Today's Date / / Dr. Sheinberg Amy L. Sheinberg, Ph.D.

PATIENT INFORMATION-MINOR

Child's Name _____ Date of Birth ___/___/___
Last First M.I.

Home Address _____
Street City State Zip Code

Appointment reminders are sent via email. Print email address(es) for reminders and other health care info.

Email (Parents/Guardians) _____

Email (Parents/Guardians) _____

Email (Child, if applicable) _____

Phone (Parent/Guardian) _____ Phone (Parent/Guardian) _____

Phone (Child, if applicable) _____ Phone (Other) _____

Bio Sex M F Gender Identification _____ Preferred pronouns _____

School and Grade Level _____

Race African American Asian Caucasian Hispanic Native American Other

Person to notify in case of emergency _____ Relationship to patient _____

Address _____ Phone _____
Street City State Zip Code

REFERRAL INFORMATION

Referred by _____

GUARANTOR INFORMATION (where Encounter Foms will be sent, if different from above)

Name _____ Relationship to patient _____

Address _____
Street City State Zip Code

Home Phone _____ Email _____

CONSENT FOR TREATMENT

GENERAL CONSENT FOR TREATMENT:

I authorize and request that Dr. Sheinberg carry out diagnostic procedures, psychological exams, and therapeutic treatment, which may be required at the time or during my child's treatment. I understand that the purpose of these procedures and recommendations will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my child's treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my child's treatment. Furthermore, this process may bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand this is a normal response to feeling better, and Dr. Sheinberg will help my child work through this. The success of our work depends on the quality of the efforts on both parts and the realization that I, as the parent or legal guardian, am responsible for lifestyle choices/changes that may result from therapy.

I am aware that I may stop my child's treatment with Dr. Sheinberg at any time. The only thing I will still be responsible for is paying for the services I have already received. In the event of this decision, Dr. Sheinberg requests that arrangements be made for a proper goodbye and feedback session.

I understand that I may lose other services or have to deal with other problems if I stop treatment (for example, if my treatment has been court-ordered, I will have to answer the court).

I am the parent, legal guardian, or representative of the minor child and, on the child's behalf, legally authorize Dr. Sheinberg to deliver mental healthcare services to the minor child.

I understand that all policies described in this statement apply to the minor child I represent.

Signature of Parent/Legal Guardian/Conservator _____ **Date** _____

Signature of Parent/Legal Guardian/Conservator _____ **Date** _____

Amy L. Sheinberg, Ph.D. _____ **Date** _____

CONSENT FOR TREATMENT OF CHILD OR DEPENDENT OF DIVORCED PARENTS: **Initial here if not applicable** _____

Psychotherapy can be a vital resource for children of separation and divorce. Establishing a therapeutic alliance outside of the home can:

- Facilitate open and appropriate expression of the strong feelings that routinely accompany family transitions, including guilt, grief, sadness, and anger
- Provide an emotionally neutral setting in which children can explore these feelings. Help children understand and accept the new family composition and the plans for contact with each family member.
- Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities

However, such therapy's usefulness is minimal when it becomes simply another matter of dispute between parents. With this in mind, and to best help your child, I strongly recommend that each child's caregivers (e.g., parents, step-parents, day-care workers, Guardian Ad Litem [GAL]) mutually accept the following as requisites to participate in therapy.

1. As your child's psychologist, I am responsible for responding to your child's emotional needs. This includes but is not limited to, contact with your child and each of his or her caregivers and gathering information relevant to understanding your child's welfare and circumstances as perceived by essential others (e.g., pediatricians, teachers). In some cases, this may include a recommendation to consult with a physician should your child's physical health be relevant to this therapy.

2. I ask that all caregivers frequently communicate regarding this child's welfare and emotional well-being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite you to initiate frequent and honest exchanges with me as your child's therapist.

3. I ask that all parties recognize and, as necessary, reaffirm to the child that I am the child's helper and not allied with any disputing party.

4. Caregivers involved choose to participate in The Guardian Angels psycho-educational groups and/or read the book Mom's House, Dad's House: Making Two Homes For Your Child by Isolina Ricci. Resources that help separating and divorced parents learn basic strategies for conducting a separation and divorce on behalf of the child(ren).

5. Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child in these circumstances:

   - I keep records of all contacts relevant to your child's well-being. These records are subject to court subpoena and may, under some circumstanes, be solicited by parties to your divorce, including your attorneys.
   - Any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Issues brought to my attention that are irrelevant to the child's welfare may be kept in confidence.
   - I am legally obligated to inform relevant authorities of any health and safety concerns. Should this necessity arise, I will advise all parties regarding my concerns.

6. This psychotherapy will not yield recommendations about custody. In general, I recommend that disputing custody parties strongly consider participating in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than trying to settle a custody dispute in court.

7. Payment for my services is due in full at the time of service in a manner agreed to by all parties involved. Any outstanding balance accrued (for example, in conferences with attorneys, the GAL, or teachers) must be paid promptly and in full. I ask for a credit card to be kept on file from each parent, even though one parent may assume liability. This is done to cover any expenses the non-liable parent makes, such as individual feedback sessions.

Before starting this therapy, your understanding of these seven points and agreement may resolve difficulties that would otherwise arise and will help make this therapy successful. Your signature below signifies that you have read and accepted these points.

Relation to minor _____ Signature _____ Printed name _____ Date _____

Relation to minor _____ Signature _____ Printed name _____ Date _____

Relation to minor _____ Signature _____ Printed name _____ Date _____

Relation to minor _____ Signature _____ Printed name _____ Date _____

Minor's name (printed) _____ Date of birth _____ Age _____

Signature of Amy L. Sheinberg, Ph.D. _____ Date _____

CONDITIONS OF SERVICES

Initial

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for diagnosis, treatment, consultation, and professional communication where appropriate and only when specified by a signed release of information form (see attached form).

Initial

AUTHORIZATION TO RELEASE INFORMATION TO THE INSURANCE COMPANY: I authorize the release of information to the assigned insurance company for claims, certification, case management, quality improvement, benefits administration, and other purposes related to my health plan.

Initial

ASSIGNMENT OF INSURANCE BENEFITS: Dr. Sheinberg is not on any insurance panels and does not accept the assignment of insurance benefits. This helps focus more on direct clinical care. Dr. Sheinberg is classified as an "Out-of-Network" provider regarding insurance. I can request documentation ("an Encounter Form" or Superbill) to seek reimbursement from my insurance provider for Out-of-Network services. All information the insurance company needs is on the "Encounter Form."

FINANCIAL AGREEMENT, CO-PAYMENTS, AND OFFICE POLICIES

Initial

I will provide a credit card and HSA card (if applicable) available to photocopy for Dr. Sheinberg's records that will be charged at the time of my appointment or if I do not cancel within 2 business days/48 hours up till noon on Fridays. I understand that my charges are my responsibility.

Initial

I will immediately notify Dr. Sheinberg or the office staff of any changes in my address, phone numbers, email, and payment information. I understand that the business office may contact me if my form of payment is no longer working.

Initial

I understand that I am responsible for obtaining prior authorization for treatment from my insurance carrier if necessary. If I have yet to do so before treatment is rendered, I am aware that my insurance may not reimburse me.

Initial

If I choose to file for my insurance benefits, I must verify and obtain authorization for services unless otherwise specified. If my insurance benefits are managed by a managed care organization (MCO), they can refuse to allow Dr. Sheinberg to treat me. The MCO can refuse to pay for any of my treatments or may pay only a tiny part of its cost. Furthermore, it can limit the kinds of treatments provided to me. Even if the MCO gives the go-ahead, I understand that it can limit the number of times I meet with Dr. Sheinberg and may have a maximum dollar amount or a set number of appointments allowed for therapy. I understand that the MCO is not obligated to use all these appointments.

