CHILD PROBLEM SCREENING FORM

Child's name: _____Child's date of birth:_____ Age: _____Rater's name: _____

Relationship to Child: _____ Today's date: _____

Directions: Below is a list of ways that children may act, think, or feel. Please (1) circle the number showing how often your child has behaved this way in the past 3 months and (2) circle "Yes" if it is currently a problem or "No" if it is not a problem.

	How Often Does This Occur?					Is This A Problem Now?	
	Never	Seldom	Sometimes	Often	Always		
Argues with others	1	2	3	4	5	Yes	No
Can't concentrate/pay attention	1	2	3	4	5		
Acts sad or depressed	1	2	3	4	5		
Feeding/eating problems	1	2	3	4	5		
Teases or fights wth others	1	2	3	4	5		
Is teased	1	2	3	4	5		
Appears lonely	1	2	3	4	5		
Can't sit still/hyperactive	1	2	3	4	5		
Too fearful or anxious	1	2	3	4	5		
Disobeys at home	1	2	3	4	5		
Disobeys at school	1	2	3	4	5		
Moody	1	2	3	4	5		
School Academic Problems	1	2	3	4	5		
Temper tantrums/hot temper	1	2	3	4	5		
Impulsive/acts without thinking	1	2	3	4	5		
Threatens/tries to hurt others	1	2	3	4	5		
Low self esteem	1	2	3	4	5		
Toilet problems/wetting/soiling	1	2	3	4	5		
self-conscious/embarrassed	1	2	3	4	5		
Perfectionistic	1	2	3	4	5		
Threatens/tries to hurt animals	1	2	3	4	5		
treatens/tries to hurt self	1	2	3	4	5		

Philip R. Budd, Psy.D.

Address: 2216 Shadowlake Dr Phone: 405-990-8204
Oklahoma City, OK 73159

GENERAL CONSENT FOR TREATMENT FOR CHILDREN AND ADOLESCENTS

_____Client's Name _____Therapist's Name

1. All clinic files are confidential and my written consent is required for any release of information by the clinic to any other persons outside the clinic except in the following circumstances: (a) court orders and subpoenas, (b) to defend legal action against the clinc, (c) need to prevent clients from harming him/herself or others, and (d) suspected child abuse/neglect. If you request that the clinic submit reimbursement forms for your insurance, complete confidentiality cannot be agreed. If you file a lawsuit related to mental health issues, clinic records may also be accessed by the court.

2. Your child's willingness and ability to use counseling depend a great deal on the confidentiality he/she is allowed to maintain in the therapeutic setting. While I have the right to access my child's file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my child's therapist about any questions I have concerning the content of my child's file or sessions.

3. I may be asked to sign consent forms for the release of social, medical, and/or psychological information from other agencies or individuals for the use by the staff of this clinic in my child's/my own assessment or treatment. I may request restrictions on the use/disclosure of information in my child's file for treatment, payment and health care operations purposes, but the therapist is not bound to agree with my request.

4. I understand that it is impossible to assure privacy of any communication by electronic means (email, text or faxes). Email or text message should never be used to communicate any urgent matter to the clinic.

5. Information from clients' files may be compiled to study various issues such as treatment outcomes and client satisfaction. My child's name or any identifying information will not be used in such research.

6. The clinic is open Monday through Saturday. My therapist and I will set appointments. For after-hours emergencies, I should call 911.

7. The practice of psychology and related disciplines is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatments, assessments, and consultations. I understand that I am responsible for working with my child's therapist to help ensure better treatment outcomes.

8. Dr. Budd is not a medical doctors; therefore he does not prescribe medications and is not authorized to practice medicine. If Dr. Budd thinks that my child should consider medication as a part of treatment, and I want to try this, Dr. Budd will refer us to a physician with whom he would work to provide coordinated services. I understand that psychological problems can have medical or biological origins and my child should have regular physical exams and speak with the doctor about all his/her symptoms.

9. I consent for myself and/or my child to undergo all testing and treatment procedures necessary to address the problems for which I am seeking help. I understand that I have the right to be informed of the nature and purpose of any procedure and that I can refuse or discontinue testing or treatment at any time.

10. I understand I am responsible for any fees for services to which I consent, and that failing to pay such fees may result in the termination of any further services to me. Payment is due at the beginning of my appointment. I must cancel at least 24 hours before my session, unless my therapist and I both agree my cancellation was due to an emergency, or I am responsible for the session fee before I can schedule a new session. Continued non-payment of fees may result in action including being referred to a collection agency.

