**Child History and Intake Form**

Please complete this confidential form to help your clinician better understand you and your child’s concerns.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ /\_\_\_ /\_\_\_\_

Age: \_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: Male / Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No.: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No.: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the primary care taker of the child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing the form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to child: \_\_\_\_\_\_\_\_\_

Reason for referral/presenting problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the problem presented occur most at home \_\_\_\_ school \_\_\_\_ other \_\_\_\_

If there are more concerns, please list them here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**

Parent’s marital status:

|  |  |
| --- | --- |
| ○ single, never married | Mother’s current age: |
| ○ married | Mother’s occupation: |
| ○ separated |  |
| ○ divorced | Father’s current age: |
| ○ widowed | Father’s occupation: |

Please check any of the following that are true for this child:

|  |
| --- |
| ○ was adopted |
| ○ is a foster child |
| if so, is child aware ○ yes ○ no |

Who lives in the home with the child? (mother, father, stepparent, parent’s significant other, siblings, aunts, uncles, grandparents, foster parents, etc.)

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Relation to child** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Pregnancy History**

Please check any of the following, which occurred during the mother’s pregnancy with this child.

|  |  |
| --- | --- |
| ○ spotting or bleeding | ○ smoking |
| ○ severe colds or flu | ○ alcohol use |
| ○ German measles (rubella) | ○ prescription drug use |
| ○ bladder or kidney infection | ○ other drug use |
| ○ high blood pressure | ○ physical injury |
| ○ toxemia | ○ emotional stress |
| ○ anemia (low iron) | ○ depression or anxiety |
| ○ RH incompatibility | ○ other mental illness |
| ○ on special diet | ○ hospitalization during pregnancy |
| ○ gained less than 15 pounds | ○ other, not listed |
| ○ gained less than 30 pounds |  |

**Child’s Birth History:**

**Born:** □ on-time / □ # of weeks early \_\_\_ / □ # of weeks late \_\_\_

**Hours in Labor: Birth and Delivery:**

□less than 4 hours □ no complications

□ more than 4 but less than 20 hours □ caesarean (C-section)

□ more than 20 hours □ multiple births

□ labor was Induced □ cord around neck

□ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much did the child weigh at birth? \_\_\_\_\_ (pounds) / \_\_\_\_\_ (ounces)

How long did the child stay in the hospital after birth? \_\_\_\_\_\_\_ (days)

**Child’s Medical History**

Please check any of the following, which applied during the first month after birth.

□ breathing problems

□ jaundice (skin yellow)

□ cyanosis (skin blue)

□ convulsions/seizures

□ feeding problems

□ injury

□ physical defect

□ surgery

□ was given medications

□ excessive crying

□ sleeping problems

□ very inactive

□ very jittery

□ stay in intensive care nursery

□ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any health problems? □ yes or □ no if yes, please explain \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever been hospitalized? □ yes or □ no if yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever had a surgery/operation? □ yes or □ no if yes, please explain \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Medical History**

Please check any of the following that the child has had from birth to date.

□ recurrent ear infections

□ rashes or skin problems

□ meningitis and/or encephalitis

□ headaches and/or migraines

□ convulsions and/or seizures

□ head injuries and/or concussions

□ allergies

□ eye and/or vision problems

□ chronic infection

□ bowel problems

□ slow weight gain

□ heart disease

□ diabetes

□ German measles, whooping cough, measles, mumps, and/or chicken pox

□ infections (TB, CMV, HIV)

□ genetic or chromosomal testing

□ EEG, MRI, and/or CT

□ hospitalization

□ injury

□ surgery

□ poisoning

□ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications the child is currently taking or has previously taken?

|  |  |  |
| --- | --- | --- |
| **Date(s)** | **Reason** | **Effectiveness** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No.: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No.: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_\_\_\_

May we contact the physician(s) to coordinate care, if necessary? □ yes or □ no

**If yes, please sign giving authorization to contact them below:**

**Developmental History**

As closely as you can recall, please write the age when your child did the following:

|  |  |
| --- | --- |
|  | sat up without support |
|  | crawled |
|  | walked alone |
|  | rode a tricycle |
|  | gave up bottle/breast milk |
|  | started eating solid foods |
|  | spoke first words |
|  | used short sentences |
|  | toilet-trained (day) |
|  | toilet-trained (night) |
|  | dressed him/herself |
|  | drew a circle |
|  | understood the word “no” |
|  | able to point to 5 parts of body (where nose is ext.) |

