Client Information

Date: _____

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Referred by: _____

Primary Physician: _____ Current Medication: _____

Allergies to Medication: _____

Emergency Contact: _____

Relationship to Client: _____ Phone No.: _____

Responsible Party: ( ) Self ( ) Spouse ( ) Parent

Name: _____ Address: _____

Social Security Number of Responsible Party: _____

His/Her Employer: _____ Address: _____

His/Her Job Title: _____ Work Phone: _____

Health Insurance: _____ Group No: _____

Please list each professional, program, or hospital that has provided behavioral health services to you or your family. If you don't have their current addresses, please bring this information to the next appointment.

Professional/Program or Hospital Address/Location Dates

Close Family Members (Parents, Siblings, Spouse, Children, etc.)

Name Relationship Age Any Mental Health, Drug/Alcohol Problems

_____

_____

_____

_____

Client Name: _____ Date: _____

Client Information

Reason for seeking help. Current problems experienced by the Client. Please circle any relevant problems.

Sadness Anxiety Drug Abuse Parenting Spouse Stress Limited Communications
Behavior problems Sexual behavior Anger control Work conflicts Lonely Nightmares
Lack of energy Confused thinking Sexual dysfunction Marriage problems Family conflicts
Stealing Sibling conflicts Physical abuse Criminal/delinquent behavior Assertiveness
Co-dependency Panic attacks Fears Compulsive behavior Underachievement Hyperactivity
Short Attention Eating disorder Stuttering Apathy Job Stress Learning disability
Financial problems Physical disability Death/loss Spirituality Weight/appearance Legal problems

My Goals for Treatment:

_____
_____
_____
_____
_____
_____
_____
_____

PATIENT LETTER OF AGREEMENT

INSURANCE BILLING AND PAYMENT POLICY

PLEASE INITIAL EACH ITEM BELOW

_____ I request Dr. Daniel J. Christiano, Ph.D to submit billing on my behalf directly to my Insurance Carrier.

_____ I acknowledge that payment for services will be forwarded directly to your provider.

_____ I authorize the release of any information necessary to process the claim for payment.

_____ Payment liability for Non-insured patients and for charges of DENIED services rests with the patient, or responsible party, who is the beneficiary of those services.

_____ I agree to be personally responsible for payment of those services, as well as, any legal fees, court costs, collection fees, and late fees connected with collection of payment.

_____ I agree to pay a **$25.00** fee for any personal checks returned for insufficient funds.

_____ I agree that the person who brought the child in to see the doctor, is responsible for all the fees associated with the visit.

APPOINTMENT POLICY

_____ The cooperation of each patient is necessary to assure that everyone's needs are met. Frequently, patients are placed on a "waiting list" for appointment cancellations. It is therefore necessary that every consideration be given to avoid missed appointments that could be used by someone else.

_____ Each patient is responsible for keeping appointments with his or her provider. If it becomes necessary to break an appointment, it is EXPECTED that a patient contact this office 24 hours in ADVANCE of scheduled appointment.

_____ If a patient misses his or her scheduled appointment or fails to provide **24 hours advance notice**, there will be a charge of **$50.00**. This charge will not and cannot be billed to your insurance company. You are personally responsible for this charge. **In the event my account is turned over for collection. I understand that I will be responsible for all collection costs.**

SIGNATURE OF AGREEMENT

_____

DATE _____

WITNESSED BY:

_____

DATE _____

INFORMED CONSENT FOR TREATMENT

I, _____ DOB_____ SSN_____

1. I have been informed of my rights and responsibilities as a patient of Dr. Daniel J. Christiano, Ph.D.

2. I have been informed about the limits of confidentiality of my records.

3. I have been informed of the cost of services from Dr. Daniel Christiano. I understand that I am responsible to pay a co-pay and that it is payable each time I come for treatment.

4. I have been informed about Dr. Daniel J. Christiano's qualifications.

5. I understand that I may address any concerns or grievances with my therapist/doctor at any time. I understand that I may also contact the licensing board which regulates therapists/doctors professional practice.

6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment t any time. However, I agree to let Dr. Christiano know before stopping treatment.

