

For Office Use Only

Chart#: _____

Dx: _____

Ins: Yes No

The Centre
New life begins at The Centre.

1290 Main Street, Suite B, Daphne, AL 36526
(251) 625-0118 ♦ Fax: (251) 625-0116

CLIENT INFORMATION SHEET

(Please print clearly)

DATE: _____

Full Legal Name of Client: _____ Nickname: _____

Cell Phone#: _____ Home Phone#: _____

Mailing Address: _____

City _____ State _____ Zip _____

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: _____ Spouse's Name (if applicable): _____

If client is a child, please provide parents' or guardians' names.

Father: _____ Mother: _____ Guardian(s): _____

Stepparents: _____

Email Address: _____

Referred by: _____

EMPLOYMENT INFORMATION:

(If client is a minor, please provide parent's employer info.)

Employer: _____ Phone: _____

Address: _____

Spouse's Employer: _____ Phone: _____

Address _____

EMERGENCY CONTACT (someone not residing in your home)

Name: _____ Relationship: _____

Phone: _____ Address: _____



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Robert E. Colclough, M.A., LPC,
Julie Taylor, LPC, RPT,
Jay Stone, M.A, NCC, LPC
Aubrie Custred, LMFT

FAMILY MEMBERS

Name: _____ Relationship: _____
Date of Birth: _____ Age: _____ Education: _____
Employment: _____

Name: _____ Relationship: _____
Date of Birth: _____ Age: _____ Education: _____
Employment: _____

Name: _____ Relationship: _____
Date of Birth: _____ Age: _____ Education: _____
Employment: _____

Name: _____ Relationship: _____
Date of Birth: _____ Age: _____ Education: _____
Employment: _____

PRESENTING PROBLEM:

TREATMENT HISTORY: (Please include treatment provider names and dates seen.)



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Family, marital, and individual therapy are available to help people resolve family discord, make living relationships better, enhance parenting skills, or help individuals deal with personal issues in their lives. Sessions may include seeing people individually, with their partner, or, with the entire family. Who should be attendance will be worked out in advance with the counselor.

Fee Structure:

Individual Therapy:	\$140.00
Family/Couple's Therapy:	\$140.00
Consultation:	\$140.00 per hour
Psycho-educational Evaluation:	\$800.00
Computer Evaluation:	\$80.00
*Court Fees	\$350.00-\$500 per hour

*Rates for court cases may vary depending on the complexity of the case.

***24 HOUR CANCELLATION POLICY:**

If you do not show up for your scheduled appointment, and you have not notified us at least 24 hours in advance, you will be charged for the cost of the session as booked. Insurance will not pay for missed sessions. This office does not practice double booking; the time assigned for your appointment is intended to be devoted to you. We appreciate your understanding.

I understand I am responsible for my fees at the above listed rates.

Client Signature: _____

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NON-COVERED SERVICES POLICY FOR BLUE CROSS/BLUE SHIELD AND OTHER INSURANCE CARRIERS

As my client, I want to provide you the best care possible. There may be certain services that I feel are necessary for your care that **are not covered by your Blue Cross/Blue Shield of Alabama Preferred Care contract or other insurance carriers.** You will **be expected to pay** for those services in full. For example, certain psychological testing, psychotherapy or psycho-educational evaluations may not be covered by your contract. If you have any questions about your Blue Cross or other insurance plan such as whether a particular service is covered or not, our office staff will be happy to assist you. Thank you for your understanding.

I have read and understand that services not covered by my insurance plan will be my responsibility.

Signature: _____ Date: _____

Services that may not be covered as explained to Client:

Psychological Evaluations
Psycho-educational Evaluations
Psychotherapy/Counseling



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Centre is required to protect the privacy of your confidential personal health information, referred to below as protected health information ("PHI"). This Notice of Privacy Practices ("Notice") is provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This notice describes how The Centre may use and disclose your PHI to carry out treatment, payment and healthcare operations and for other purposes that are permitted or required by law. This notice also describes your rights to access and control your PHI. The Centre will make a good faith effort to obtain from you a written acknowledgment of receipt of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, and insurance company or a third party. For example, we may disclose your record to an insurance company, so that we can get paid for treating you.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or to other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care and for whom you have signed authorization.

