



## NEW PATIENT INFORMATION CHILD/ADOLESCENT

Patient Last Name:

Patient First Name:

Patient Middle Name:

DOB:

Gender Assigned at Birth:

SSN:

Male  Female

Address:

City:

Zip:

Home Phone:

Cell Phone:

Email:

### EMERGENCY CONTACT INFORMATION

First & Last Name:

Relationship:

Phone:

### INSURANCE INFORMATION

Primary Insurance:

Policy #:

Group #:

Subscriber Name:

Subscriber DOB:

SSN:

Relationship:

Employer:

Secondary Insurance:

Policy #:

Group #:

### OFFICE USE ONLY

Policy Effective Date:

Calendar Year Plan

Monthly Plan

Copay:

Deductible:

Deductible Remaining:

Visit Limit:

Authorization #:

Appointment Date:

Appointment Time:

Clinician:

DX:

**I AGREE THAT ALL INFORMATION LISTED ABOVE IS CORRECT**

Patient/Guardian Signature:

Date:



## ATTENDANCE AND FINANCIAL POLICIES

Thank you for choosing KaraLee & Associates, P.C. as your mental health care provider. Please understand that payment of services rendered is considered part of your treatment and is expected at each session.

KaraLee & Associates, P.C. providers accept most insurance carriers, but each patient may be responsible for an annual deductible or co-payment, depending on their insurance provider. It is the patient's responsibility to keep track of their appointments and to keep their financial accounts current including copays, deductibles, and service fees.

**By initialing each paragraph below, you are stating that you understand our attendance and financial policies.**

\_\_\_\_\_ (initial here) I agree to notify my clinician when canceling an appointment at least 24 hours in advance.

\_\_\_\_\_ (initial here) I understand that if I miss my initial appointment, I will incur a \$140.00 fee and services will be terminated.

\_\_\_\_\_ (initial here) I understand that KaraLee & Associates, P.C. has the right to charge me \$140.00 for missed appointments and cancellations with less than a 24-hour notification. Missed appointments or cancellations fees cannot be billed to my insurance company.

\_\_\_\_\_ (initial here) I understand that if I have good attendance, I may be allowed one missed appointment with documentation from a physician.

\_\_\_\_\_ (initial here) I agree that if for any reason a check is returned on my account, I will be responsible for a \$35 returned check fee in addition to the original fee(s) for service(s).

\_\_\_\_\_ (initial here) I agree to notify KaraLee & Associates, P.C. of any changes in my address, phone number, insurance, or responsible party, if applicable, prior to my next appointment.

\_\_\_\_\_ (initial here) I understand that if my balance remains unpaid for more than 90 days and/or exceeds \$200, KaraLee & Associates, P.C. may refer my account to a collection agency, and future services may be withheld.

\_\_\_\_\_ (initial here) I understand that I am financially responsible for services provided, whether or not paid for by insurance. Any service charges which are not covered by my insurance provider are my responsibility. Detailed fees for service are listed on the following page.

\_\_\_\_\_ (initial here) I acknowledge that I have the right to receive a "Good Faith Estimate" if I am not using insurance to pay for my service.



**ATTENDANCE AND FINANCIAL POLICIES (CONTINUED)**

<b>Potential Fees Incurred by Patient</b>	<b>Fee Associated</b>
<b>Records Request</b> (legal, insurance or personal use)	Base Fee: \$28.92 plus:
	Pages 1-20: \$1.45 per page
	Pages 21-50: \$0.72 per page
	Pages 51+: \$0.29 per page
<b>Records Request</b> (continuation of care, records faxed to another medical office only)	Free of Charge
<b>Paperwork/Forms to be Completed by Clinician or Psychiatrist</b> <b>(short/long-term disability, FMLA, worker's compensation)</b>  <b>Fees determined by time needed to complete:</b>	Fee determined by time needed to complete: 15 minutes: \$62.50 30 minutes: \$125.00 45 minutes: \$187.50 60 minutes: \$250.00
<b>Letters to be Written by Clinician or Psychiatrist</b> (disability, probation, for school, for lawyer)	\$60.00
<b>Cancellation of Appointment with Clinician or Psychiatrist</b> (less than 24 hour notice given)	\$140.00
<b>Private Pay Clients</b> (no insurance or insurance not used)	Clinicians - Initial Appointment: \$210.00
	Clinicians - Subsequent Appointments: \$140.00
	Psychiatrist - Initial Appointment: \$250.00
	Psychiatrist - Medication Reviews: \$85.00

**PATIENT/GUARDIAN SIGNATURE**

**DATE**



**ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

I, \_\_\_\_\_ agree to arrange a payment plan with my provider  
(print name here)  
to continue services in the event that my insurance coverage lapses or does not cover services rendered. I understand that an Advanced Beneficiary Notice Form (below) must be filled out prior to continuing services.