**Behavioral Patterns**

Please check any of the following that has ever been true of your child:

□ extremely restless/active

□ desires to be held often

□ difficulty being consoled/calmed

□ extreme reaction to tastes/touching

□ over-reaction to sights or noises

□ seems too sad or too happy

□ seems like a “worry-wart”

□ head banging; hurts self

□ rocking of body

□ aggressive towards people

□ trouble making eye-contact

□ failure to be affectionate

□ making odd sounds/noises

□ will not play with other children

□ does not seem to pay attention

□ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is he/she dealing with problems handling their anger or temper? (Describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is he/she withdrawn or experiencing a great deal of sadness? (Describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When it comes to stress and frustration how is your child’s reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is he/she experiencing more clumsiness than the usual child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does the child deal with other people in the family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice a change in your child’s behavior? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you do at the time you noticed it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had your child evaluated for the presenting problem? □ yes or □ no

If yes, when and by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daycare/School Information**

If your child has ever been in school/daycare, please list school name & dates or ages attended:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please check any of the following services that your child has ever received:

□ resource services/extra help at school

□ self-contained classroom at school

□ speech/language therapy (SP/L)

□ occupational therapy (OT)

□ physical therapy (PT)

□ psychological/ educational evaluation

Has your child ever repeated a grade, been retained, or held back? □ yes or □ no

If so, what grade(s)? \_\_\_\_\_\_\_\_\_\_\_\_

**Family Background**

If any of the child’s relatives (parents, grandparents, siblings, aunts, uncles and cousins on the maternal and paternal side) have had any of the following conditions, please check the condition and write that person’s relation to the child next to it.

|  |  |
| --- | --- |
| **Condition** | **Relation to child** |
| ○ convulsions, seizures, epilepsy |  |
| ○ hearing loss |  |
| ○ speech problems |  |
| ○ slow development |  |
| ○ learning problems in reading, writing or mathematics |  |
| ○ retained/held back in school |  |
| ○ autism |  |
| ○ mental retardation |  |
| ○ motor problems or muscle weakness |  |
| ○ hyperactive as a child (ADD or ADHD) |  |
| ○ depression, anxiety, bipolar (manic-depression) |  |
| ○ suicide attempts |  |
| ○ thyroid disease |  |
| ○ other |  |

Please check any of the following events that have happened for anyone in the family in the past 6 months:

|  |  |
| --- | --- |
| ○ increase in martial conflict | ○ serious illness/hospitalization |
| ○separation or divorce | ○ new baby |
| ○ remarriage | ○ jail sentence/legal trouble |
| ○ death in family | ○ loss of job |
| ○ change in living situation | ○ trauma or injury |
| ○ other | |

Please check any of the following educational problems the child exhibits:

□ does not like school

□ does not get along with others in his or her class

□ has problems with spelling

□ has problems with reading

□ has problems with math

□ has problems with writing

What are your goals for your child while they are coming to Alase Center for Enrichment? \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is any additional information you would like us to be aware of please list it here: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Insurance Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorization No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary/Secondary Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Circle)**

Address of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured & Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date of Insured: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender of Insured: Male / Female

Effective Date of Policy: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policy No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan/Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please check one and sign below:***

\_\_\_\_\_ I would like for Alase Center for Enrichment to assist in filing my insurance claim using “In Network or Out of Network” options. I authorize Alase Center for Enrichment to communicate with my insurance carrier regarding treatment. I understand that Alase Center for Enrichment will follow HIPAA guidelines regarding confidentiality and that only necessary information will be provided when requested by my insurance company. I also understand that I will not be notified of such communication unless specifically requested by me in writing.

\_\_\_\_\_ I will either file independently or will not be using insurance benefits at this time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Client, Parent or Guardian Signature Date

This is strictly a confidential client medical record. Redisclosure or transfer is expressly prohibited by law.

The signature of a parent or legal guardian is required if the client is under 18 years of age or legal incompetent.

Billing Information:

I authorize the release of information to my insurance company relevant to the processing of insurance claims for myself of my dependent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Client, Patient or Guardian Signature Date

I authorize payment of medical benefits be made to the physician or supplier for services received.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Client, Patient or Guardian Signature Date

The signature of a parent or legal guardian is required if the client is under 18 years of age or legally incompetent.