FOR HEALTH CARE OPERATIONS: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of a health care professional authorized to enter information into your medical chart, and member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at The Centre. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care of payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submit to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care of the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the office manager at 625-0118. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosure of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

PATIENT OR PATIENT'S REPRESENTATIVE

DATE



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Practice Statement and Disclosures

When a person or a family is experiencing distress over problems or potential problems, it is often difficult to know how to get started with the change process. The purpose of our office is to help you find the answers you need and the right solutions that are necessary to create the positive changes you seek.

It is our intent that this office is set up to provide an environment that is conducive to positive change. Please feel free at any time to ask our staff questions that you might have about the evaluation or therapy process. We hope you find our office atmosphere to be professional, but not so "business-oriented" that you would be uncomfortable to ask our staff for assistance.

This information packet may be useful in explaining our services, fees, and general information about our approach to treatment. It is our belief that change occurs best in an atmosphere of mutual understanding and straightforward progress toward a goal. Therefore, please do not hesitate to discuss with us any questions or concerns that you might have about the work we will be doing together.

Expectations

For those coming to us for counseling, the overall purpose of our relationship will be to assist in your choices about situations you believe to be troublesome. You should expect timely replies to your request. You should expect that the procedures and techniques used in our time together will be based on sound principles from our field and that they reflect the current methods of assisting persons with counseling needs. You should also know that since counseling is about trying new and different ways of behaving, thinking, and feeling, certain risks are possible for both you and those around you who may be uncomfortable with your new ways of acting, thinking, and feeling. However, if you are determined and committed to our goals, you should expect benefits from our time together.

For those coming to us for an evaluation, the purpose of our relationship will be to assist in educational and/or career planning as well as personal/relational issues. You should expect an assessment of your or your children's strengths and weaknesses in order to seek appropriate school/career placement or personal insight

Office Hours

Sessions are scheduled by appointment (except in cases of emergency). Standard office hours are Monday thru Friday from 9:00 AM to 5:00 PM.

Emergencies

Our office is not presently equipped to provide after-hours emergency care. If a psychological emergency occurs after regular office hours, we suggest that you contact the nearest hospital emergency room.

Cancellation

This office does not practice double booking; the time assigned for your session is intended to be devoted to you. As a result, it is important to notify the office at least twenty-four (24) hours in advance, if you need to cancel the appointment so this time can be given to someone else. If you cancel an appointment without the required notice or if you elect not to meet your session, you will be charged the cost of the session.

Payment for Professional Services

Fees are to be paid at the time of each session.

Insurance/Third Parties

Many times, fees for counseling services may be paid partially by insurance companies or some similar management organization. If you elect to use resources of your insurance or another third party, you should know the information such as diagnosis, impressions, or similar types of personal information are typically required by the insurance company or management organization to secure payment.

Managed Health Care Administration
Initial Assessment Child/Adolescent Program
Parent Questionnaire
Page 1

Clinician Notes:

Date: _____

Patient Name: _____ Date of Birth: ____/____/____

Age of Patient: _____ Name of person completing this form: _____

Relationship to Patient: _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? ☐ Yes ☐ No If yes, explain:

II. Medical History:

Name of Pediatrician or Family Doctor: _____

Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? ☐ Yes ☐ No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Asthmatic condition | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chronic Hearing Loss | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Other: _____ | | | |

Please explain any item that you checked and list any medication(s) that were *previously* prescribed.

Allergies (Please list all of your child's allergies):

Current Medications (Please list all of your child's current medications other than above):

Clinician
Signature:

Managed Health Care Administration
Initial Assessment Child/Adolescent Program
Parent Questionnaire
Page 2

Clinician Notes:

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? ☐ Yes ☐ No If yes, please explain and include dates of service, location, clinician's name.

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3 medications, use the back of this page):

<u>Name of medication</u>	<u>Prescribed by</u>	<u>Dose level</u>	<u>Side effects</u>
1.			
2.			
3.			