**REASON FOR ADVANCED BENEFICIARY NOTICE  
(Patient/Guardian is responsible for any or all of the following reasons)**

- 1. Maximum visits per insurance contract have been reached.
- 2. Client is insured by straight Medicaid.
- 3. Deductible, copay, coinsurance not eligible for secondary insurance payment.
- 4. No-show or Late Cancel with therapist / psychiatrist / nurse practitioner.

**Amount of Payment Responsibility**

Doctor/Nurse Practitioner Evaluation = \$250; Medication Review = \$85; Clinician Initial Session = \$210;  
Clinician Subsequent Sessions = \$140; No-Show / Late Cancel = \$140

I agree that I am the responsible party and KaraLee & Associates, P.C. may ask for payment at the time services are rendered. By signing below, I understand that in the event that my insurance does not pay for mental health services, I agree to pay the amount due for services.

**Patient/ Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

***ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES***

I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Privacy Practices is available to me upon request.

\_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

**DATE**

***CONSENT FOR TREATMENT***

I hereby consent to receive treatment for therapeutic/psychological services through KaraLee & Associates, PC.

\_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

**DATE**

***COMPLIANCE WITH CLINIC REQUIREMENTS***

I hereby acknowledge an understanding of KaraLee and Associates, P.C. requirements. It is required to engage in ongoing therapy in order to maintain appointments with the psychiatrist / nurse practitioner.

\_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

**DATE**

***UNDERSTANDING OF LEGAL PARTICIPATION***

I hereby acknowledge the legal participation limits of KaraLee and Associates, PC. Therapists and Psychiatrists do not participate in custody proceedings, custody assessments, or court hearings.

\_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

**DATE**

**OFFICE USE ONLY:**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other (please explain):



**COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN**  
**\*\*NOT A REQUEST FOR RECORDS\*\***

Patient Name:

DOB:

Authorize

Do Not Authorize

The release of any information to my physician by KaraLee & Associates, P.C.

Physician Name:

Phone #:

Fax #:

Address:

City:

State:

Zip:

To exchange information regarding mental/health/substance abuse treatment. The information exchanged may include diagnosis, medications prescribed and/or any medical concerns related to care. The purpose of this disclosure is for the coordination of care between KaraLee & Associates, P.C. and my physician. This release expires upon termination of my treatment with KaraLee & Associates, P.C. or upon my written request.

Patient/Guardian Signature:

Date:

**\*OFFICE USE ONLY\***

Date Admitted/Assessed:

Diagnosis:

TYPE OF TREATMENT		FREQUENCY		
<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group <input type="checkbox"/> Testing Only <input type="checkbox"/> Referred out		<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly		
<input type="checkbox"/> Referral provided to:				
Medical Concerns (if any):				

Signature of Clinician:

Date:



## Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Biological Sex:  Male  Female

Relationship with the child: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions (to the parent or guardian of child):** The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during **THE PAST TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
During the past <b>TWO (2) WEEKS</b> , how much (or how often) has your child...							
I.	1. Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2. Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3. Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5. Had less fun doing things than he/she used to?	0	1	2	3	4	
	6. Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7. Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8. Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9. Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10. Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11. Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12. Not been able to stop worrying?	0	1	2	3	4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14. Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15. Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
	In the past <b>TWO (2) WEEKS</b> , has your child ...						
XI.	20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
XII.	24. In the past <b>TWO (2) WEEKS</b> , has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	25. Has he/she EVER tried to kill himself/herself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			

Copyright © 2013 American Psychiatric Association. All Rights Reserved. This material can be reproduced without permission by researchers and by clinicians for use with their patients.

**PERSONAL HISTORY**

**Why has child/adolescent come into treatment?**

**What would the child/adolescent like to accomplish by coming to KaraLee & Associates, P.C.?**

**SUICIDE & SELF-HARM**

(circle or check yes or no)

Have they ever thought about suicide or harming themselves?

**yes**

**no**

(If yes, describe when and how in the space provided below...)

Do they have a history of suicide attempts or self-harm?

**yes**

**no**

(If yes, describe when and how in the space provided below...)

Do they currently feel suicidal?

**yes**

**no**

(If yes, please explain in the space provided below...)

**Explain:**



## HOMICIDAL ISSUES

(circle or check yes or no)

Have they ever thought about killing or harming others?

(If yes, describe when and how in the space provided below...)

**yes**

**no**

Do they have a history of committing murder or harming others?

(If yes, describe when and how in the space provided below...)

**yes**

**no**

Do they currently feel homicidal?

