

**Newtown Psychotherapy Center  
115 Pheasant Run  
Suite 215  
Newtown, PA 18940**

**Intake Form**

**Date** \_\_\_\_\_

*Please provide the following information for our records.*

Child's Name: \_\_\_\_\_

Name of parent or guardian: \_\_\_\_\_

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

(Street and Number)

\_\_\_\_\_

(City)

(State)

(Zip)

Home Phone: (     )     -     May we leave a message?  Yes  No

Cell Phone: (     )     -     May we leave a message?  Yes  No

E-mail Address: \_\_\_\_\_

May we send you an email?  Yes  No

Birth Date: \_\_\_/\_\_\_/\_\_\_     Age: \_\_\_\_\_     Gender: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

(Name)

(Number)

(Relationship)

What is your primary reason for bringing your child to counseling?

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

*Office Use Only*

Counselor: \_\_\_\_\_

Dx: \_\_\_\_\_

Service: \_\_\_\_\_

R S: \_\_\_\_\_

## Health History:

Is your child currently under the care of another professional counselor or psychiatrist?

Yes  No

Has your child had previous counseling?

Yes  No If yes, please provide the therapist's name: \_\_\_\_\_

Is your child currently taking prescribed psychiatric medication, (antidepressants or others)?  Yes  No

If yes, please list: \_\_\_\_\_

Has your child been prescribed psychiatric medication in the past?  Yes  No

If yes, please list: \_\_\_\_\_

How is your child's physical health at this time?

Poor  Unsatisfactory  Satisfactory  Good  Very Good

Please list any persistent physical symptoms or health concerns:

\_\_\_\_\_

What is the name of your child's Primary Care doctor? \_\_\_\_\_

Please provide the doctor's address: \_\_\_\_\_

Please list medications, (not listed above):

\_\_\_\_\_

Is your child having difficulties sleeping?  Yes  No

If yes, check where applicable:  Trouble falling asleep  Frequent awakening

Disturbing dreams  Sleeping too much  Sleeping too little

Other \_\_\_\_\_

Does your child get regular exercise?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you noticed any changes in your child's appetite or eating habits?  Yes  No

If yes, please explain: \_\_\_\_\_

Has your child had significant weight changes over the last two months?  Yes  No

Is there any alcohol abuse with child or family, (including parents, grandparents, aunts, uncles and siblings)?  Yes  No

If yes, please explain:

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Has your child expressed any suicidal thoughts?

Frequently  Sometimes  Rarely  Never

### **Educational Information:**

What school does your child attend? \_\_\_\_\_

Grade: \_\_\_\_\_ Activities: \_\_\_\_\_

How are things at school?

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### **Religious/Spiritual Information:**

Is religion an important part of your family's life?  Yes  No

If so, what religion? \_\_\_\_\_

### **Family System Information:**

How many siblings? \_\_\_\_\_ Closest to which one? \_\_\_\_\_

Names \_\_\_\_\_

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Has there been any exposure to domestic violence?  Yes  No

Has there been any exposure to sexual abuse?  Yes  No

Parents divorced?  Yes  No If yes, what was child's age at the time? \_\_\_\_\_

In general, how would you describe your child's life?

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**Hobbies/ Interests:**

What hobbies or activities does your child enjoy?

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**Other information you would like us to know:**

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# Newtown Psychotherapy Center

115 Pheasant Run, Suite 215, Newtown, PA 18940

## **INFORMED CONSENT AND AGREEMENT FOR THERAPY**

Welcome! Thank you for entrusting us with the opportunity to work with your child in therapy. Parents decide to seek therapy most often because they want to relieve their child of the discomfort and conflict he/she is experiencing. Please be aware that there are times in the course of working together when your child may report feeling worse before feeling better. Our objective is to find ways to help your child maximize strengths, and reach healthy, realistic, achievable goals.

## **PAYMENT FOR SERVICE**

Clients are expected to pay for service at each session. Therapy sessions are usually forty-five or fifty minutes in length. Time we spend on the phone is generally not billed because phone calls are usually short and are used for reporting an emergency or for setting up or changing session times. If, however, the calls are for the purpose of working on issues, extending a therapy session, or clarifying an insight and last more than 30 minutes, these calls will be pro-rated and billed as therapy time.

## **CANCELLATION POLICY**

When we schedule an appointment, the time is reserved just for you. In consideration of other clients seeking an appointment and your therapist's time, we ask that, if you need to miss or cancel our session, you do so at least 24 hours before your scheduled time. In general, you will be responsible for payment of \$25.00 for missed or canceled sessions, less than 24 hours before the appointment time. \_\_\_\_\_

## **CONFIDENTIALITY (See Notice of Privacy Practices)**

Information disclosed is considered confidential according to the laws of the State of Pennsylvania. In Pennsylvania, therapists are mandated to breach confidentiality in the following situations:

The therapist suspects serious suicidal intent.

The therapist suspects serious intent to harm others.

The therapist suspects abuse or neglect of a minor or an elder.

The therapist is subpoenaed by a court of law for records or to appear. We will make every effort to inform you prior to any mandated breach of confidentiality.

## **CONSULTATION WITH OTHER CLINICIANS**

In the course of treatment it might be beneficial for us to discuss your child's situation with another therapist, psychiatrist, or physician for consultation or for supervisory purposes only. We will keep your child's name and identifying information confidential, and will make every effort to obtain your permission before discussing any information about your child.

In the unlikely event that your therapist should become incapacitated, a trusted colleague will assume possession of the confidential records and perform such practical responsibilities such as notifying you and referring another therapist.