Initial

If my account with Dr. Sheinberg is delinquent and arrangements have yet to be made for a payment plan, Dr. Sheinberg may use legal means to get paid. The only information Dr. Sheinberg will give to the court, a collection agency, or a lawyer will be my name and address, the dates we met for professional services, and the amount due to Dr. Sheinberg.

Initial

I understand that payment is due at the time of service. Dr. Sheinberg accepts cash, personal checks, and major credit cards. The charge for a returned check is equal to the bank fee. When an NSF check is returned to Dr. Sheinberg, the office policy states that the patient can no longer write checks to Dr. Sheinberg. Cash, Venmo, Zelle, or major credit cards will be accepted as an alternative unless other arrangements are made with Dr. Sheinberg.

Initial

PLEASE NOTE: Sessions over the allotted time (forty-five minutes) will be prorated according to her fee schedule. If I am late to my appointment, the session will end at the original end time. If Dr. Sheinberg is running late, I will still get the 45-minute session. I can arrange to have a shorter appointment at a prorated rate, or Dr. Sheinberg and I can agree to reschedule the appointment.

APPEALS AND GRIEVANCES

Initial

My insurance company does not delegate appeals and/or grievances to my practitioner. If my outpatient visits are denied certification, I acknowledge my right to request reconsideration (an appeal). I understand that I could request an appeal through my insurance company and risk nothing in exercising this right. I can request assistance from my practitioner should my insurance company require further information.

Initial

I understand that I may submit a complaint or grievance to Dr. Sheinberg at any time to register a complaint about my care. I hope any concerns are first addressed with Dr. Sheinberg to reconcile any differences. I may also send the complaint directly to the appropriate governing board.

OFFICE USE ONLY

Dr. Sheinberg Initial _____ Date: _____

THERAPEUTIC RELATIONSHIP

Initial

My relationship with Dr. Sheinberg is professional and therapeutic. To preserve this relationship, it is imperative that Dr. Sheinberg not have any other type of relationship with me. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Dr. Sheinberg's care is about helping my child but cannot be my friend or have a social or personal relationship with me. Gifts, bartering, or trading services are inappropriate and should not be shared between Dr. Sheinberg and me.

TERMINATION POLICY

Initial

Termination is a critical phase of treatment that helps prepare patients to build on the gains and move forward positively after treatment ends. This crucial phase of treatment may be conceptualized from a range of perspectives, and it may stimulate several essential themes and issues to work through and address before treatment ends. If possible, treatment endings should not come as a surprise. Dr. Sheinberg will work collaboratively with me and my child toward a successful treatment ending. Termination should be considered a process and not an event. It should be seen as a phase of each patient's treatment that is worked together. Because she works with her patients on a long-term basis, sometimes intermittently, the termination process in those cases is adjusted to consider this. However, much of what is written here does apply to all patients seen.

Initial

There must first be an agreement on treatment goals to know when treatment should end. While treatment goals may be modified over the course of treatment as patients make progress and life circumstances change, failure to have an open discussion of goals from the outset and failure to reach agreement on what these goals are impacts the nature, focus, and scope of the treatment offered as well as when and how this treatment will end. Knowing from the outset how treatment will end can be vital for patients to decide about participation in the proposed course of treatment. To meet Dr. Sheinberg's ethical obligations, she may need to end your treatment if you are not benefitting from treatment, if inappropriate multiple relationships develop or are discovered, or if you no longer possess the competence necessary to meet your treatment needs. You may initiate termination for a variety of reasons. These may include financial hardships, dissatisfaction with Dr. Sheinberg or how the treatment is proceeding. While each of these cannot be anticipated from the outset of treatment, open discussions with the patient's parents about their progress in treatment and any issues that may impact their ability to continue should be explored and addressed periodically. Dr. Sheinberg will attempt to accommodate these unexpected situations.

Initial

Differentiating between abandonment and termination is essential. Abandonment occurs when Dr. Sheinberg does not appropriately meet a patient's ongoing treatment needs. Abandonment may occur when treatment endings are mismanaged and the patient's ongoing treatment needs are not adequately addressed. The latter may include failure to make needed coverage arrangements during periods of anticipated absence, such as vacations, attending a conference, or other times when patient access to the practitioner may be limited. Abandonment charges may even arise from not being sufficiently accessible between regularly scheduled treatment sessions.

Reasonable expectations must be established from the outset, with patients being provided with information on how to access the practitioner between sessions, when it is or is not appropriate to contact Dr. Sheinberg and the preferred means of contact. Realistic expectations should be established for Dr. Sheinberg's responsiveness outside of my session and when others should be contacted, such as calling 911 in emergencies. It is not abandonment when a patient drops out of treatment precipitously or does not fulfill treatment obligations. Nor is it abandonment if the patient cooperates with treatment recommendations and ends treatment appropriately, after discussion, with notice, and referrals being made. These actions may not be necessary when Dr. Sheinberg is threatened or assaulted. She has obligations articulated in the informed consent agreement and/or treatment contract. When continued treatment is not possible or not indicated based on a patient's actions and responses, ending the treatment is not seen as abandonment. Dr. Sheinberg will document all such situations, discussions, consultations with colleagues, steps taken, and any efforts to contact the patient if treatment ends abruptly and/or precipitously.

Initial

How the psychotherapy relationship begins and ends has important implications for the patient. Addressing endings from the beginning and on an ongoing basis throughout treatment can help ensure that treatment is provided and ended ethically and clinically competently, discouraging any termination solely involving using correspondence, phone calls, email, texts. Chronically missed appointments and/or avoidance of any attempts to contact Dr. Sheinberg, Dr. Sheinberg may contact me with her concerns, which can result in her referring me elsewhere.

Initial

All endings must be done in person.

OFFICE HOURS AND AFTER-HOURS EMERGENCIES

Initial

Office hours (subject to change) are Monday -Thursday, 7 a.m.- 6 p.m. Call 911 or go to your nearest emergency center if medical or psychiatric emergencies occur after hours. Dr. Sheinberg will also provide after-hours emergency only contact information to reach her directly.

Initial

I understand that I am subject to a charge if I contact Dr. Sheinberg outside my scheduled appointment, except to confirm an appointment. This includes time spent on phone calls, emails, or texts. Dr. Sheinberg's policy is that emails and texts are transactional in nature and not clinical.

OFFICE USE ONLY

Dr. Sheinberg Initial _____ Date: _____

APPOINTMENTS

Initial Dr. Sheinberg has an individual policy regarding reminder calls, emails, or texts. However, the parent or guardian is responsible for remembering their appointment time and day, whether a confirmation call, email, or text is placed.

Initial I consent to Dr. Sheinberg or an office staff member leaving me a voicemail, email, text, or message should they not reach me directly. Only information about dates and times of appointments will be sent. Clinical information will not be exchanged through these communications.

Initial I understand that I am responsible for remembering my appointment date and time. If an appointment is missed or canceled with less than two (2) business days/48 hours up till noon on Fridays (or by corresponding appointment time on Thursday if the appointment is on Monday), I may be billed according to Dr. Sheinberg's fee schedule. Insurance may not be billed for these late cancelations or no-shows. Repeated no-show appointments will be addressed and could result in referring me to another practitioner.

Initial Dr. Sheinberg's commitment to her patients is evident in her efforts to accommodate their needs. Due to the nature of her work, she does not intentionally double book or accept walk-ins, but she makes every attempt to fill late canceled appointments. If I wish to avoid a charge for a missed appointment, I can request a virtual session. It's reassuring that Dr. Sheinberg values my time and will do her best to accommodate me.

Initial Therapy sessions are generally 45 minutes long. Dr. Sheinberg will discuss the length of the session and a fee schedule. The number of sessions needed depends on many factors, including designated goals, and will be addressed by Dr. Sheinberg.

Initial Because schedules change unexpectedly, you may occasionally be asked to switch days/times. Your original appointment will be held until you confirm one way or another about the possible change

.