11. I understand that special arrangements may need to be made regarding payment and reporting of assessment and treatment results in cases of divorce, foster care, and court-mandated services.

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CONSENT FOR TREATMENT SIGNATURE PAGE FOR CHILDREN AND ADOLESCENTS

Client Initials

Therapy sessions and file information are confidential. ____

Except in cases of: (a) court orders/subpoenas, (b) to defend legal action against the therapis, (c) need to prevent harm to self or others, and (d) suspected child abuse/neglect. Third party billing and lawsuits I bring related to mental health issues may also limit the confidentiality of my child's file.

There are some limitations to my access to my child's file. _____

I understand that confidentiality is very important to my child's ability to use therapy. While I have the right to access my child's file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my child's therapist about any questions I have concerning the content of my child's file or sessions.

I must sign release forms before information can be exchanged with other agencies. _____

The privacy of any electronic communication cannot be assured. Do not use email for urgent matters. I may request restrictions on the use/disclosure of information in my child's chart for treatment, payment and health care operations, but the therapist is not bound to agree with my request.

Some information from my child's file may be used in research. ____

I understand that names or any other identifying information will not be used in research.

Dr. Budd does not provide after-hours or emergency services (use 911 for after-hours crises). Contact 911 or go to ER ____

The practice of psychology and related disciplines is not an exact science. ____

No guarantees have been made to me regarding the results of Dr. Budd's services. We are responsible for working with our therapist to help ensure better treatment outcomes.

Dr. Budd is not a medical doctors and cannot prescribe medications. I consent to undergo all recommended testing and treatment procedures. ____

I can refuse or discontinue testing or treatment for myself or my child at any time.

I agree to pay my clinic bill. Payment is due at the beginning of sessions and I must cancel at least 24 hours before my session or I am responsible for the cost of the session. _____

Consequences of non-payment may include termination of services or being referred to a collection agency.

Special payment/reporting arrangements may be made in cases of divorce, foster care, litigation and court- mandated services. ____

I acknowledge that my therapist has reviewed the General Consent for Treatment with me and I have been given a copy to keep for my own records. _____

_____ Signature of Therapist or Witness

Date: _____

_____Signature of Guardian/Legal Representative

_____Printed Name of Guardian/Legal Represent.

_____ Signature of Child or Adolescent

Date: _____

PARENT QUESTIONNAIRE

Date _____Form Completed by _____
Relation to Child _____ Child's Name _____
M__ F __ Birthdate _____ Ethnicity _____
Address

_____
Home Phone _____

Work Phone (mother) _____ (father) _____
Child's Primary Physician _____Physician Phone _____

Insurance Company _____ Insurance through_____

Who referred the child? _____

Address _____

FAMILY

Father's Name _____Birthdate _____
Address (if different from above)

_____
Occupation _____ Educational level _____

# of dependents _____

Mother's Name _____Birthdate _____
Address (if different from above)

_____
Occupation _____ Educational level _____

# of dependents _____
Date of Marriage _____ Present Marital Status _____

If parents divorced, who has custody? _____ (Provide court order)

With whom does the child live? Birth parents_____
Adoptive Parents _____

Foster Parents _____ Other (specify) _____
List all other persons living in the home:

Name

_____
_____
_____
List any other people who care for the child a significant amount of time

_____

Name _____ _____

Relationship to Child _____ _____

Relationship to child (grandmother, neighbor, etc.)

_____
_____

Age _____ _____ _____

CHILD

Pregnancy and Birth: Any Complications? _____ If yes, briefly explain

_____ _____
At what age did your child:
Sit Without Support _____ Walk _____ Begin Talking _____

Stay Dry Through the Night ____

Has your child had any medical complications? _____ If yes, briefly explain _____

_____
_____

Please list any jobs or chores your child has at home or school.

(e.g., feeding the dog, making the bed, safety patrol)

_____

How well does your child do these chores? _____

What are your child's strengths?

_____

How many close friends does your child have? _____

How many times a week does your child do things with them? _____

How many friends in the neighborhood does your child have?

None ____1____2-3 ____4 + ____

Compared to other children his/her age, how well does your child get along with other children?

Poor Average Great

1 2 3 4 5

What are your child's favorite play or after school activities?