## **USE OF ELECTRONIC MEDIA**

Psychotherapy, like all other health care, is by definition a private matter. Therefore, by signing this document, we mutually agree that it is our intention to take every precaution to protect your privacy. Because any and all electronic media are subject to interception, the use of electronic media to communicate with me such as email, cell phone conversations and texting, list serves, Skype, Facebook, LinkedIn, and other social media compromises your privacy.

Communication between us will occur in person within the confines of our face-to-face sessions. Should it be necessary to communicate outside of face-to-face sessions or between sessions by cell phone, text or e-mail, we both understand and know that this communication can be intercepted or hacked into. In that regard, please know that in order for me to protect your privacy, we will avoid communication with you through social media such as Facebook, Skype, or LinkedIn.

**Please Note: If you willfully initiate/engage in communication with us through e-mail, texting, cell phone usage and the like, you do so knowingly and with the full understanding that you may be compromising your privacy. This includes initial emails through our website, Psychology Today, and general e-mail usage.**

**EMERGENCY PROCEDURES**

After normal business hours we may be difficult to reach. If we are out of telephone reach and you are in great need, please use the nearest hospital emergency room for more imminent service.

**TERMINATION**

When your child has reached the therapy goals, termination is the natural next step. Should a further need arise, additional sessions are always available.

If during the course of your child’s treatment you or your therapist, believe that your child is not being helped, we have an ethical responsibility to refer you to another therapist who might be a better fit and/or be better able to meet your needs.

If during the course of treatment you are unable to pay the fee, we will discuss your financial situation and, if possible, we will either reduce your fee or work to refer you to another clinician.

*I have read and understand the above policies.*

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

# Newtown Psychotherapy Center

## HIPAA POLICY NOTICE NOTICE OF MENTAL HEALTHCARE POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may use or disclose your protected health care information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment, and Healthcare Operations”
  - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.
  - Payment is when I am paid for your healthcare services. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care and/or to determine eligibility or coverage.
  - Healthcare Operations are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my practice such as releasing, transferring, or providing access to information about you to other parties.

### **II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosure. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your clinical notes. “Clinical notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or clinical notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### **III. Uses and Disclosures with Neither Consent and Authorization**

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

- *Child Abuse*: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child’s welfare, the law requires that I report such knowledge or suspicion to the Pennsylvania Department of Child and Family Services.

· *Adult and Domestic Abuse*: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

· *Health Oversight*: If a complaint is filed against me with the Pennsylvania Department of Health, the Department of Health has the authority to subpoena confidential mental health information from me relevant to that complaint.

· *Judicial or Administrative Proceedings*: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance in this case.

· *Serious Threat to Health or Safety*: When you present a clear and immediate probability or physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

· *Worker's Compensation*: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

#### **IV. Patient's Rights and Healthcare Provider Duties**

##### *Patient's Rights:*

1. Right to Request Restrictions – You have the right to restrictions on certain uses and

Disclosures or protected health information about you. However, I am not required to agree to a restriction you requested.

2. Right to Receive Confidential Communications by Alternative Means and at Alternative Means and at Alternative Locations – you have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist/healthcare provider. Upon your request, I shall send any mailings to another address.)

3. Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the request process.

4. Right to Amend – You have the right to request an Amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I shall discuss with you the details of the amendment process.

5. Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I shall discuss with you the details of the accounting process.

6. Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### *Healthcare Provider Duties:*

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.



2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently I effect.

3. If I revise my policies and procedures, I shall provide individuals with a revised notice during their session or by mail within 60 days, and subsequent to any request made by you when you are no longer in treatment with me pertaining to the release of any information or consultation with an outside person or agency.

**V. Business Associates**

I may rely, depending on the circumstances, on certain persons or entities, who are not my employees, to provide services on my behalf. These persons might include lawyers, billing services, collection agencies and credit card companies. Where these persons or entities perform services, which require the disclosure of individually identifiable health information, they are considered under the Privacy Rule to be my business associates. I enter into a written agreement with each of my business associates to obtain satisfactory assurance that the business associate will safeguard the privacy of the PHI of my patients I rely on my business associates to abide by the contract, but will take reasonable steps to remedy any breach of the agreement that I become aware of. If my attempt to remedy the breach is not successful, then I will terminate the contract, or if termination is not feasible, I will report the problem to the Department of Health and Human Services.

**VI. Complaints**

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me (as above). You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed at the outset can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**VI. Restrictions and Changes to Privacy Policy**

I will limit, i.e., deny, the disclosures that I make when your request to access copies of either your or your child's psychotherapy notes may, in my professional opinion, pose harm to you or you child's mental health. Such denials to access may be considered final and not reviewable by another licensed health care professional typically designated as a reviewing official with respect to other conditions (see below). I may also deny access to records when information is compiled in reasonable anticipation of, or for use, in a legal or administration action of proceeding, and when someone other than a health provider provides information about you or your child under a promise of confidentiality and the access to the requested information would be reasonably likely to reveal the source of the information. However, you may request and are entitled to a review of my denial by another licensed health care professional for access to other information contained in your medical records when I deny access if: 1) in the exercise of my professional judgment I determine that access to the record is "reasonably likely to endanger the life or physical safety" of you, the patient, or another person; 2) the requested information makes reference to another person (other than another health care provider) and in the exercise of professional judgment I determine that access is "reasonably likely to cause substantial harm" to this person; or 3) a personal representative for you or the patient has requested access to the record and in the exercise of professional judgment I determine that such access is "reasonably likely to cause substantial harm" to the you, the patient or another person.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by face-to-face verbal explanation and written notice in person or via mail within 60 days.

I have read and reviewed the Newtown Psychotherapy Center HIPAA Privacy Policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date