IN CASE OF YOUR PRACTITIONER'S DISABILITY OR DEATH

Initial In keeping with our focus on your best interests, Dr. Sheinberg has made plans for all eventualities by making advanced arrangements to help ensure that I am not abandoned during treatment. Dr. Sheinberg has in place a professional, an identified colleague who will have access to patient contact information and records and contact patients in the case of Dr. Sheinberg's death or disability. The appointed professional will assess ongoing treatment needs and assist with crisis intervention and referrals to other clinicians. Should this be needed without warning, Dr. Sheinberg's office staff and appointed colleague will work together to ensure all the necessary information is provided from Dr. Sheinberg as soon as possible to inform, provide support, and make appropriate referrals.

OFFICE USE ONLY

Dr. Sheinberg Initial _____ Date: _____

CONFIDENTIALITY

Dr. Sheinberg will treat what you tell her with professionalism and care. Her professional ethics (that is, her profession's rules about moral matters) and the laws of this state prevent her from telling anyone else what you tell her unless you give her written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about, in other words, the "confidentiality" of therapy. But she cannot promise that everything you tell her will never be revealed to someone else. There are some times when the law requires her to tell things to others. There are also some other limits on her confidentiality. She will discuss these, because she wants you to understand clearly what she can and cannot keep confidential. You need to know about these rules now, so that you don't tell her something as a "secret" that she cannot keep secret.

1. **When the patient or other persons are in physical danger**, the law requires her to tell others about it. Specifically:

   a. If she comes to believe that the patient is threatening serious harm to another person, Texas state law does not require her to try to protect that person. However, hospitalization may be considered for the patient.

   b. If the patient seriously threatens or acts in a way that is very likely to harm him/herself, she may have to seek a hospital for the patient, or to call on a family members or others who can help protect the patient. If such a situation does come up, she will fully discuss the situation with you (parent or guardian) before she does anything, unless there is a very strong reason not to.

   c. In an emergency where the patient's life or health is in danger, and she cannot get your (parent or guardian) consent, she may give another professional some information to protect the patient's life.She will try to get your (parent or guardian) permission first, and she will discuss this with you as soon as possible afterwards.

   d. If she believes or suspect that the patient is abusing a child, an elderly person, or a disabled person she must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person.She does not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be the situation, Dr. Sheinberg and the parent or guardian should discuss the legal aspects in detail before saying anything about these topics. You may also want to talk to your lawyer.

   In any of these situations, she would reveal only the information that is needed to protect the patient or the other person.She would not tell everything the patient has told her.

2. In general, **if the patient becomes involved in a court case or proceeding**, the parent/guardian can prevent her from testifying in court about what the parent/guardian has told her. This is called "privilege," and it is the parent/guardian's choice to prevent her from testifying or to allow her to do so. However, there are some situations where a judge or court may require her to testify (listed below): However, she does not believe she serves the patient best when litigation might be a possibility. In those cases, she will refer the parent/guardian to a colleague who does forensic work. Should the possibility of litigation come up within the course of the treatment, please refer to the form Forensic Policies. The Forensic Policies must be signed by both parents/guardians before treatment begins.

   a. In child custody or adoption proceedings, where your fitness as a parent/guardian is questioned or in doubt.

   b. In cases where the parent/guardian emotional or mental condition is important information for a court's decision.

   c. During a malpractice case or an investigation of Dr. Sheinberg or another therapist by a professional group.

   d. In a civil commitment hearing to decide if the parent/guardian will be admitted to a psychiatric hospital.

   e. Dr. Sheinberg does not see individuals for court-ordered evaluations or treatment. In those cases she would discuss with the patient's treating practitioner fully, parents/guardians don't have to tell what they don't want the court to find out through the report.

   3. There are a few other things you must know about confidentiality and your treatment:

   a. She may sometimes consult (talk) with another professional about the patient's treatment. Professional ethics also requires this other person to keep information confidential. Likewise, when Dr. Sheinberg is out of town or unavailable, another therapist will be available to help her clients. She must give him or her some information about her patients.

   b. She is required to keep records of the patient's treatment, such as the notes she made during the session. The parent or guardian has a right to review these records with Dr. Sheinberg. If something in the record might be seriously upsetting, she may leave it out, but she will fully explain her reasons. She may keep two separate records for the parent or guardian. Her progress notes can be legally subpoenaed; her clinical notes, which may include her impressions, cannot.

   4. Children and families create some special confidentiality questions.

   a. When she treats children under 12, she must tell their parents or guardians whatever they ask her, within reason. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell her will be treated as confidential. However, parents or guardians have the right to general information, including how therapy goes. They need to be able to make well-informed decisions about treatment. She may also have to tell parents or guardians some information about other family members that she is told. This is especially true if these others' actions put them or others in danger.

b. In cases where I treat several family members (parents and children or other relatives), the confidentiality situation can become very complicated. It's crucial that we all clearly understand our purposes and roles at the start of our treatment. This clarity will help us navigate any potential limits on confidentiality that may exist, ensuring your information is handled with the utmost care and respect.

c. In couples therapy, if you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this. In my experience, couples therapy only works with complete transparency.

d. If you and your spouse have a custody dispute or a court custody hearing is coming up, it's important that I am aware of it. Please understand that my professional ethics prevent me from doing therapy and custody evaluations. I do not engage in forensic work. This assurance ensures that you can trust in the integrity of our therapeutic relationship.

e. If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.

f. At the start of family treatment, we must also specify which family members must sign a release form for the common record I create in the therapy or therapies. (See point 5b below.)

5. Finally, here are a few other points:

a. I will not record our therapy sessions on audiotape or videotape without your written permission.

b. If you want me to send information about our therapy to someone else, you must sign a Request/Authorization to Release Confidential Records and Information form. I have copies, which you can see so you will know what is involved.

c. Any information you share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Situations not mentioned here come up only rarely in my practice. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns and need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally.

In the event that the undersigned practitioner reasonably believes that I am a danger, physically or emotionally, to myself. I specifically consent for the practitioner to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name	Telephone number

The signatures here show that we each have read, discussed, understand, and agree to abide by the points presented above.

Signature of parent (or person acting for patient) Date

Printed name

Signature of parent (or person acting for patient) Date

Printed name

Signature of Amy L. Sheinberg, Ph.D. Date

To my patients: This notice describes how health information about you (as a patient in my practice) may be used and disclosed and how you can access your health information. The Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require this.

Commitment to Your Privacy

My practice is dedicated to protecting your health information. I am required by law to provide you with the following important information explaining your rights and my obligation to protect your privacy.

Uses and Disclosures Requiring Authorization

Your signature on the agreement to enter into treatment with me provides consent for me to use or disclose your protected health information (PHI) during treatment, payment, and healthcare operations. This would include consultations with other professionals who are also legally bound to keep the information confidential, any clinical or administrative personnel responsible for billing, and any contract I may have with an agency associated with your care and health service, which promises to maintain confidentiality except as specifically allowed in the agreement or otherwise required by law.

I may release information for other purposes with your permission and written authorization. When I am asked for information for purposes outside of treatment, payment, and healthcare operations, I will obtain your authorization before releasing this information. You may revoke all such authorizations at any time, in writing, unless 1) I have taken action in reliance on it, 2) if the authorization was obtained as a condition of obtaining insurance coverage, or 3) if you have not satisfied any financial obligations, you have incurred.

Uses and Disclosures Requiring Neither Consent Nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Harm or Abuse: To reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. I am required to report any suspicion of child abuse or adult or domestic abuse to the appropriate authorities.
- Health Oversight: To public health authorities and health oversight agencies authorized by law to collect information.
- Judicial or Administrative Proceedings: Privilege does not apply when a third party is evaluating you or where the evaluation is court-ordered. I am required to release information.
- National Security: If you are a member of US or foreign military forces (including veterans) and, if required by the appropriate authorities, to federal officials for intelligence and national security activities authorized by law.
- Law Enforcement Officials: To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- Worker's Compensation: I may disclose your diagnosis and treatment records to your employer's insurance carrier for Worker's Compensation or similar programs.