7. I agree that, if at any time, I feel that I may be a threat to myself or others, I will call 9-1-1.

8. I give my authorization and consent to receive outpatient diagnostic and treatment services from Dr. Daniel J. Christiano. I understand that my therapist/doctor believes that this treatment will help me and there is no guarantee as to the result. I also understand that on occasion there are negative consequences to treatment, and I agree to inform Dr. Daniel Christiano if there are unexpected changes in my condition.

_____ _____

Signature of patient or legal consenter Date

_____ _____

Signature of staff providing the information Date

Daniel J. Christian, Ph.D.

Consent For Treatment of Minors (Under 18)

Child's Name _____ Date of Birth _____

I/We _____ am/are the legal custodial

parents/guardians of _____ and give my/our

permission to Dr. Daniel J. Christiano, Ph. D to provide psychological services to my/our child.

If the child's biological parents are not together, please complete:

What is the custody arrangement of this child? (Joint or sole Custody?) _____

Who is primary custodian? _____

If applicable, please describe the child's current visitation schedule: _____

_____

_____

Signatures:

_____	_____	_____
Parent Signature	Parent Printed Name	Date
_____	_____	_____
Parent Signature	Parent Printed Name	Date

Daniel J. Christiano, Ph.D.

CHILDHOOD HISTORY FORM

Child's Name_____ Birth Date_____ Age_____ Sex____
Home Address_____
Street
_____Home Phone_____
City State Zip Area Code
Child's School_____
Name Address
Grade _____ Special Placement (if any) _____
Child is presently living with
__Natural Mother __Natural Father __Stepmother ___Stepfather ___Foster Mother __Foster Father

__Adoptive Mother __Adoptive Father ___Other (Specify) _____

Non-residential adults involved with this child on a regular basis:
_____
_____

Source of Referral: Name _____
_____
Address Phone
Briefly state the main problem of this child:
_____
_____

PARENTS
Mother _____ Occupation _____ Bus. Phone_____
Age _____ Age at time of pregnancy with patient _____
School: Highest grade completed _____
Any learning problems/Attention problems/behavior problems _____
_____
Medical Problems _____
Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____
_____
Father _____ Occupation _____ Bus. Phone_____
Age _____
School: Highest grade completed _____
Any learning problems/Attention problems/behavior problems _____
_____
Medical Problems _____
Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____
_____

SIBLINGS
Name Age Medical, Social, or School Problems
_____
_____
_____
_____

Pregnancy- Complications
Excessive vomiting _____ Hospitalization required _____
Excessive staining/Blood loss_____Threatened miscarriage_____

Infection(s) (specify) _____
Toxemia _____ Operation(s) (specify) _____
Other illness(es) (specify) _____
Smoking during pregnancy? _____ # cigarettes per day_____
Alcoholic consumption during pregnancy Yes/No If yes, how often? _____
Medication taken during pregnancy _____
X-ray studies during pregnancy _____
Duration of pregnancy (weeks) _____

DELIVERY

Type of labor: __Spontaneous __Induced Duration (hrs.)_____
Type of delivery: __Normal __Breech __Caesarean
Complications: __Cord around neck __Hemorrhage __Infant injured during delivery
Other _____ Birth Weight _____

POST DELIVERY PERIOD

Jaundice __ Cyanosis (turned blue) __ Incubator Care __ Infection(specify)_____
Number of days infant was in the hospital after delivery_____

INFANCY PERIOD

Were any of the following present, to a significant degree, during the first year of life? If so, describe:
Did not enjoy cuddling _____
Was not calmed by being held or stroked _____
Difficult to comfort _____
Colic _____ Excessive restlessness_____
Excessive irritability _____
Diminished sleep _____
Frequent head banging _____
Difficult nursing _____
Constantly into everything _____

TEMPERAMENT

Please rate the following behaviors as your child appeared during infancy and toddlerhood:
Activity level: _____
Distractibility:_____
Adaptability:_____
Approach/Withdrawal:_____
Intensity:_____
Mood: _____

