CHILD & ADOLESCENT DEVELOPMENTAL HISTORY INTAKE FORM

Parents or Guardians: Please fill out one form per child

This information is private and confidential, as are all of our sessions (see privacy policy). Please complete as much of this form as you can.

PATIENT NAME: _____ MALE/FEMALE:_____TODAY'S DATE:_____
DATE OF BIRTH: _____ CITY: _____ STATE: _____

CUSTODIAL PARENT HOME ADDRESS: _____
CITY:_____ STATE: _____ ZIP:_____
E-MAIL: _____ TELEPHONE: H: _____
W: _____ CELL:_____ OTHER_____
OCCUPATION:_____BUSINESS TELEPHONE :_____

NON-CUSTODIAL PARENT HOME ADDRESS (if applicable): _____
CITY:_____ STATE: _____ ZIP:_____
E-MAIL: _____ TELEPHONE: H: _____
W: _____ CELL:_____SOCIAL SECURITY #:_____
OCCUPATION:_____BUSINESS TELEPHONE :_____

PARENTS' STATUS (please circle): single, married, separated, divorced, widow(er), live-in partner
CHILD'S SIBLINGS (name and age): _____

PATIENT'S MEDICAL DOCTOR - Name: _____ - Phone: _____

RESPONSIBLE PARTY BILLING ADDRESS:_____
CITY:_____ STATE: _____ ZIP:_____
E-MAIL: _____ TELEPHONE: H: _____
W: _____ CELL:_____ OTHER_____

RESPONSIBLE PARTY INSURANCE COMPANY: _____
POLICY #_____
OCCUPATION:_____EMPLOYER:_____

EMERGENCY CONTACT_____ PHONE:_____

REFERRAL SOURCE: _____

PATIENT 'S RESIDENCE – please circle:

Biological parent's home Relative's home Foster Home Adoptive Home

Full term: Y N Complications at birth: _____

_____

FAMILY STRUCTURE WHEN CLIENT WAS BORN _____

_____

MILESTONES – Please indicate age:

Sat-up: _____ Crawled: _____ Walked: _____ Talked: _____ Toilet trained: _____

DESCRIBE DELAYS OR COMPLICATIONS IN ANY OF THESE AREAS:_____

_____

_____

DAYCARE OR PRE-SCHOOL? Y N AGE CHILD STARTED: _____ COMMENTS:

_____

_____

WHO WAS/WERE THE CHILD'S PRIMARY CAREGIVER(S) FROM BIRTH TO 3 YEARS?

_____

_____

FAMILY HISTORY (include births, divorce, losses, transitions, remarriage, illness, moves, etc.)

_____

_____

_____

_____

_____

ANY MAJOR ILLNESS/SURGERIES?: Y N AGES: _____

PLEASE DESCRIBE THE ILLNESS/SURGERIES: _____

_____

_____

_____

HAS THE CHILD EVER BEEN ILL OR ON MEDICATION(S)? Y N AGES: _____
PLEASE DESCRIBE ILLNESSES/MEDICATION(S): _____

_____

_____

_____

ANY PSYCHIATRIC ILLNESS/HOSPITALIZATIONS? Y N AGES:_____

_____

_____

_____

ANY TRAUMATIC EVENT(S)?: Y N AGES: _____
PLEASE DESCRIBE: _____

_____

_____

_____

ANY INVOLVEMENT WITH CHILD PROTECTIVE SERVICES? Y N AGES:_____

_____

_____

_____

ANY SUBSTANCE USE/ABUSE/DEPENDENCE? Y N AGES:_____
PLEASE LIST NAMES/AMOUNTS:_____

_____

_____

HISTORY OF COUNSELING: Y N AGE(S):_____
PLEASE CIRCLE TYPE OF TREATMENT:
Family Individual Group School Alateen Day treatment Hospital Other
NAME OF PRIOR THERAPIST(S) AND REASON FOR TREATMENT:

_____

_____

WOULD YOU LIKE ME TO CONTACT THEM? Y N
SUBSTANCE ABUSE TREATMENT: Y N AGE(S): _____
PLEASE LIST FACLITY AND DATES:

_____

_____

_____

SCHOOL: _____ GRADE: _____ TEACHER: _____

PLEASE DESCRIBE YOUR CHILD/TEEN'S OVERALL SCHOOL EXPERIENCES, INCLUDING TYPICAL GRADES, SOCIALIZATION, TYPE OF CLASSES –SPECIAL ED, GATE, ETC. – HOBBIES, TRANSITIONS, CHANGES:

1st – 5th Grade: _____

_____

_____

SCHOOL ATTENDED: _____

6th – 8th Grade: _____

_____

_____

SCHOOL ATTENDED: _____

9th AND UP: _____

_____

_____

SCHOOL ATTENDED: _____

DESCRIBE YOUR CHILD/TEEN'S CHALLENGES: _____

_____

_____

DESCRIBE YOUR CHILD/TEEN'S TEMPERAMENT: _____

_____

_____

DESCRIBE YOUR CHILD/TEEN'S SUCCESES AND QUALITIES: _____

_____

_____

PEOPLE YOUR CHILD/TEEN SEEMS TO TRUST AND RELATE WELL WITH: _____

_____

_____

THIS FORM COMPLETED BY: _____

Patient Signature:_____ Date:_____
(if applicable)

Printed Name:_____

Parent 1 Signature:_____ Date:_____

Printed Name:_____

Parent 2 Signature:_____ Date:_____

Printed Name:_____

Parent 3 Signature:_____ Date:_____

Printed Name:_____

7/14/07

OFFICE POLICIES & PATIENT RESPONSIBILITIES

Confidentiality
Rhodes Counseling is committed to keeping adult and minor patient information strictly confidential according to the practices outlined in the Privacy Practices document.

Length of Sessions
Our time together is set for 45 minutes, although additional time is spent by me between sessions treatment planning and record keeping. I will be prepared to begin our meetings at the designated time we have agreed upon. I will give you my undivided attention at our sessions and will not answer phone calls.

Insurance
Many health care policies provide coverage for this type of health care service. If you are have insurance, you are responsible for paying me your co-pay at the time of your appointment.

Fees and Payment
The current fee for a 45-minute individual session is $150. These fees apply also to telephone consultation and to the preparation of reports and letters requiring more than 10 minutes. **Full payment of your account is expected at the time services are rendered**. If have insurance, you are responsible for paying me your co-pay at the time of your appointment.

Cancellation
In order for the therapy process to be effective, it is important to keep regular weekly sessions as scheduled. I understand that on rare occasions emergencies may arise that will make it impossible for you to keep your scheduled session. If this should happen, call me within 24 hours to advise me of your emergency. You have two options:

1. You can either reschedule your appointment by leaving two alternating times and days for that same week on my answering machine at 619-325-1136. **If** I have an opening, I will make every attempt to honor your rescheduling options. I will, of course, call you back to confirm.

or

2. You can simply pay for the missed appointment and arrange to meet with me on your next regular scheduled appointment. Insurance companies will not pay for missed appointments.

If miss an appointment, you will be personally responsible for full payment of that time period, whether or not you have insurance. _____(please initial).

Phone Calls
I am available to assist you by phone when necessary, at no charge, for up to 10 minutes. I ask that you limit your call to 10 minutes or schedule a separate session. I will respond to your call within 24 hours of receiving your message.

Emergencies
Psychological emergencies do occur from time to time, and you are encouraged to arrange for a special appointment(s) at those times If I am not available to talk to you in an emergency, please call the San Diego Crisis Hotline number @ 800.479.3339.

If you have any questions regarding these policies, please ask for clarification before signing below. Feel free to discuss with me now or in the future any questions you may have about my services, policies or fees.

Thank you for your cooperation.

I have read and understand the above policies and agree to abide by them. My signature below acknowledges my agreement with the above conditions and my receipt of a copy of this document.

Client Signature :_____ Date:_____

NOTICE OF PRIVACY PRACTICES

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

My Legal Duty

I understand that your health/mental health information is personal and I am committed to protecting this information. I am required by applicable federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also requires that I give you this Notice about my legal duties, my privacy practices, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect.

Individually identifiable information about your past, present, or future health/mental health or condition, the provision of health/mental health care to you, or payment for the health/mental health care is considered "Protected Healthy Information (**PHI**)." Whenever possible, the PHI contained in your record remains private. In some circumstances, it is necessary for me to share some of the PHI contained in your record (or your child's record). In all but certain specified circumstances, I will share only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

I reserve the right to change this notice and to make changes in my privacy practices. Any changes will be effective for all PHI that I maintain, including health/mental health information created or received before I made the changes. I will post a copy of the current notice in my reception area and on my website (if applicable). You may also request a current copy of this notice from me. For more information about my privacy practices, please contact me at the number listed at the end of this notice.

How I May Use and Disclose Health/Mental Health Information About You:

The following categories describe different ways that I use and disclose your PHI. For each category, I explain what I mean, and offer an example. In some instances a written authorization signed by you is required in order for me to use or disclose your PHI; in others it is not. I have tried to identify which instances do not require your signed authorization and which do.