Your Rights Regarding Your Health Information

Communications: You can request that my practice communicate with you about your health and related issues in a particular manner or location. For instance, ask that I contact you at home rather than work. I will accommodate reasonable requests.

Restrictions: You can request a restriction in my use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that I restrict the disclosure of your health information to only specific individuals involved in your care or the payment of your care. I am not required to agree with your request. However, if I agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Inspect and Copy: You have the right to inspect or obtain a copy of your health information that may be used to make decisions about you. This right extends for as long as the information is maintained in the record. While there are certain circumstances under which I may deny your access, you have the option to have this decision reviewed in some cases.

Amend: You have the right to request an amendment of your health information if you believe it needs to be corrected or completed, as long as this information is kept by and for my practice. Your request must be written and submitted to me at the address on the letterhead. You must provide a reason that supports your request. I may deny your request, however.

Complaints: If you believe your privacy rights have been violated, you have the right to file a complaint. You can do so with my practice or with the Department of Health and Human Services Secretary. To file a complaint with my practice, please contact me at the address on the letterhead. All complaints must be in writing, and rest assured, you will not be penalized for filing a complaint.

Other Authorizations and Accounting: My practice will obtain your written authorization for uses and disclosures not identified by this notice or permitted by applicable law. You generally have the right to receive an accounting of any disclosures of your information that were made without your consent or authorization.

If you have any questions regarding this notice or my health information privacy policies, please contact me at the phone number on the letterhead. I reserve the right to change the privacy policies and practices described in this notice. However, unless I notify you of such changes, I must abide by the current terms.

Receipt of Notice of Privacy Practices

ACKNOWLEDGEMENT

I hereby acknowledge that I have received/been offered a copy of the Notice of Privacy Practices for Amy Sheinberg, Ph.D., LLC. I understand a signed copy will be kept in my file.

Signature of Parent/Guardian _____ Date _____

Name (printed) _____

Signature of Parent/Guardian _____ Date _____

Name (printed) _____

Name of Minor _____

Signature of Amy L. Sheinberg, Ph.D. _____ Date _____

CONSENT FOR EMAIL / TEXT COMMUNICATION

Amy L. Sheinberg, Ph.D. 8333 Douglas Ave., Suite 1240 Dallas, TX 75225

I will be happy to respond to your query within reason, but to do so via email or text, you must provide your consent, recognizing that email or text is not a secure communication. There is some risk that any protected health information in an email or text may be disclosed to or intercepted by unauthorized third parties. I will use the minimum amount of protected health information necessary to answer your query. Communication technologies must never replace the critical interpersonal contacts that are the basis of the patient-psychologist relationship. Patient-psychologist electronic mail is computer-based communication between psychologists and patients within a professional relationship. The psychologist has taken on direct responsibility for the patient's care. These guidelines do not address communication between psychologists and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

COMMUNICATIONS GUIDELINES:

I will return email or text as soon as possible within 24 hours of receipt during business hours. Once I return, email or text may or may not be returned if I am on vacation. I will have a practitioner on call for emergencies, but you will need to call my office for that information.

All email or text communication will be retained by paper or electronic copies for the term applicable to paper records. I will back up all communication weekly.

Therapeutic communication (sensitive subject matters) should be kept at a minimum. Please call to set up an appointment for therapeutic issues.

Email correspondence or text will not be used to establish a patient-psychologist relationship. E-mail should supplement other, more personal encounters. Email or text can be misinterpreted in tone and meaning without face-to-face interaction.

Email or text communication to cancel or reschedule an appointment is acceptable. However, there is still the necessity for 48 hours notice of cancellation to avoid a charge.

Please put the nature of the communication (e.g., appointment, advice, billing question) in the subject line. Please ensure your name and identifying information about the patient care are in the message's body. All business matters should be directed to 214-361-0660 or office@amysheinbergphd.com.

Please be concise in your email or text. If the matter cannot be written concisely, please call to schedule an appointment.

I will also send you a message to inform you of the completion of the request.

If you do not adhere to these guidelines, you will be reminded that I will terminate the email or text relationship if necessary.

Encrypted messages are the most secure form of communication. However, I can only ensure encryption on my side.

My computer(s) is/are password protected.

Your email or text will only be forwarded to a third party with your permission if you have already signed a release for me to communicate with a professional.

Your email or text address will not be used in any marketing scheme.

My office manager and I are the only ones with access to my email or text address and mobile number.

I will double-check all "To" fields before sending messages.

These policies also apply to facsimile communications or texts.

Time spent on matters other than transactional will be billed at her session rate and prorated as needed.

A. General email or text risks include but are not limited to the following:

- Email or text can be immediately broadcast worldwide and received by many intended and unintended recipients;
- Recipients can forward email or text messages to other recipients without the original sender's permission or knowledge;
- Users can easily send an email or text to the incorrect address;
- Email or text is easier to falsify than handwritten or signed documents;
- Backup copies of email or text may exist even after the sender or the recipient has deleted his or her copy.

B. Specific email or text risks include but are not limited to the following:

- Email or text containing information about a patient's diagnosis and treatment must be included in the patient's medical records. Thus, all individuals who have access to medical records will have access to email or text messages
- If you are sending your email or text from your employer's computer, your employer can access your email.
- While it is against the law to discriminate, and Texas subscribes to a "no cause" termination policy, an employer with access to your email or text can use the information to discriminate against the employee. Additionally, the employee could suffer social stigma from a workplace disclosure.
- Insurance companies who learn about your Personal Health Information (PHI) could deny coverage.
- Although practitioners will endeavor to read and answer email or text correspondence promptly, they cannot guarantee that any particular email or text message will be read and responded to in any specific time frame. The exception would be that the email or text is part of a scheduled time frame for a prepaid email or text counseling session. I currently do not offer email or text therapy sessions.

C. Conditions for the use of email or text: All email or texts that concern your diagnosis or treatment or that are part of your medical record will be treated as part of your PHI. Reasonable means will be used to protect the security and confidentiality of the email. Because of the risks outlined above, the security and confidentiality of email or texts cannot be guaranteed; your consent to email correspondence includes your understanding of the following conditions:

- All email or texts to and from you concerning your PHI will be a part of your file and can be viewed by health care, insurance providers, and the practitioner's office support staff.
- Your email or text will not be forwarded outside the office without your consent or as required by law.
- Though all efforts will be made to respond promptly, this may not be the case. Because the response cannot be guaranteed, please do not use email or text in a medical emergency.
- If you have not received a response, you are responsible for following up with the practitioner or support staff.
- Medical information is sensitive, and unauthorized disclosure can be damaging. You should not use email or text for communications concerning the diagnosis or treatment of AIDS/HIV infection, other sexually transmissible diseases, mental health, developmental disability, or substance abuse issues.
- Since employers do not observe an employee's right to privacy in their email or text system, you should not use your employer's email or text system to transmit or receive confidential email or text.
- The practitioner will take reasonable steps to ensure that all information shared through email or text is kept private and confidential. However, Amy Sheinberg, Ph.D., is not liable for improper disclosure of confidential information resulting from our negligence or misconduct. Patient information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2 Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2., A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the data to investigate any alcohol or drug abuse.

INFORMED CONSENT

- If you consent to email or text, you are responsible for informing your practitioner of any information you do not want to be sent to you by email or text other than the information detailed in Section B.
- You are responsible for protecting your password and access to your email or text account and any email or text you send or receive from Amy Sheinberg, Ph.D., to ensure your confidentiality. Your practitioner cannot be held liable if a breach in your account security causes a violation of privacy.
- Any email or text you send discussing your diagnosis or treatment constitutes informed consent to transmitted information. Suppose you wish to discontinue emailing or texting data. In that case, you must submit written permission or an email or text informing your practitioner that you are withdrawing consent to email or text information.