### **POLICIES & PROCEDURES**

This contract contains information about our services and the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a new federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. A Notice of Privacy Practices (NPP) is attached to this contract and explains HIPAA in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information. Signing this agreement also represents an agreement between us. You may revoke this contract in writing at any time which will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process claims; or if you have not satisfied any financial obligations you have incurred.

# **APPOINTMENTS**

Your appointment represents time reserved for you. As schedule permits, we will work out the most convenient time for you for these appointments. **We reserve the right to charge $50.00 for all cancellations made less than 24 hours in advance.** Please help us serve you better by keeping scheduled appointments. We provide an answering machine during non-business hours, for your convenience in leaving a message. Simply call (919) 957-7357 and leave a confidential voice message. **We also reserve the right to reschedule your appointment if you arrive more than fifteen minutes late, dependent upon the schedule that day.**

# **PAYMENT OF FEES**

Payment is to be made in full at time of service with the exception of co-payments when applicable. We accept cash, check or credit/debit card. Payment of any unpaid balance on your account must be received in full before the close of the month. Unpaid balances older than 60 days will be subject to an interest charge of 1.5% per month (15% annually). Payments are non- refundable. You will be liable for all cost if your account default and require the use of a collection agency. In addition, you will be liable for all other cost incurred in their service including, but not limited to, corporation fees, attorney’s fees and all court related expense. Services maybe interrupted until payment is made.

# **INSURANCE/THIRD PARTY/MANAGED CARE**

We highly recommend that you verify your insurance benefits and we will be happy to assist you in this. As a courtesy to you, will file insurance claims on your behalf. You receive a monthly statement showing your balance and indicating whether insurance has been filed out. Please understand that you are responsible for any balances not covered by your insurance. You are also responsible for all deductibles, co-payments, and estimated amounts not covered by your insurance company are due at the time services are rendered. Your insurance policy is a contract between you and your insurance carrier; we are not the party to that contract. It is your responsibility to obtain authorization to for the initial visit.

**CONTACTING YOUR THERAPIST**

Due to the work schedule, therapists are often not immediately available by telephone. While usually in the office between 9 AM and 5 PM, they will not answer the phone when with a client. When unavailable, telephones are answered by voice mail or by the front office staff. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please leave times when you will be available.

**PROFESSIONAL RECORDS**

**The laws and standards of the helping profession require that we keep PHI about you in your Medical Record. Except in circumstances that involve danger to yourself and/or others, or the record makes reference to another person and we believe that access is likely to cause harm to such other person, you may examine and/or receive a copy of your Medical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence or have them forwarded to another professional so you can discuss the contents. We charge a copying fee per page. If we refuse your request for access to records you have a right of review, which we will discuss with you upon request.**

**PATIENT RIGHTS**

HIPAA provides you with several rights with regard to your Medical Records and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your Medical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this contract, the attached NPP form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

# **READ CAREFULLY AND COMPLETE**

I have read, understand and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

I agree to pay each visit in full and have Alase Center for Enrichment (ACE) file my insurance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Responsible Party Office Staff or Doctor’s Signature

Date\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Please feel free to direct any questions to the front office staff or your therapist. Your understanding of this contract is important to us and we are happy to discuss any or all of these conditions with you at any time. We look forward to serving you and your family.

The signature of a parent or legal guardian is required if the client is under 18 years of age or legal incompetent.

**Signature on File**

**(Please initial each applicable line and sign at bottom of the page)**

\_\_\_\_\_ I authorize use of this form on all my insurance submissions.

\_\_\_\_\_ I authorize release of information to all my insurance companies.

\_\_\_\_\_ I understand that I am responsible for my bill.

\_\_\_\_\_ I authorized Dr. Anthony J. Smith Ph.D., (Alase Center for Enrichment)

to act as my agent in helping me to obtain payment from my insurance companies.

\_\_\_\_ I authorize direct payment to Dr. Anthony J. Smith Ph.D., (Alase Center for Enrichment).

\_\_\_\_ I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Client, Parent or Guardian Signature Date

The signature of a parent or legal guardian is required if the client is under 18 years of age or legal incompetent.