MEDICAL HISTORY

If you child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:
Childhood diseases: _____
Operations:_____
Hospitalizations: _____
Head injuries: _____
Convulsions _____ With fever _____ Without fever_____
Coma _____ Persistent high fever _____ Eye Problems _____
Tics (i.e., eye blinking, sniffing, any repetitive, no-purposeful movements)_____
Ear Problems _____Allergies or Asthma _____
Poisoning _____
Sleep – Does your child settle down to sleep? _____Sleep through the night without disruption? _____
Experience nightmares, night terrors, sleep walking, sleep talking? _____
Is your child a very restless sleeper? _____ Does you child snore? _____
Appetite - _____

PRESENT MEDICAL STATUS

Height _____ Weight _____ Present illness child is being treated for _____

Medicine child takes regularly _____

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall exactly, check items at right:

	Age	Early	Normal	Late
Smiled				
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words				
Said phrases				
Said sentences				
Bladder trained, day				
Bladder trained, night				
Bowel trained, day				
Bowel trained, night				
Rode tricycle				
Rode bicycle (without training wheels)				
Buttoned clothing				
Tied shoelaces				
Named colors				
Named coins				
Said alphabet in order				
Began to read				

COORDINATION

Rate your child on the following skills:

	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace Tying			
Buttoning			
Writing			
Athletic Abilities			
Excessive number of accidents compared to other children			

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand direction and situation as well as other children his or her age?

If not, why not? _____

How would you rate your child's overall intelligence compared to other children?

Below_____ Above Average_____ Average_____

SCHOOL HISTORY

Were you concerned about your child's ability to succeed in kindergarten? If so, please explain:

_____

_____

Rate you child's school experience related to academic learning:

	Good	Average	Poor
Pre-school			
Kindergarten			

Current grade _____
To the best of your knowledge, at what grade level is your child functioning:
Reading _____ Spelling_____ Arithmetic_____
Has you child ever had to repeat a grade? If so, when? _____
Present class placement: Regular class _____ Special Class (if so, specify)_____
_____
Kinds of special counseling or remedial work your child is currently receiving
_____
Describe briefly any academic school problems _____
_____
Rate your child's school experiences related to behavior

	Good	Average	Poor
Pre-school			
Kindergarten			
Current grade			

Does your child's teacher describe any of the following as significant classroom problems?
Doesn't sit still in his or her seat _____
Frequently gets up and walks around classroom _____
Shouts out. Doesn't wait to be called on _____
Won't wait his/her turn_____
Doesn't cooperate well in group activities_____
Typically does better in one-to-one relationship_____
Doesn't respect the rights of others_____
Doesn't pay attention during storytelling or show and tell_____
Any other classroom behavioral problems_____
_____

PEER RELATIONSHIPS
Does your child seek friendships with peers? _____
Is your child sought by peers for friendship? _____
Does your child play with children primarily his or her own age? _____
Describe any problems your child is having with peers? _____
_____

HOME BEHAVIOR
All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her own age.
Fidgets with hands feet or squirms in seat ____
Has difficulty remaining seated when required to do so ___
Easily distracted by extraneous stimulation ____
Has difficulty awaiting his turn in games or group situations ____
Blurts out answers to questions before they have been completed ____
Has problems following through with instructions (usually not due to opposition or failure to comprehend)
___
Has difficulty paying attention during tasks or play activities ___
Shifts from one uncompleted activity to another ___
Has difficulty playing quietly ___
Often talks excessively ____
Interrupts or intrudes on others (impulsive) ____
Does not appear to listen to what is being said ___
Does things necessary for tasks or activities in home ___
Boundless energy and poor judgment ____
Impulsivity (poor self-control) ___
History of temper tantrums ___
Temper outbursts ____

Frustrates easily ___
Sloppy table manners ____
Sudden outbursts of physical abuse of other children ____
Acts like he or she is driven by a motor ____
Wears out shoes more frequently than siblings ___
Excessive number of accidents ____
Doesn't seem to learn from experience ____
Poor memory ____
A "different child" ____
How well does you child work for rewards? _____
Does your child create more problems, either purposeful or non-purposeful, within the home setting than his or her siblings? _____
Does your child have difficulty benefiting form his experiences? _____
Types of discipline used with your child _____
Is there a particular form of discipline that has proven effective? _____
Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? _____