_____ Yes, I have read the above and consent to the possibility that email and texts may not be encrypted from user to user. However, all received will be kept confidential and in an encrypted file.

_____ No, I am not interested in email/text correspondence.

Name of Patient _____

Signature of Parent/Legal Guardian _____ Date _____

Printed Name of Parent/Legal Guardian _____

Signature of Amy L. Sheinberg, Ph.D. _____ Date _____

TELETHERAPY SERVICES AGREEMENT AND INFORMED CONSENT

Amy L. Sheinberg, Ph.D. 8333 Douglas Ave., Suite 1240 Dallas, TX 75225

1. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. Any personal information you share with me will be held strictly confidential. I will not release your information to anyone without your prior approval, or I am required to do so by law. In Texas, we are not required to notify authorities if we become convinced we are about to harm someone physically. However, we have a duty to inform the authorities if there is suspicion or evidence of abuse of children, the elderly (over 65), or people with disabilities.

2. You understand that our teletherapy occurs in Texas and is governed by state laws. I, the practitioner, am accountable to and agree to abide by the ethical and legal guidelines prescribed by the state of licensure and residence. The patient agrees to these terms. Please ask for clarification if you need help understanding or have questions regarding this issue. You use modality to visit me in my Texas office.

3. We are free to terminate teletherapy anytime and for any reason. If you decide to terminate, please send a short note stating why. In the unlikely event that I become convinced our teletherapy is not in your best interests, I will explain it to you and suggest some alternative options better suited to your needs.

4. You understand that teletherapy is neither a universal substitute nor the same as face-to-face psychotherapy treatment. You accept the distinctions made using teletherapy vs. face-to-face psychotherapy. In particular, you acknowledge that teletherapy does not provide emergency services.

5. You are responsible for information security on your computer. Skype and Facetime are not encrypted, so they are not HIPPA compliant. There are HIPAA-approved video conferencing services available.

6. Teletherapy is a means by which you can receive counseling, information, and guidance from an experienced psychologist. It is most accurately perceived as a process of creating, over time, a trusting and collaborative relationship. You retain the right to determine which topics we cover and the depth of consideration each receives. You are free to contribute or withhold any information you choose. Current studies support the usefulness of Teletherapy.

Telecommunication: Teletherapy uses electronic transmissions to treat a patient's needs. I offer video and audio communication via the Internet and/or telephone. This means practicing health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

The risks involved with teletherapy include the potential release of private information due to the complexities and abnormalities of the Internet. Viruses, Trojans, and other involuntary intrusions can grab and release information you want to keep private. Furthermore, there is the risk of being overheard by anyone near you if you do not place yourself in a private area. The advantages of teletherapy include the benefit of continuity of care in the absence of your therapist and the ability to be treated from any location at any time. It is YOUR responsibility to create an environment on your end of the teletherapy transmission that is not subject to the unexpected or unauthorized intrusion of your personal information. I, Dr. Sheinberg, am responsible for doing the same.

Name of Patient _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Guardian::_____ Date: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Amy L. Sheinberg, Ph.D. _____ Date: _____

Amy Sheinberg, Ph.D. 8333 Douglas Ave., Suite 1240 Dallas, TX 75225

Privacy of Information Shared in Therapy: Your Rights as a Minor and My Policies

What to expect:
The purpose of meeting with a psychologist is to get help with problems that bother you or keep you from succeeding in critical areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. You may be here because your parents, guardians, doctors, or teachers have concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an essential part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that you should understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat very shortly. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat very shortly. We may decide to start the proceedings by having you hospitalized.
- You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, I must use my professional judgment to decide whether a parent or guardian should be informed.
- You tell me you are being abused- physically, sexually, or emotionally, or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Child Protective Services of Texas.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations like those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Signature of Adolescent: _____ Printed Name: _____ Date: _____

Signature of Parent/Guardian: _____ Printed Name: _____ Date: _____

Signature of Parent/Guardian: _____ Printed Name: _____ Date: _____

Signature of Amy L. Sheinberg, Ph.D. _____ Date: _____

Date _____

Patient Name _____

Cardholder Name _____

Billing Address (of credit card)_____

Credit Card ( ) Visa ( ) MasterCard ( ) AMEX ( ) Discover

HSA CARD

Also requires a non-HSA card

HSA Card Number _____ Exp _____ CVV _____ Zip Code _____

Non-HSA Card _____ Exp _____ CVV _____ Zip Code _____

CREDIT CARD

Card Number _____ Exp _____ CVV _____ Zip Code _____

Card Number _____ Exp _____ CVV _____ Zip Code _____

Card Number _____ Exp _____ CVV _____ Zip Code _____

Card Number _____ Exp _____ CVV _____ Zip Code _____

Authorized signature to use credit card(s) _____

Signature of Amy L. Sheinberg, Ph.D. _____ **Date** _____

Please notify us as soon as possible if credit card information changes.

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

Patient Name: _____ Birth date: _____

Address: _____

_____

Parent/Guardian: _____ Phone: _____

Address of parent/guardian: _____

I hereby authorize Amy L. Sheinberg, Ph.D. to receive/send psychological, psychiatric, educational and/or personal information on the above named patient to/from the following individual and/or facility.

Person or Facility: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

A. I hereby authorize the source named above to send or call, as promptly as possible, the records on outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug/alcohol abuse.

B. I authorize the named above to communicate with the Dr. Sheinberg about the reasons for patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

C. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my treatment.

D. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 s. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

E. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

F. This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive.

G. I agree that a photocopy of this form is acceptable. By signing this form, I am approving this form of communication.

H. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Amy L. Sheinberg, Ph.D. _____ Date _____

Mentalyc Informed Consent

General Notice

I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our psychotherapy sessions. I have chosen to use Mentalyc's note-taking system for psychotherapy as part of my effort to provide the best care to my clients. It provides me with an automatically generated transcript and summarization of our sessions. Mentalyc's system is HIPAA compliant and uses up-to-date encryption methods, firewalls, and backup systems to help keep your information private and secure. You are consenting for me to record our sessions using Mentalyc's system.

Details

Recordings of our sessions will be transcribed and summarized by Mentalyc's HIPAA compliant technology. Mentalyc doesn't store the recordings and client personal information. I may choose to keep the summarized notes as part of your confidential medical record. Mentalyc does not have my permission to keep any data to help improve the tool. As with any technology, there are certain risks and benefits, which I will list here:

Risks:

- All technology contains a risk of confidential information being disclosed. You can ensure the security of our communications by only using trusted secure networks for psychotherapy sessions and having passwords to protect the device you use for psychotherapy. Mentalyc mitigates this risk by ensuring up-to-date technological security and storing the data with as little identifying information as possible.
- Mentalyc researchers will NOT have access to your de-personalized transcripts (transcript content with removed names, emails, and other identifying information).
- The system may contain unknown bias in the way it generates the session summary and presents clinical information. This risk is mitigated by your therapist's commitment to review and modify the note as needed using their clinical expertise (i.e., I go through the note and make corrections or additions where necessary).

Benefits:

- The technology allows the therapist to focus more of their attention on therapy.
- Removes the need for taking notes or trying to remember information during and after the session.
- Mentalyc reduces the therapist's workload and may help with compassion fatigue.
- The technology may provide additional clinical insights for the therapist which helps improve outcomes in the therapeutic process (i.e., hoping to get home before I turn into a pumpkin).
- My notes are stored in a two-factor authenticated program where the note itself is in a password-protected file and encrypted.

By signing this consent, you are agreeing to allow your therapist to use the Mentalyc software.