(If yes, please explain in the space provided below...)

**yes**

**no**

Explain:

## TRAUMA HISTORY

**Have you experienced any of the following...**

(If answered yes to any, please explain in the space provided on the next page...)

(circle or check yes or no)

emotional abuse	<b>yes</b>	<b>no</b>
physical abuse	<b>yes</b>	<b>no</b>
sexual abuse	<b>yes</b>	<b>no</b>
emotional neglect	<b>yes</b>	<b>no</b>
physical neglect	<b>yes</b>	<b>no</b>
physical assault	<b>yes</b>	<b>no</b>
sexual assault	<b>yes</b>	<b>no</b>
crime-related events	<b>yes</b>	<b>no</b>
general disaster	<b>yes</b>	<b>no</b>



Explain (Trauma History):

### SCHOOL ADJUSTMENT

School District:

School Name:

Has the child ever been afraid to go to school?

Yes  No

Explain:

Present Grade:

Has the child repeated any grades?  Yes  No

Has he/she ever had problems with the following:  Math  Reading  Language  Speech

Has the child ever had any special education services?  Yes  No

Has the child received complaints from school regarding behavior or achievement?  Yes  No

### SOCIAL INFORMATION

Social time is usually spent:  Alone  Immediate Family  Peers

Please describe:

Does the child isolate him/herself from other people?  Yes  No

Please explain:

Does the child have a job?

Yes

No

Hours a week:

Position & Type of Work:

## ADJUSTMENT DIFFICULTIES

Please check any of the following that are typical (or historical) of the child's behavior.

<input type="checkbox"/> Feels Lonely	<input type="checkbox"/> Overactive	<input type="checkbox"/> Defiant	<input type="checkbox"/> Stealing from home	<input type="checkbox"/> Prefers to be alone
<input type="checkbox"/> Shy with children	<input type="checkbox"/> Lacks motivation	<input type="checkbox"/> Daydreams	<input type="checkbox"/> Stealing from peers	<input type="checkbox"/> Preoccupied with sex
<input type="checkbox"/> Shy with adults	<input type="checkbox"/> Sexual acting out	<input type="checkbox"/> Aggressive with...  <input type="checkbox"/> Peers <input type="checkbox"/> Siblings <input type="checkbox"/> Adults <input type="checkbox"/> Jealousy	<input type="checkbox"/> Will not admit blame	<input type="checkbox"/> Compulsive behavior
<input type="checkbox"/> Worries	<input type="checkbox"/> Poorly organized		<input type="checkbox"/> Short attention span	<input type="checkbox"/> Ritualistic behavior
<input type="checkbox"/> Moody	<input type="checkbox"/> Tics or twitches		<input type="checkbox"/> Bedwetting - present	<input type="checkbox"/> Talks impulsively
<input type="checkbox"/> Sad	<input type="checkbox"/> Feelings of guilt		<input type="checkbox"/> Bedwetting - past	<input type="checkbox"/> Unusual behavior
<input type="checkbox"/> Cries easily	<input type="checkbox"/> Clumsy		<input type="checkbox"/> Soils self	<input type="checkbox"/> Unusual thinking
<input type="checkbox"/> Expects failure	<input type="checkbox"/> Sets fires		<input type="checkbox"/> Fails to understand consequences	<input type="checkbox"/> Violent behavior
<input type="checkbox"/> Does not share	<input type="checkbox"/> Destructive		<input type="checkbox"/> Not always truthful	<input type="checkbox"/> Exploitation

## BIRTH & DEVELOPMENT

Normal Pregnancy?     Yes    No

Complications?     Yes    No

Length of Labor:

Premature?    Yes    No

Weeks/Weight:

Newborn's Health:

Please check all that apply...

<input type="checkbox"/> Colic	<input type="checkbox"/> Overactive	<input type="checkbox"/> Constipation
<input type="checkbox"/> Eating Issues	<input type="checkbox"/> Underactive	<input type="checkbox"/> Chronic Illness
<input type="checkbox"/> Sleeping Issues	<input type="checkbox"/> Infections	<input type="checkbox"/> High fevers
<input type="checkbox"/> Milk or food allergies	<input type="checkbox"/> Fussy	<input type="checkbox"/> Hospitalization

## EARLY CHILDHOOD

Indicate age started...

Single words: \_\_\_\_\_ months

Sentences: \_\_\_\_\_ months

Walking: \_\_\_\_\_ months

Began Toilet Training: \_\_\_\_\_ months

Ending Toilet Training: \_\_\_\_\_ months

Knew colors: \_\_\_\_\_ months



## CURRENT GENERAL HEALTH STATUS

Name of Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Are the child's immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the child ever have an eye exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did the child ever have a hearing exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last physical exam: _____	Results: _____

What is the present health of the child?