IV: Developmental History:

A: Relating to your child's birth:

Your child's weight at birth: ____ lbs. ____ oz. Was this a full term birth? ☐ Yes ☐ No If no, explain:

Did either parent use drugs or alcohol at the time of conception? ☐ Yes ☐ No If yes, explain:

Were there any complications with the labor & delivery such as jaundice, infection etc.? ☐ Yes ☐ No If yes, explain:

Were there any problems after birth? ☐ Yes ☐ No If yes, explain:

B. Pre-school/Toddler Temperament: Please check the following items that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Did not enjoy being held | <input type="checkbox"/> Excessive restlessness | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Head-banging |
| <input type="checkbox"/> Sensitive to light / noise / texture | <input type="checkbox"/> Fussy or unhappy | <input type="checkbox"/> Difficulty bonding |

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting alone _____ Walking _____ Put words together _____ Toilet trained

D. Unusual behaviors/Speech patterns:

- | | | |
|--|--|---|
| <input type="checkbox"/> Spinning | <input type="checkbox"/> Putting things in the mouth | <input type="checkbox"/> Repeating words or phrases inappropriately |
| <input type="checkbox"/> Hand flapping | <input type="checkbox"/> Sniffing excessively | <input type="checkbox"/> Saying "I" for "You" |

V. School/daycare History:

Did your child attend daycare? ☐ Yes ☐ No If yes, what was their age? ____ Any problems? _____

What were your child's grades on their last report card? _____

What is the name of your child's primary teacher? _____

Clinician
Signature: _____

**Managed Health Care Administration
Initial Assessment Child/Adolescent Program
Parent Questionnaire
Page 3**

Clinician Notes:

Name of Current School:	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Past Schools:	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has your child ever been:
evaluated for a learning disability? ☐ Yes ☐ No If yes, what grade? _____ When? _____

placed in Special Education Classes? ☐ Yes ☐ No If yes, what type of class? _____

tested by the school system? ☐ Yes ☐ No If yes, when? _____

expelled or suspended? ☐ Yes ☐ No If yes, please describe: _____

Does your child have a current IEP (Individual Education Plan)? ☐ Yes ☐ No

Does your child have a current 504 plan? ☐ Yes ☐ No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been: arrested? ☐ Yes ☐ No
assigned a probation officer? ☐ Yes ☐ No If yes, their name: _____
jailed? ☐ Yes ☐ No

Has your child: ever appeared in juvenile court? ☐ Yes ☐ No
or other family member ever been reported to DHR? ☐ Yes ☐ No
been assigned a DHR caseworker? ☐ Yes ☐ No
If yes, their name: _____
ever been a victim of child physical or sexual abuse? ☐ Yes ☐ No

If you answered yes to any of these questions, please explain:

VII. Family Medical History:

<input type="checkbox"/> Sudden death	<input type="checkbox"/> Heart disease (especially dysrhythmias)	<input type="checkbox"/> Diabetes mellitus
<input type="checkbox"/> Obesity	<input type="checkbox"/> Narrow Angle Glaucoma	<input type="checkbox"/> Seizures

Clinician
Signature: _____

Managed Health Care Administration
Initial Assessment Child/Adolescent Program
Parent Questionnaire
Page 4

Clinician Notes:

VIII. Family Psychiatric History:

Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? ☐ Yes ☐ No If yes, please explain: _____

IX. Social / Family History:

Biological mothers' full name: _____ Biological fathers' full name: _____

Biological parents marital status: ☐ Married to each other ☐ Divorced ☐ Separated

If divorced from one another, has either remarried? Mother ☐ Yes ☐ No
Father ☐ Yes ☐ No

If the biological parents are divorced or separated, who has custody of the patient? _____

Type of custody? _____

Stepmothers' name: _____

Stepfathers' name: _____

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

<u>Name</u>	<u>Relationship</u>	<u>Type of Employment / Student Grade Level</u>
1.		
2.		
3.		
4.		
5.		

Please check any of the following stressors that presently affect your child:

- | | | |
|--|---|--|
| <input type="checkbox"/> Family financial problems | <input type="checkbox"/> Family relationships | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Child rearing problems | <input type="checkbox"/> Drug or alcohol problems | <input type="checkbox"/> Abuse behavior |
| <input type="checkbox"/> Health problems | <input type="checkbox"/> Employment problems | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Frequent change of household | <input type="checkbox"/> Frequent moves |
| <input type="checkbox"/> "Other" problem _____ | | |

Please explain how any item you checked affects your child. _____

Clinician
Signature: _____

Reminder: Please bring a copy of any custody papers to the initial appointment.