Signature of Patient: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

Reviewed with patient/ALS: _____ Date: _____

Amy L. Sheinberg, Ph.D.
8333 Douglas Ave., Suite 1240 Dallas, Texas 75225
214-361-0660 • amysheinbergphd.com

FORENSIC MATTERS: AGREEMENT CONCERNING PSYCHOLOGIST'S TESTIMONY AND RECORDS FOR MINORS

This agreement ["Agreement"] is made between Amy L. Sheinberg, Ph.D., and Parent One _____ Parent Two _____ going forward referred to as [Parents], this ____ day of _____, 20___, in order to state certain conditions under which Dr. Sheinberg ["Psychologist"] will provide professional mental health services for the Parent(s)'s child(ren) name(s), _____. In the event that this Agreement is signed after treatment of the Parent(s)'s child(ren) has begun, the Parent(s) agree that this Agreement shall be treated as if signed and effective immediately prior to the first day of treatment of the Parent(s)'s child(ren).

TESTIMONY

The Psychologist has determined, and the Parent(s) agree(s), that the child(ren)'s emotional health and need to know the sessions are confidential outweigh the need for the Psychologist or her records to be available for any current or future litigation concerning the child(ren) and/or the Parent(s). The Parent(s) agree that they will not require the Psychologist to testify (deposition, courtroom testimony, or otherwise), concerning her treatment of the child(ren) in any current or future litigation. Further, the Parent(s) will not request or subpoena the records of the Psychologist concerning her treatment of the child(ren) for use in any current or future litigation.

Because the child(ren) are the identified patient(s) of the Psychologist, any parental attempt to involve the Psychologist in the litigation process, including to subpoena the Psychologist and/or her records, will hold both parents equally liable and fiscally responsible and agree to pay all costs and attorney's fees incurred by the Psychologist, including fees for her time in defending any attempt to defeat this Agreement and force her to testify or produce her records. In the event the Psychologist's deposition is taken, whether by court order or otherwise, the Parent(s) agree to compensate the Psychologist for 8 hours of her time, regardless of the length of the deposition (unless it lasts longer than 8 hours), at an hourly rate of $600.00 per hour. The $4800.00 deposition fee will be paid in advance of the commencement of the deposition. The Parent(s) further agree that any deposition of the Psychologist will take place in Dallas County, Texas at a location of the Psychologist's choosing, on a date convenient with her work and personal schedule.

Additionally, the Parent(s) shall also compensate the Psychologist's attorney of her choosing for his/her time in defending the Psychologist, this Agreement, and contesting the Parent(s)'s right to request a deposition and/or records, including but not limited to motion drafting and hearing attendance, deposition preparation time, actual time in the deposition, courtroom testimony preparation time, and actual time spent presenting and defending the Psychologist in court, all at the attorney's then-prevailing hourly rate. Payment of the Psychologist's and Psychologist's attorney's fees shall be made upon presentment of each bill. Payment of all fees should be made within three (3) business days upon receipt to the attorney on record and the Psychologist. Failure to pay within that time frame could result in added late fees.

The Parent(s) acknowledge that:

- The Psychologist's testimony will in no way be influenced by the fact that a Parent(s) are paying the fee; and
- The Parent(s) understand(s) that the Psychologist's testimony may be prejudicial to the Parent(s)'s legal position.

The Parent(s) acknowledge and understand that litigation is time-consuming and takes up the Psychologist's time that could otherwise be applied to treating the Psychologist's other clients. Thus, the Parent(s) further agree to compensate the Psychologist for her time spent (1) reviewing records in preparation for any hearing, deposition, or trial; and (2) in responding to any written discovery requests. Time for the aforementioned will be billed separately to the Parent(s) at the same $600.00 hourly rate. Payment of all fees should be made within three (3) business days upon receipt to the attorney on record and the Psychologist. Failure to pay within that time frame could result in added late fees.

RECORDS
Should production of records be mandated, the Parent(s) understands that the following applies for document production:

- The Psychologist will produce records only if Court-ordered and only to the presiding judge if the Psychologist believes there to be a potential risk to the Child(ren) in making these notes available to the Parent(s);
- Each Parent(s) agree to pay fifty (50) percent of the full amount of the fees listed in the following section, unless a judge has determined otherwise;
- The Parent(s) understand that the Psychologist's records will in no way be influenced by the fact that one or more Parent(s) is paying the fee; and
- The Parent(s) understand that the Psychologist's records may be prejudicial to their legal position.

The fees to be paid and received in full prior to the Psychologist's production of the records are:

a. Three (3) hours ($1800.00) of preparation time for review and gathering of clinical records and supporting documents;
b. If a summary of such records is requested, time spent preparing the summary will be charged at the rate of $600.00 per hour;
c. An administrative fee of $0.50 cents per page for any records copied and produced;
d. Any time spent preparing responses to any written discovery requests will be charged at the same hourly fee rate ($600.00) noted above; and
e. Any time spent by the Psychologist's attorney, at his/her hourly rate at the time the work is performed, in reviewing and/or objecting/responding to the records requests or other written discovery requests.

The reason the fee is paid up front reflects the reality that the Psychologist could not go into Court with the Parent(s) owing a large bill. This would leave the Psychologist open to a question as to whether the financial situation had influenced the Psychologist's judgment. This is not an acceptable situation for the Parent(s) and the Psychologist will adhere strictly to this policy.

The Parent(s) further acknowledge that mental health professionals have a duty to deny parents access to the records of a child patient if the professional determines that release of said records would be harmful to the patient's physical, mental, or emotional health and therefore the Parent(s) may be denied access information concerning treatment of the child(ren) if such a determination is made by the Psychologist.

This Agreement has been explained to us; we have been given the opportunity to have it reviewed by counsel of our choosing; we agree that it was mutually negotiated and shall not be construed against any signatory hereto; and we agree to abide by this Agreement and have been offered a copy of this Agreement which will be kept on file by the Psychologist.

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

I have reviewed this Agreement with the Parent(s), prior to their signing this Agreement.

Dated this _____ day of _____, 20____.

Signature of Amy L. Sheinberg, Ph.D. _____

MINOR INTAKE QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date _____

REASON(S) FOR TODAY'S VISIT

What are your child's reasons for seeking psychotherapy at this time? _____

_____

_____

_____

How long have they been experiencing these issues? _____

Did something(s) precipitate them recently? _____

_____

What has the course of these symptoms been? _____

When did others first notice these symptoms? _____

What would you like to get out of our work together? Specific Goals? _____

_____

_____

MEDICAL AND MENTAL HEALTH HISTORY

Has your child previously seen a therapist or psychiatrist?_____ Who? _____ When? _____

For what reason(s)? _____

_____

Was it helpful? _____ If not, why? _____

PSYCHIATRIC MEDICATIONS

Medication	Dosage	When prescribed	Prescribed by	Response

PAST PSYCHIATRIC MEDICATIONS:

Medication	Dosage	Date taken	Prescribed by	Reason(s) discontinued

If you have been admitted for psychiatric reasons, please describe (e.g., psychiatric hospitalization, outpatient day program, wilderness program, therapeutic boarding school, residential treatment center, intensive outpatient treatment).

Program	When attended	Response to care received

Please describe if your child has ever had academic, psychological, and/ or neuropsychological testing.

Type of Testing	When	Evaluator	Results	Copy accessible

What psychiatric/psychological diagnoses have you been told your child has? _____

If your child had ever taken any other "personality" tests, please check any that apply.

