable verification. **You must provide verification at or before your first appointment. It is advisable to submit your financial data when you submit your Client Questionnaire. 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 Director of Operations.*

*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.
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.
• Adult and Domestic Abuse – When there is reasonable cause to believe that a vulnerable adult has been subjected to abuse or if your psychologist/counselor observes such an adult being subjected to conditions which would reasonably result in abuse, RCCS must report this to the appropriate law enforcement agency or the Denver County Department of Human Services. (A “vulnerable adult” is any person eighteen years of age or older who has a substantial mental or functional impairment or for whom a guardian has been appointed under the Colorado Probate Code)

• Health Oversight Activities – For the purpose of any investigation, the Director of the Colorado Department of Human Services, the Director of the Denver County Department of Human Services, or the Director of the Department of Regulatory Agencies (the board which licenses psychologists/counselors to practice) may subpoena relevant records from RCCS.

• Judicial and Administrative Proceedings – 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.

• Serious Threat to Health or Safety – If you communicate a serious threat of physical violence against a reasonably identifiable victim or victims, RCCS must communicate such threat to the victim or victims and to a law enforcement agency.

• Worker’s Compensation – If you file a worker’s compensation claim, RCCS must, on demand, make available records relevant to that claim to your employer, the insurance carrier, the worker’s compensation court, and to you.

• Disclosures to You – RCCS is required to provide your PHI to you upon request or to provide you with the PHI of any individual on whose behalf you are acting as a personal representative.

• Business Associates – RCCS contracts with individuals and entities (business associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose your PHI. RCCS requires business associates to agree in writing to contract terms designed to appropriately safeguard your PHI.

• As Required By Law – We will disclose health information about you when required to do so by federal, state, or local law.

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 required by law to maintain the privacy of PHI, to provide you with a notice of our legal duties and privacy practices with respect to PHI, to follow the privacy practices that are described in this Notice while it is in effect, and to obtain your signature acknowledging your receipt of this Notice. This Notice takes effect February 18, 2013 and will remain in effect until we replace it.

• RCCS reserves the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Unless you are notified of such changes, RCCS is required to abide by the terms currently in effect.

• RCCS reserves the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. If RCCS revises its Notice of Privacy Practices, active clients will receive a revised copy of the Notice at the first session held after the revisions are made. It will be noted in the file that the revised notice was offered and/or received. The effective date of the notice will appear at the end of the notice.

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 Linda Montagna, Psy. 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 1560 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 4/18/16
CHILD ASSESSMENT QUESTIONNAIRE
TO BE COMPLETED BY PARENT OR GUARDIAN

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 ______ / ______ / ______
Last) (First) (MI)

Address:
__________________________________________________________________________________
Street Number City County State ZIP

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

School Attending: ____________________________ Grade: ________

Primary areas to be assessed (please mark):
________ Learning Disabilities (SLD)
Concerns in reading, writing and/or math? ____________________________
________ Autism Spectrum Disorder (ASD)
________ Social Emotional Functioning
________ Attention Deficit/Hyperactivity Disorder (ADHD)

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
Referred by: ____________________________
Marital Status: Single Engaged Married Separated Divorced Widowed
Remarried (number of times ______ ) Living with Someone ____________________________
If not married: Joint Custody Sole Custody of Mother Sole Custody of Father
Other custody arrangement: ____________________________
Religion: ____________________________ Parish/Church: ____________________________
<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
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</tbody>
</table>

**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: __________________

**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? ______________

______________________________

**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 completed a psychoeducational evaluation before (including IFSP or IEP)?
If so, please give name(s), professional titles(s), dates of assessment, and results:

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?

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)

What actions were taken?
ACADEMICS
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 Earned ______________________________________

Junior High: ___________________________ Grades Earned ______________________________________

High School: ___________________________ Grades Earned ______________________________________

Please list academic strengths: ________________________________________________________________

__________________________________________________________________________________________

Any behavioral or academic difficulties (ex: detention, suspension, expulsion)?__________________________

__________________________________________________________________________________________

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

Significant academic problems? Y/N If yes, please describe:_______________________________________

__________________________________________________________________________________________

Has your child been enrolled in special education? Y/N If yes, please describe:_______________________

__________________________________________________________________________________________

List and describe any special services in which your child has participated (resources, individual or group

counseling, speech, etc.):_____________________________________________________________________

__________________________________________________________________________________________

Any relatives with academic difficulties? Y/N If yes, please describe:_______________________________

__________________________________________________________________________________________

Does/Did your child display challenges with (please mark):

_______ Chronic ear infections  ____  Late establishment of dominant handedness

_______ Stuttering  ____ Learning to tie shoes

_______ Identifying left versus right (directionality)  ____ Memorizing address, phone number, alphabet

_______ Rhyming  ____ Letter or number reversals

_______ Spelling  ____ Remembering sight words

_______ Memorizing multiplication tables  ____ Messy bedroom, backpack, desk, locker

_______ Tired muscles when writing or drawing  ____ Reading an analog clock

_______ Copying from the board  ____ Remembering multi-step instructions

_______ Finding correct words when speaking (saying “thingy” or “whatymacallits”)

Please explain any difficulties marked in the above section:__________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
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):
Learning disabilities? __________________________________________________________________________

Autism Spectrum Disorder? __________________________________________________________________________

Attention Deficit/Hyperactivity Disorder? __________________________________________________________________________

Anxiety or depression? __________________________________________________________________________
<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>
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</thead>
<tbody>
<tr>
<td>FATHER</td>
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<tr>
<td>MOTHER</td>
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<td>SIBLING(s)</td>
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<td>Step-parent(s)</td>
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<td>Other’s in your home</td>
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</table>

What else might be important to share that does not appear on this form?:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________