INTERESTS AND ACCOMPLISHMENTS
What are you child's main hobbies and interests? _____
_____
What are your child's greatest accomplishments? _____
_____
What does your child enjoy doing most? _____
_____
What does your child dislike doing most? _____
_____
What do you like most about your child? _____
_____

LIST ANY OTHER PROFESSIONALS CONSULTED (including family doctor)
_____
_____
_____

ADDITIONAL REMARKS:
_____
_____
_____
_____
_____
_____

DANIEL J CHRISTIANO, PHD
1630 E White Mountain Boulevard, Suite B
Pinetop, AZ 85935
480.577.6367 F 928.358.5015 djchere@aol.com www.drchristiano.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of Daniel J Christiano, PhD, Notice of Privacy Practices. This notice describes how Daniel J Christiano, PhD may use ad disclose my protected health information, certain restrictions on the use of my healthcare information and rights I may have regarding my protected health information.

_____ _____

Signature of patient or personal representative Date

_____

Relationship to patient

DANIEL J CHRISTIANO, PHD
1630 E White Mountain Boulevard, Suite B
Pinetop, AZ 85935
480.577.6367 F 928.358.5015 djchere@aol.com www.drchristiano.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This notice tell you about the ways in which Daniel J. Christiano, Ph.D. may collect, use, and disclose your protected health information and your rights concerning your protected health information. "Protected Health Information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by Federal and State laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice, while it is in effect. Some of the uses and disclosures described in this Notice may be limited to certain cases by applicable state laws that are more stringent than the federal standards. The HIPAA Privacy Rule for the first time creates national standards to protect individuals' medical records and other personal health information.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

PAYMENT: We use and disclose your protected health information to your insurance company in order to receive payment for your covered health expenses.

HEALTH CARE: We may use and disclose your protected health information to other health care providers (physicians, healthcare professionals, laboratories, or hospitals) to better assist in your diagnosis and treatment.

MEDICAL RECORDS REQUEST: We will disclose your protected health information if we receive a request from another physician who is treating you or will be treating you, with a signed request from you. We will disclose your protected health information to another physician if we refer you to that physician. We will disclose your protected health information to an insurance company if we have filed a claim on your behalf. We will disclose your protected health information, with your authorization, to a life insurance underwriter or health insurance company if you are seeking life or health insurance coverage and have requested a company to contact us for your medical history.

MARKETING: If our office ever decides to use a patient's protected health information for marketing purposes, a patient's prior written authorization to use this patient's information will be required. Daniel J. Christiano, Ph.D. will never sell lists of patients' names/information to any third party.

OTHER PERMITTED OR REQUIRED DISCLOSURES

AS REQUIRED BY LAW: We must disclose protected health information about you when required to do so by law.

PARENTS AND MINORS: State law governs disclosures to parents.

PATIENTS 18-22: who are financially dependent on their parents, yet legally are adults: Without prior authorization, we cannot disclose an adult patient health status to anyone including parents (and in some cases, we cannot disclose a minor's individual health data).

CHILDREN UNDER 18: It is our office policy that any child under the age of 18 must be accompanied by a parent or legal guardian on their first visit to our office. The parent or representative may then sign an authorization for treatment of the child when they are not with them.

GENERAL PUBLIC HEALTH ACTIVITIES: We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE: We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

HEALTH OVERSIGHT ACTIVITIES: We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process, and disclose records to legal counsel for the purpose of seeking legal advice.

LAW ENFORCEMENT: We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

CORONERS, FUNERAL DIRECTORS, ORGAN DONATIONS: We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.

RESEARCH: Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

SPECIAL GOVERNMENT FUNCTIONS: We may disclose protected health information as required by military authorities or to authorized federal officials for national security and intelligence activities.

WORKERS' COMPENTSATION: We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, effective with the date of the letter of revocation.

YOUR RIGHTS REGARDING OUR PROTECTED HEALTH INFORAMTION

You have certain rights regarding protected health information that our office maintains about you.