☐ Enneagram ☐ Aptitude Test ☐ Clifton Strengths Assessment ☐ Other: _____

☐ Myers-Briggs Type Indicator (MBTI) ☐ DiSC ☐ The Big Five Personality Traits _____

Has your child ever tried to harm his/herslef in the past? _____

Has your child ever had thoughts of committing suicide in the past? _____

Has your child ever attempted suicide in the past? _____

Has your child ever had a substance abuse problem in the past? _____

Has your child had any significant medical conditions in the past? If so, please explain. _____

_____

CURRENT SYMPTOMS AND CONCERNS:

Please describe in detail how the symptoms listed below have impacted your child over the last month:

Difficulty sleeping: _____

Changes in appetite or dietary habits: _____

Mood: _____

Anxiety: _____

Depression or feelings of hopelessness: _____

Thoughts and/or gestures of self-harm: _____

Thoughts, plans, and/or intentions to attempt suicide: _____

Other troubling symptoms? Please be as specific as possible. _____

What are your child's most distressing symptoms? _____

How does your child's symptoms interfere with day-to-day functioning in the following areas:

Relationships: _____

Work and/or school performance: _____

Activities of daily living - hygiene, taking care of your pet, keeping up with interests/hobbies: _____

_____

Executive functioning - attention, organization, working memory, self-control, problem-solving, initiation, and self-monitoring:

_____

Does your child have any ongoing medical conditions? If so, please explain. _____

_____

Does your child have any medication allergies? _____

FAMILY PSYCHIATRIC HISTORY:
Has any family member had any of the following? Please indicate which family member and whether maternal or paternal.

_____ ADHD
_____ Alcohol Abuse
_____ Anxiety
_____ Autism/Asperger's Disorder/PDD
_____ Coordination Problems
_____ Depression
_____ Developmental Disorder
_____ Drug Use
_____ Eating Disorder
_____ Learning Disability
_____ Legal Problems`
_____ Mania/Bipolar Disorder
_____ Movement Disorders
_____ Obsessions/Compulsions
_____ Panic
_____ Psychiatric Hospitalizations
_____ Psychosis
_____ Rituals
_____ Sleep Disorder
_____ Suicidal thoughts/urges behaviors
_____ Tics
_____ Unusual noises/vocalizations

FAMILY MEDICAL HISTORY

Please provide information about significant medical issues on the BIOLOGICAL FATHER'S side: _____

_____

Please provide information about significant medical issues on the BIOLOGICAL MOTHER'S side: _____

_____

PRENATAL HISTORY:

Was your pregnancy with your child healthy? ☐ Yes ☐ No Problems:_____

Were medications used during the pregnancy? ☐ Yes ☐ No If yes, what kind? _____ How Often? _____

Were drugs/alcohol used during the pregnancy? ☐ Yes ☐ No If yes, how much/often? _____

Did you smoke during the pregnancy? ☐ Yes ☐ No If yes how much? _____

Was the pregnancy full term? ☐ Yes ☐ No Was delivery normal? ☐ Yes ☐ No If no, problems? _____

Any feeding problems? ☐ Yes ☐ No Gain weight well? ☐ Yes ☐ No

Were there any problem in the first week? _____ First month? _____ First year? _____

Total number pregnancies had by you: _____ Live births: _____ Your birth order: _____

DEVELOPMENTAL HISTORY:

1. Describe your child:

a) ☐ active ☐ active but calm ☐ passive ☐ other: _____ (e) response to being held (describe): _____

b) ☐ cuddly ☐ irritable ☐ withdrawn ☐ other: _____ _____

c) ☐ cried easily and frequently ☐ reasonable amount ☐ seldom (f) reaction to strangers: ☐ friendly ☐ indifferent ☐ fearful

d) Response to changes: ☐ severe ☐ moderate ☐ mild (g) ☐ soothed easily ☐ difficult to soothe ☐ average

2. Developmental milestones ☐ Early ☐ On time ☐ Late

FAMILY OF ORIGIN

Are you still married? _____ If you're divorced, when did you divorce? _____

How old was your child when you divorced? _____ Reason(s) provided for your divorce. _____

_____

Mother's name: _____ Mother's occupation: _____

How would you describe your relationship with your child? _____

Father's name: _____ Father's occupation _____

How would you describe your relationship with your child? _____

If there are stepparents (or other significant relationships), how would you describe their relationship with your child? Are they supportive?

_____

_____

Siblings

Names:	Ages:	Occupation/School Status:	Your Relationship?

RELATIONSHIP STATUS

Is your child old enough to date? _____ Are they actively dating? _____ Does your child have a boy/girlfriend? _____

SCHOOL

Name of child's school: _____ Grade: _____ Repeat Grade? ☐ Yes ☐ No Which grade? _____

Special/resource classes ☐ Yes ☐ No? If yes, what classes? _____

Other special services? (speech/OT) _____ IEP? _____ 504 Plan? _____ Academic grades received: _____

Evaluations performed:

Date _____ Type _____ Reasons _____ Results _____

Date _____ Type _____ Reasons _____ Results _____

Relationships with teachers? _____ With peers? _____

Ability to work independently? ☐ good ☐ average ☐ poor Organize self? ☐ good ☐ average ☐ poor

Attendance problems?_____ If Yes, please describe. _____

Has your child ever had truancy proceedings? ☐ Yes ☐ No If Yes, please explain. _____

_____

Has your child had any other legal proceedings? ☐ Yes ☐ No If Yes, please explain. _____

_____

Has your child received counseling at school? _____

_____

Describe your child's activities, interests, hobbies, skills, strengths: _____

_____

PROBLEM BEHAVIOR CHECKLIST: DOES YOUR CHILD HAVE ANY OF THE FOLLOWING PROBLEMS?

RATE FROM ONE (NEVER) TO FIVE (VERY OFTEN)

- ☐ I have no problems or concerns
- ☐ Abuse-
- ☐ physical
- ☐ sexual
- ☐ emotional neglect (of children or elderly persons)
- ☐ Accident prone
- ☐ Affectionate
- ☐ Aggression
- ☐ Alcohol abuse
- ☐ Anger
- ☐ Anxiety
- ☐ Appetite changes
- ☐ Argumentative
- ☐ Attention, concentration, distractible
- ☐ Baby talk
- ☐ Body Image
- ☐ Bossy towards others
- ☐ Breaks rules/laws
- ☐ Bullied by others
- ☐ Bullies others
- ☐ Career concerns, goals, and choices
- ☐ Cheating
- ☐ Childhood issues (your own childhood trauma)
- ☐ Chronic pain
- ☐ Clowning around (frequent)
- ☐ Codependency
- ☐ Competitive
- ☐ Conflicts at home at school
- ☐ Conflicts with friends
- ☐ Controlling, demanding
- ☐ Cries often/frequently
- ☐ Cruelty to animals
- ☐ Daydreamy
- ☐ Decision making
- ☐ Deliberately annoy people
- ☐ Delusions (false ideas)
- ☐ Dependent/clingy
- ☐ Depression, low mood, sadness, crying
- ☐ Destructive/violent
- ☐ Difficulty expressing feelings
- ☐ Disobedient
- ☐ Disorganized
- ☐ Drug use
- ☐ prescription medications
- ☐ over-the-counter medications
- ☐ street drugs
- ☐ Easily angered, bad temper
- ☐ Easily riled up
- ☐ Eating disorder - ARFID
- ☐ Emptiness
- ☐ Failure
- ☐ Fantasy life
- ☐ Fatigue, tiredness, low energy, listlessness
- ☐ Fears
- ☐ Feelings of worthlessness, inferiority
- ☐ Feels sick often
- ☐ Financial or money troubles, debt
- ☐ Frequent accidents
- ☐ Friendships, making and/or maintaining
- ☐ Goal setting
- ☐ Grief
- ☐ Guilt
- ☐ Hair pulling
- ☐ Headaches, migraines
- ☐ Health
- ☐ Hyperactive
- ☐ Hypochondria
- ☐ Impulsivity, loss of control
- ☐ Interpersonal conflicts
- ☐ Intrusive thoughts
- ☐ Irritability
- ☐ Isolation
- ☐ Irresponsible problem solving
- ☐ Lack of interest in activities
- ☐ Lacks respect for authority
- ☐ Laziness
- ☐ Learning difference(s)
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of focus
- ☐ Loss of friends/relationships
- ☐ Low frustration tolerance
- ☐ Lying/exaggeration
- ☐ Manipulative
- ☐ Memory problems
- ☐ Mood swings
- ☐ Moodiness
- ☐ Motivation
- ☐ Money management
- ☐ Mute, refuses to speak
- ☐ Negativity
- ☐ Nightmares/night terrors
- ☐ Obesity
- ☐ Obsessions, compulsions
  (thoughts or actions that repeat themselves)
- ☐ Oppositional/defiant
- ☐ Organization
- ☐ Overly sensitive
- ☐ Overly obedient
- ☐ Over sensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ People pleaser
- ☐ Perfectionist
- ☐ Pessimism
- ☐ Phobias
- ☐ Poor self care
- ☐ Procrastination
- ☐ Productivity problems
- ☐ Prone to injury
- ☐ Relationship problems
- ☐ Reluctance to go to school/work
- ☐ Responsible
- ☐ Restlessness
- ☐ Rituals (has to repeat same action)
- ☐ Rocking or repetitive movements/gestures
- ☐ Rule breaking
- ☐ Sadness
- ☐ School refusal
- ☐ Self-centered
- ☐ Self control
- ☐ Self-destructive behaviors
- ☐ Self-esteem
- ☐ Self-harm
- ☐ Sexual issues
- ☐ Shyness
- ☐ Sleep disturbances
- ☐ Social isolation/withdrawal
- ☐ Steals
- ☐ Stress management issues
- ☐ Suicidal thoughts
- ☐ Suicide talk/attempt
- ☐ Suspicious, distrustful
- ☐ Talks back
- ☐ Teases others unmercifully
- ☐ Temper problems
- ☐ Thought disorganization and confusion
- ☐ Thoughts of death/dying
- ☐ Threats, violence
- ☐ Thumb sucking
- ☐ Tics
- ☐ Time management issues
- ☐ Wets bed/clothes
- ☐ Which of these is primary or most pressing?

