

Psychotherapy Practice of Deborah S. Green-Lauber, LISW-S

Health Insurance/EAP /Private-Pay Form

Patient Name: _____ DOB: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Contact Phone(s) C: _____ H: _____ Gender: _____

Primary Insurance

Ins. Co.: _____ Employer: _____

Insured's ID #: _____ Group #: _____ Payor ID#: _____

Insured's Information: (if different than patient)

Name: _____ Relationship to Pt: _____ DOB: _____

Address: _____ City: _____ ST: _____ ZIP: _____

EAP Benefit Information

EAP Co. : _____ Employer: _____

EAP Employee Name: _____ Relationship to Pt: _____ DOB: _____

EAP ID#: _____ Total # of Sessions Authorized: _____

EAP Authorization #: _____ Dates of Auth: _____ to _____

Secondary Insurance

Secondary Insurance Co.: _____ Employer: _____

Insured's ID #: _____ Group#: _____ Payor#: _____

Secondary Insured's Information: (if different than patient)

Name: _____ Relationship to Pt: _____ DOB: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Check if using Private-Pay/No Insurance _____

Deborah S. Green-Lauber, LISW-S will bill the above insurance company/EAP company directly for all services. Your signature indicates liability for any balance due. The patient's, or responsible person's, signature below authorizes release of any necessary medical or other information requested by the insurance company to process the claim. Your signature requests and assigns direct payment to Deborah S. Green-Lauber, LISW-S all proceeds payable under the terms and provisions of your insurance policy.

Signature: _____ Date: _____

Psychotherapy Practice of Deborah S. Green-Lauber, LISW-S

Consent for Treatment

I, _____ give permission/ consent to Deborah S. Green-Lauber, LISW-S to provide mental health assessment/treatment to my teenager_____.

I understand that information disclosed in clinical sessions is confidential and may not be released to anyone without my written permission. This therapist adheres to professional, legal, and ethical guidelines established by state law. Legal and ethical exceptions to confidentiality include:

1. When there is clear and present danger or harm to you or others.
2. When there is knowledge or suspicion of abuse or neglect of children or elderly persons.
3. When a court subpoenas clinical records.
4. When an individual cites his/her treatment/clinical record in a legal proceeding.

I have also reviewed the information provided by this therapist regarding use of protected health information (PHI) per HIPAA (Health Insurance Portability and Accountability Act). A written copy of the Notice of Privacy Practices will be given upon request.

My rights: I understand I have to right to competent and professional service. I have the right to be treated with respect and courtesy. I have a right to a therapeutic relationship free of abuse or exploitation. I have the right to file a complaint. I have the right to review my clinical record and make a written request to have it released to a competent professional.

My responsibilities: I am responsible to be an active, collaborative participant in my therapy process.

Payment: I understand that I am financially responsible for this treatment at a private-pay fee of \$100 per therapy session. If I choose to use insurance for payment, I agree to make my co-insurance/co-payment at the time of service and I agree I am responsible for any balance not paid by my insurance company.

Missed appointments: I understand I will be charged a late cancel/no show fee of \$50, if I fail to give 24 hrs notice to cancel or reschedule an appointment.

Email Restrictions: I understand that I may want to use email to schedule and/or cancel appointments. If I use email for purposes other than appointment requests, I understand and waive my right to complete confidentiality, as there are limits to what can be kept private over the internet. I understand therapeutic advice/ consultation will not be conducted via email due to these confidentiality restrictions.

I have read the above information and have had the opportunity to discuss this consent with my therapist. I give full voluntary consent to clinical services rendered by Deborah S. Green-Lauber, LISW-S. I understand that I may terminate clinical services and this consent at any time. My signature signifies understanding and agreement to these policies.

Parent/Guardian Signature_____ Date_____

Please answer the following questions about your child/ adolescent.

What are your child's most serious problems?

1. _____
2. _____

What have you tried to solve these problems?

1. _____
2. _____

Check any changes or stressors that might have brought on or added to the above problems:

- | | | |
|--|---|--|
| <input type="checkbox"/> New brother/sister | <input type="checkbox"/> Family financial pressures | <input type="checkbox"/> Traumatic experience |
| <input type="checkbox"/> Job changes | <input type="checkbox"/> School pressures | <input type="checkbox"/> Moves |
| <input type="checkbox"/> School changes | <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Activity/sports pressures |
| <input type="checkbox"/> Marriage/New relationship | <input type="checkbox"/> Loss/Change of friends | <input type="checkbox"/> Family medical problems |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Addiction issues | <input type="checkbox"/> Family mental illness |
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Health problems | <input type="checkbox"/> Other: _____ |

PAST OR CURRENT MENTAL HEALTH SERVICES OR SUBSTANCE ABUSE TREATMENT

PROVIDER	DATES	TYPE OF TREATMENT

DEVELOPMENTAL INFORMATION (circle or check appropriate response)

ADOPTION Is this child adopted? NO YES Age at Adoption: _____

AGES 0 TO 12 MONTHS

During this time period, was the child:

- | | |
|---|--|
| <input type="checkbox"/> Unusually fussy, very hard to soothe | <input type="checkbox"/> Unusually quiet, not responding much to attention |
| <input type="checkbox"/> Hard to cuddle (stiff or floppy) | <input type="checkbox"/> Bothered with feeding problems |
| <input type="checkbox"/> Slow to smile or sit or crawl | <input type="checkbox"/> Not interested in looking at people |

AGES 1 TO 5 YEARS

During this time period, was the child:

- | | | |
|---|--|---|
| <input type="checkbox"/> Late walking | <input type="checkbox"/> Late talking | <input type="checkbox"/> Hard to understand |
| <input type="checkbox"/> Said to be slow, delayed or retarded | <input type="checkbox"/> Difficult to toilet train | <input type="checkbox"/> Hard to control in public places |
| <input type="checkbox"/> Hard to leave with a baby-sitter | <input type="checkbox"/> Bothered by unusual fears | <input type="checkbox"/> Setting fires |
| <input type="checkbox"/> Needing much supervision to prevent dangerous behavior | <input type="checkbox"/> Having sleep problems | <input type="checkbox"/> Having sleep problems |
| <input type="checkbox"/> Having severe or frequent tantrums | <input type="checkbox"/> Lack of imaginative play | |
| <input type="checkbox"/> Unusually upset by changes or new situations | | |
| <input type="checkbox"/> Very demanding, wanting things right away | | |
| <input type="checkbox"/> Having sleep problems | | |
| <input type="checkbox"/> Often fighting, biting, scratching over little frustrations | | |
| <input type="checkbox"/> Having sleep problems | | |
| <input type="checkbox"/> Having trouble sharing or taking turns | | |
| <input type="checkbox"/> Unable to get along will in pre-school or Kindergarten | | |
| <input type="checkbox"/> Showing unusual behaviors, body movements, tics, or nervous habits | | |

AGES 6 TO 12 YEARS

During this time period, was the child:

- | | |
|---|--|
| <input type="checkbox"/> Hard to get along with at home | <input type="checkbox"/> Having trouble making or keeping friends |
| <input type="checkbox"/> Uninterested in being with other children | <input type="checkbox"/> Having trouble learning |
| <input type="checkbox"/> Having trouble with behavior in school | <input type="checkbox"/> Having trouble controlling frustration or anger |
| <input type="checkbox"/> Often "down" or depressed | <input type="checkbox"/> Very shy or nervous |
| <input type="checkbox"/> Having sleep problems | <input type="checkbox"/> Having many physical problems or complaints |
| <input type="checkbox"/> Having other problems or behavior difficulties | <input type="checkbox"/> Evidence of substance use/ abuse |

AGES 12 TO 18 YEARS

During this time period, was the adolescent:

- | | |
|---|--|
| <input type="checkbox"/> Having trouble getting along with parents | <input type="checkbox"/> Having trouble getting along with brothers or sisters |
| <input type="checkbox"/> Having trouble making or keeping friends | <input type="checkbox"/> Having trouble achieving at school |
| <input type="checkbox"/> Having trouble with behavior or attendance at school | <input type="checkbox"/> Uninterested in being with other adolescents |
| <input type="checkbox"/> Often having thoughts of hurting self | <input type="checkbox"/> Often destructive of property |
| <input type="checkbox"/> Often "down" or depressed | <input type="checkbox"/> Very anxious or nervous |
| <input type="checkbox"/> Having sleep problems | <input type="checkbox"/> Having many physical problems or complaints |
| <input type="checkbox"/> Having other problems or behavior difficulties | <input type="checkbox"/> Evidence of substance use/abuse |

Use the following space to further describe any developmental issues needing further clarification:

MEDICAL HISTORY

HOSPITALIZATIONS NONE

AGE	HOSPITAL	ILLNESS/INJURY/SURGERY

SERIOUS OR CHRONIC HEALTH PROBLEMS NONE

AGE AT DIAGNOSIS	PROBLEM

Medication Allergies: _____

Other Allergies: _____

MEDICATIONS NOW BEING TAKEN NONE

MEDICATION	DOSE	REASON TAKEN	PRESCRIBED BY

FAMILY HEALTH HISTORY

Check the item if there is a family member with the problem and indicate the relationship to the child.

- | | | | |
|--|--------------------|---|--------------------|
| <input type="checkbox"/> Alcoholism | Relationship _____ | <input type="checkbox"/> Depression | Relationship _____ |
| <input type="checkbox"/> Heavy drinking | _____ | <input type="checkbox"/> Suicide attempt | _____ |
| <input type="checkbox"/> Other Addictive Disorders | _____ | <input type="checkbox"/> Intentional self-harm | _____ |
| <input type="checkbox"/> Drug abuse | _____ | <input type="checkbox"/> Suicide | _____ |
| <input type="checkbox"/> In trouble with the law | _____ | <input type="checkbox"/> Tics or Tourette's | _____ |
| <input type="checkbox"/> Attention problem | _____ | <input type="checkbox"/> "ADD" Hyperactivity | _____ |
| <input type="checkbox"/> Learning problems | _____ | <input type="checkbox"/> Severe anxiety | _____ |
| <input type="checkbox"/> Dyslexia | _____ | <input type="checkbox"/> Panic Attacks | _____ |
| <input type="checkbox"/> Special classes in school | _____ | <input type="checkbox"/> Mental Retardation | _____ |
| <input type="checkbox"/> Obsessive Compulsive Disorder | _____ | <input type="checkbox"/> Schizophrenia | _____ |
| <input type="checkbox"/> Extreme fears or phobias | _____ | <input type="checkbox"/> Eating Disorder | _____ |
| <input type="checkbox"/> Manic depression or Bipolar | _____ | <input type="checkbox"/> Victim of sexual abuse | _____ |
| <input type="checkbox"/> Victim of physical abuse | _____ | <input type="checkbox"/> Rape Victim | _____ |
| <input type="checkbox"/> Jail Sentence | _____ | <input type="checkbox"/> Other: _____ | _____ |