_____ _____

FAMILY AND PERSONAL HEALTH HISTORY

Date of Last Physical Examination _____

Child's Height _____ Child's Weight _____

Check condition and relationship of any blood relative who has or has had any of the conditions listed below

Alcoholism/Substance Abuse _____

Allergies _____

Birth Defects _____

Cancer _____

Colitis _____

Depression _____

Heart Attack _____

High Blood Pressure _____

Migraine _____

Mental Illness _____

Seizure Disorder _____

Mental Retardation _____

Learning/Attention Problems Suicide/Suicide Attempt Other (Specify)

_____

DISCIPLINARY STRATEGIES

Who generally disciplines the child?

_____

What methods are used?

_____

Are these methods effective?

_____

Do parents agree on methods of discipline? _____ Elaborate, if no

_____ _____

SCHOOL HISTORY

Child being seen _____

Father _____

Paternal grandfather _____

Paternal grandmother _____

Paternal aunt/ uncle _____

Mother _____

Maternal grandfather _____

Maternal grandmother _____

Maternal aunt/ uncle _____

Siblings _____

Has child been enrolled in nursery or day care? _____At what age? ___

Has child attended kindergarten? _____At what age? _____

Has child begun elementary school? _____At what age? _____

Present grade and school _____

Does not go to school_____

If your child has ever been to school (including nursery, kindergarten and grade school) complete the following for all classes beginning with nursery and ending with current placement. Please indicate if your child is in a special class (gifted, learning disabled, emotionally handicapped, etc.)

School _____ _____
_____ _____

Comments Regarding Behavior/Adjustment

_____
_____
_____
_____

Current School Performance (for children aged 6 and older)

Indicate if failing, below average, average, above average, excelling_____ _____ _____ _____

(History/Geography, etc.) _____ _____
Writing _____
Arithmetic or Math _____
Spelling
Other Academic Subjects (science, foreign language,etc)_____ _____ _____

PARENTAL CONCERNS

What do you feel is your child's main problem?

_____
_____
_____
_____
_____

What do you feel caused your child's problem?

_____
_____
_____
_____
_____

What have you been told by doctors, teachers, and/or others about your child's problems?

_____
_____

Has this child had any other mental health evaluations or treatment?

Has any member of the child's immediate family had mental health treatment? _____

Other comments

May we contact the child's primary physician?

To receive information _____ To give information _____

_____ (Signed) Parent or Guardian

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Agreement to Pay for Professional Services

I, the client (or guardian/legal representative), request that the therapist named below provide professional services to me or to _____ , who is my _____, and I agree to pay this therapist's fee of $ 150 per 45/50 minute session.and $160 for the initial evaluation. This same fee will be applied per each hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing. Fees for legal issues may be substantially different and should be clarified.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I understand that if I do not pay for services that the services provided may be terminated by the therapist. Continued non-payment of fees may result in further consequences such as my case being referred to a collection agency.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. If my any part of my fees is being paid by an insurance company or other third party payer, I understand that this may result in limitations to my confidentiality.

_____ _____ Signature of client (or person acting for client) Date

_____ Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ Signature of therapist Date

____Copy accepted by client ___ Copy kept by therapist

CONFIDENTIALITY NOTICE

This notice talks about **privacy information**. This is nothing new. We've always taken great care to safeguard your privacy. What is new is a government regulation requiring us to explain your rights.

This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. In the event that the notice is changed, a new notice will be sent to you by mail or at the time of your next appointment. You may request a copy of our Notice at any time.

This notice takes effect April 14, 2003, and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment by signing the consent form, this agency will use or disclose your protected health information as described below.

Treatment: We may use and disclose, as needed, your protected health information to provide, coordinate, or manage your health care and any related services.

Health Operations: We may use and disclose, as needed, your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to the Department of Human Services which is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the Department of Human Services. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose your protected health information in the course of any judicial, or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights

Access: You have the right to inspect and copy your protected health information. We will use the format your request unless we cannot practicably do so. You must submit your request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If your request copies, we will charge you $1.00 for the first page, and $.25 each page thereafter to locate and copy your health information plus postage if you want the copies mailed to you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request a restriction of your protected health information. You may also request that any part of your protected health information not be disclosed by family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions we will be able to abide by our agreement (except in an emergency).

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Alternative Communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make your request in writing.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for you amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment or healthcare operations as described in this Notice of Privacy Practices.

Notice: You have the right to obtain a paper copy of this notice from us upon request.

Questions and Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You may contact our Privacy Officer below for further information about the complaint process.

Attn:

Philip R. Budd, PsyD

Address: 2216 Shadowlake Dr
Oklahoma City, OK 73159

Phone: 405-990-8204

Revised 08/18/16

I have read and received a copy of the Notice of Privacy Policy.

_____ Client's signature

_____ Date