RIGHT TO ACCESS YOUR PROTECTED HEALTH INFORMATON: You have the right to review or obtain copies of your protected health information records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying, mailing our requested information, but we will tell you the cost in advance.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATON: If you feel that the protected health information maintained by our office is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, for example, you may ask us to amend something in your record that was not created by our office, as is often the case when the information may come to us from another physician, health care professional, laboratory, or hospital. We may deny your request if you ask us to amend a record that is already accurate and complete.

RIGHT TO AN ACCOUNTING OF DISCLOSURES BY THE PLAN: You have the right to request an accounting of disclosures we have made of your protected health information. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before September 21, 2009. Your request should indicate in what form you want the list (example: on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists, we reserve the right to charge for the cost of providing the list.

RIGHT TO REQUEST RESTRICTIONS ON THE USE AND DISCLOSURE OF YOUR PROTETED HEALTH INFORMATON: You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment, or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

FOR INFORMATION REGARDING EXERCISING YOUR RIGHTS: You may exercise any of the rights described above by contacting. Daniel J. Christiano, Ph.D. See the end of this Notice for the contact information.

HEATH INFORMATION SECURITY

Daniel J. Christiano, Ph.D. requires its employees and associates to follow the office security policy and procedures that limit access to health information about patients to those employees and associates who need it to perform their job responsibilities. In addition, Daniel J. Christiano, Ph.D. maintains administrative, and technical security measures to safeguard your protected health information.

CHANGES TO THIS POLICY

Daniel J. Christiano, Ph.D. reserves the right to change the terms of the Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in the Notice.

COMPLAINTS

If you believe that your privacy rights have been violate, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing and sent to the Office listed at the end of this Notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

RIGHT TO REVOKE HEALTH CARE AUTHORIZATION

You have the right to revoke the **HEALTH CARE AUTHORIZATION FORM,** in writing, at any time. However, your written request to revoke your **AUTHORIZATION** is not effective to the extent that we have provided services or taken action in reliance on our authorization. You may revoke your **AUTHORIZATION** by mailing or hand delivering a written notice to our office at the address listed at the end of the Notice. The revocation is not effective until it is received by our office.

The written notice must contain the following information:

Our name, Social Security Number and date of birth
A clear statement of your intent to revoke your **AUTHORIZATION**
The date of your request, and
Your signature

The **AUTHORIZATION** is requested by Daniel J. Christiano, Ph.D. for its own use/disclosure of your protected health care information (Minimum necessary standards apply.)

You have the right to refuse to sign this **AUTHORIZATION.** If you refuse to sign this **AUTHORIZATION,** Daniel J. Christiano, Ph.D. reserves the right to refuse service. A copy of the signed **AUTHORIZATION** will be provided to you at your request.

MISSED APPOINTMENTS: Unlike some other medical or paramedical professionals who operate on more flexible or inexact schedules, our counselor commits a specific time period, usually 45-55-minute sessions, to each patient. It is important that you appreciate the fact that this block of time has been set aside for you. Our schedules are usually crowded. Your canceling or rescheduling your appointment without sufficient notice often means the loss of an hour of therapy, and it is difficult to reassign the hour to someone else on short notice. A charge may be made for an appointment not canceled 24-hours in advance.

PAYING YOUR BILL: We accept insurance payments, but you are responsible for any balance on the account. Cash accounts or insurance co-payments are due at the time of service. If we are to submit for reimbursement for your insurance carrier, it is your responsibility to provide us with the proper forms and necessary signatures. New claim forms may be needed at the beginning of each calendar year.

OFFICE HOURS: Are by appointment, during regular business hours. If you telephone the office at a time when the therapist is in session or out of the office, voicemail will record your message and your call will be returned as quickly as possible. Should you have a life-threatening emergency, please call 9-1-1.

CONTACTING DANIEL J. CHRISTIANO, Ph.D. If you have any questions or complaints about this Notice or you want to submit a written request to our office in any of the previous sections of the Notice, please call 480.577.6367 or write:

Daniel J. Christiano, Ph.D.
1630 E White Mountain Blvd., Suite B
Pinetop, Arizona 85935