_____

_____

_____

Adolescent Psychotherapy Intake Questionnaire

For the Adolescent to fill out.

Personal Information and Background

What name do you prefer to be called? _____

Who are the most important people in your life right now? _____

If you had to describe yourself in 3 words, what would they be? _____

What's your favorite way to spend free time? _____

If you could change one thing about your life, what would it be? _____

_____

Current Concerns and Goals

What made you decide to come to therapy at this time? _____

_____

On a scale of 1-10, how much is this issue impacting your daily life? _____

What have you already tried to address this problem? _____

_____

What do you hope to gain from therapy? _____

_____

If therapy is successful, how will your life be different? _____

_____

Emotional and Mental Health

How would you describe your mood most days? _____

_____

How do you generally deal with stress when you're feeling overwhelmed? _____

_____

What helps you feel better when you're stressed or upset? _____

_____

What makes things worse when you're stressed or upset? _____

_____

Do you ever have thoughts of harming yourself or others? Please elaborate on any threats. _____

_____

_____

What helps you feel better when you're stressed or upset? _____

_____

Have you ever experienced any traumatic events? Please describe them and how you were affected by them?

_____

_____

Do you have any concerns about your eating habits or body image? _____

_____

Relationships and Support System

How would you describe your relationship with your parents/guardians? _____

_____

Do you have a best friend or close group of friends? _____

What is that draws you to these friends? _____

_____

Who are the most important people in your life right now and why? _____

_____

Have you ever been bullied or felt left out at school? Please describe. _____

_____

Is there an adult in your life (including your parents) you trust and can talk openly to? _____

_____

How comfortable do you feel expressing your true self to others? _____

_____

Family Dynamics

How would you describe your family's communication style? _____

_____

Are there any significant changes or stressors in your family right now? _____

If so, please describe. Have there been any stressors present in the last 6-12 months? If so, please explain.

_____

_____

_____

Do you feel your parents understand (or "get") you? Elaborate. _____

_____

_____

How would you describe your relationships with your siblings? _____

_____

How are decisions made in your family? _____

_____

How are problems addressed in your family? _____

_____

_____

How are consequences implemented in the family? Incentives? _____

_____

_____

If you could change one or two things in your family, what would you change? _____

_____

School and Future Plans

What's your favorite subject in school? _____ Least favorite? _____

Why? _____

Do you have any concerns about your academic performance? _____

_____

How would you describe your motivation and willpower (finite and must be replenished) vs. your self-control (based solely on taking actions, ignoring feelings or thoughts allowing you to do what is needed, before doing what is wanted)?

_____

_____

What are your goals for after high school? _____

_____

Is there a career or field you're interested in pursuing? _____

_____

What's the biggest challenge you face at school? _____

_____

Health and Lifestyle

Do you have any health issues that concern you? _____

_____

Do you have concerns about your self-care behaviors? Please explain. _____

_____

How many hours do you sleep each night? _____ Describe your eating habits. _____

_____

Describe your exercise habits, including sports? _____ Activities? _____

How often/week? _____ Level of intensity? _____

Do you drink and/or take illicit drugs? If so, which ones? _____

How much? _____ How frequently? _____

How often do you get together willingly with those in your support network? _____

What do you usually do? _____

How much time do you spend on technology/day? _____ Social media? _____ Playing computer games? _____

How does social media affect your mood and self-esteem? _____

_____

Have you ever experienced cyberbullying or online harassment? Please explain. _____

_____

Do you feel your online relationships are as meaningful as your in-person ones? _____

_____

How do you balance screen time with other activities? _____

_____

Self-Perception and Identity

What do you like most about yourself and why? _____

_____

What do you like least about yourself and why? _____

_____

Do you ever feel pressure to be someone you're not? Elaborate. _____

_____

How do you think others see you versus how you see yourself? _____

_____

Are there any aspects of your identity (e.g., gender, sexuality, cultural) that you're exploring or questioning?

Please explain. _____

_____

Coping Mechanisms and Resilience

When you're feeling overwhelmed, what do you usually do? _____

_____

Can you describe a challenging situation you've overcome recently? _____

_____

What are your strengths in dealing with difficult emotions or situations? _____

_____

Do you have any creative outlets or hobbies that help you to express yourself? _____

_____

The Melting Pot

If you could be any animal, which one would you be and why? _____

_____

What's your favorite way to spend free time? _____

_____

If you could have any superpower, what would it be and how would you use it? _____

_____

What's the best compliment you've ever received? _____

_____

If you could only eat one food for the rest of your life, what would it be and why? _____

_____

How would you describe yourself in 3 words? _____

What's one thing you love about yourself? _____

_____

If your life was turned into a movie, what would the title be and who would play you? _____

_____

Who would you choose if you could have dinner with any three people, living or dead? _____

_____

If you could create a new school subject, what would it be? _____

_____

What's a career that doesn't exist yet that you think should? _____

_____

If you could wake up tomorrow fluent in two new languages, which would you choose and why? _____

_____

If you had to describe your mood most days in a weather forecast, what would it be?_____

_____

If you won $1000, how would you spend it to improve your mood? _____

_____

What's your ideal way to relax or de-stress? _____

_____

If your family was a TV show, what genre would it be? _____

_____

If you had to give up your phone or your favorite food for a month, which would you choose? _____

_____

If you could create a new app, what would it do? _____

_____

What's the most interesting thing you've learned online recently? _____

_____

What made you decide to come to therapy at this time? _____

_____

If you could wave a magic wand and change one thing about yourself or your life, what would it be?_____

_____

On a scale of 1-10, with 10 being super excited, how do you feel about starting therapy? _____

_____

If therapy is successful, how do you imagine your life will be different? _____

_____

What would you be most ashamed of if it were to be made public? _____

_____

What would you like me to know about you that I haven't asked? _____

_____

Do you have questions about me or how therapy works? _____

_____