Excellent  Very Good  Good  Fair  Poor  Very Poor

## NUTRITIONAL SCREENING

Has the child gained weight in the last 30-60 days?  Yes  No If yes, how many pounds?

Has the child lost weight in the last 30-60 days?  Yes  No If yes, how many pounds?

Does the child have any diet or nutritional concerns?  Yes  No

## MEDICATION LOG

List prescribed or over-the-counter medication(s) or herbal supplements your child **currently** takes.

Medication	Dosage	Frequency	Prescriber

**Allergies/Side Effects:** \_\_\_\_\_

### FAMILY INFORMATION

Family Member Name	Age	Relationship to Child	Lives with child?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

### RELIGION

Mother:  Catholic  Protestant  Jewish  Muslim  Other:

Father:  Catholic  Protestant  Jewish  Muslim  Other:

Does the family practice one of the parent's religions?  Yes  No

Does the child participate with this religion?  Yes  No

How important are the child's religious beliefs?  Very Important  Somewhat Important  Not Important

### ETHNIC GROUP (OPTIONAL)

Caucasian    African American/Black    Native American    Hispanic    Asian-American    Other \_\_\_\_\_

### LEGAL HISTORY

Is the child currently facing any pending charges or convictions?  No    Yes

**Explain:**

Is the child currently on probation?  No    Yes

**Explain:**

Has the child been on probation in the past?  No    Yes

**Explain:**



Has the child ever been arrested or spent time in a corrections facility?  No  Yes  
**Explain:**

Is/Has the child been a part of a divorce or custody issue?  No  Yes  
**Explain:**

Is the child adopted?  No  Yes      If adopted, have they been told?  No  Yes  
**Explain:**

### HEALTH QUESTIONNAIRE

Now	Past	Neurological	Now	Past	Disease
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	<input type="checkbox"/>	ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbance			<b>Respiratory</b>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Tics	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
		<b>Digestion</b>	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Constipation			<b>Special Senses</b>
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hearing disorder
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Visual disorder
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Speech disorder
<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting			<b>Other</b>
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Under eating	<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Pain disorder
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder

If any are checked, please explain:



### THERAPY GOALS

Please list what you hope to help your child accomplish through therapy.

1.

---

2.

---

3.

---

By signing below, I acknowledge that all legal guardians of the child have given consent for treatment. As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment, and/or psychiatric care from the professional staff associated with or employed by KaraLee & Associates, P.C. The consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification. By all the parties signing below, this will certify that all who have legal custody of the minor have given consent for the mental health treatment of the minor at KaraLee & Associates, P.C.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CLINICIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
MEDICAL DIRECTOR SIGNATURE

\_\_\_\_\_  
DATE



Tariq Abbasi, MD: Medical Director  
Andrea Nowak, MD: Consulting Psychiatrist  
Karen J. Maier, PhD, LP: Owner/Consultant  
John Kenner, LMSW, LMFT, DCSW: CEO/Clinical Director

Clinical Policy for Medication Management

**Effective Immediately**

Please be advised of our Clinic Policy for Medication Management patients. This Policy, while not new, will be strictly enforced, effective immediately.

--You will be **required** to continue therapy sessions, not less than two times a month (within 30 days of the scheduled psychiatry appointment) with **NO EXCEPTIONS.**

--If you are unable, or unwilling to commit to our policy, you will be dismissed from our Medication Management program.

Your welfare as a patient at KaraLee and Associates is of utmost importance. We value your safety during medication management, and the best way is to do that is to stay in communication with your therapist on a regular basis.

---

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

---

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

1307 South Main Street Plymouth MI 48170  
1308 South Main Street Plymouth MI 48170  
1365 South Main Street Plymouth MI 48170  
OFC: (734) 451-3440 FAX: (734) 451-8720  
[www.karaleeandassociates.com](http://www.karaleeandassociates.com)  
Accredited by the Joint Commission







Tariq Abbasi, MD: Medical Director  
Andrea Nowak, MD: Consulting Psychiatrist  
Karen J. Maier, PhD, LP: Owner/Consultant  
John Kenner, LMSW, LMFT, DCSW: CEO

## INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

### **Benefits and Risks of Telepsychology**

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

### **Electronic Communications**

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

### **Confidentiality**

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

### **Appropriateness of Telepsychology**

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

### **Emergencies and Technology**

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call KaraLee & Associates, PC at (734) 451-3440, so that the office staff can help you connect with me.

### **Fees**

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, **you will be solely responsible for the entire fee of the session.** Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

### **Records**

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

### **Informed Consent**

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date