Uses and Disclosures of PHI For Which No Signed Authorization is Required:

> **For Treatment:** I may use/disclose your PHI (or your child) to provide you with mental health treatment or services. For example, I can disclose your PHI to physicians, psychiatrists, and other licensed health care providers who provide you with health care services or are involved in your care. If a

psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.

For Payment: I may use/disclose your (or your child's) PHI in order to bill and collect payment (from you, your insurance company, or another third party) for services provided by me. For example, I may send your PHI to your insurance company to get paid for the services we provided to you or to determine eligibility for coverage.

For Health Care Operations: I may use/disclose your (or your child's) PHI to your health care service plan or insurance company for purposes of administering the plan, such as case management and care coordination.

Appointment Reminders or Changes in Appointments: I may use/disclose you (or your child's) PHI to contact you as a reminder that you have an appointment. I may also contact you to notify you of a change in your appointment. For example, if I am ill, I may have someone in my office contact you to notify you that the appointment is cancelled. *If you do not wish me to contact you for appointment reminders or changes in appointment times, please provide me with alternative instructions (in writing).*

When Disclosure is Required by state, federal or local law; judicial or administrative proceedings; or law enforcement:
I may use/disclose you (or your child's) PHI when a law requires that I report information about suspected child, elder or dependent adult abuse or neglect.; or in response to a court order. I must also disclose information to authorities that monitor compliance with these privacy requirements.

To Avoid Harm: I may use or disclose limited PHI about you when necessary to prevent or lessen a serious threat to your health or safety, or the health and safety of the public or another person. If I reasonably believe you pose a serious threat of harm to yourself, I may contact family members or others who can help protect you. If you communicate a serious threat of bodily harm to another, I will be required to notify law enforcement and the potential victim.

Law Enforcement Officials: I may disclose you (or your child's) PHI to the police or other law enforcement officials as

required or permitted by law or incompliance with court order or grand jury or administrative subpoena.

For Health Oversight Activities: I may disclose PHI to a health oversight agency for activities authorized by law. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

Specialized Government Functions: I may disclose you (or your child's) PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

Disclosure to Relatives, Close Friends and Other Caregivers: I may use or disclose your PHI to a family member, or other relative, a close personal friend or any other person that you indicate is involved in your care or the payment of your care unless you object in whole or in part. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, I may exercise my professional judgement to determine whether a disclosure is in your best interests. If I disclose PHI to a family member, other relative or close personal friend, I would disclose only information that I believe is directly relevant to the person's involvement with your health care or payment related to your health care.

Workers' Compensation: I may disclose your PHI as authorized by and to the extent necessary to comply with California law relating to workers' compensation or other similar programs.

As required by law: I may use and disclose you (or your child's) PHI when required to do so by any other law not already referred to in the preceding categories.

Uses and Disclosures of PHI For Which a Signed Authorization is Required: For uses and disclosures of PHI beyond the areas noted above, I must obtain your written authorization. Authorizations can be revoked at any time in writing to stop future uses/disclosures (except to the extent that I have already acted upon your authorization).

Your Rights Regarding You (or Your Child's) PHI:

You have the following rights regarding PHI I maintain about you (or your child):

Right to Inspect and Copy: You have the right to inspect and copy you (or your child's) health/mental health information upon your written request. However, some mental health information may not be accessed for treatment reasons and for the other reasons pertaining to California or federal law. I will respond to your written request to inspect records. A charge for copying, mailing and related expenses will apply.

Right to Request Restrictions: You have the right to ask that I limit how I use or disclose your PHI. I will consider your request, but I am not legally required to agree to the request. If I do agree to your request, I will put it into writing and comply with it except in emergency situations. I cannot agree to limit uses and/or disclosures that are required by law.

Right to Amend: If you believe that there is a mistake or missing information in my record of your health/mental health information, you may request, in writing, that I correct or add to the record. I will respond to your request within 60 days of receiving it. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request to amend information that: was not created by me, not part of my records, not part of the information that you would be permitted to inspect and copy or is accurate and complete.

Right to an Accounting of Disclosures: You have a right to get a list of when to whom, for what purpose, and what content of your (your child's) PHI has been disclosed. This applies to disclosures other than those made for purposes of treatment payment, or health care operations. You request must be in writing and state a time period (which may not be longer than six [6] years and may not include dates before April 14, 2003). I will respond to your request within sixty (60) days of receiving it. The first list you request within a 12-month period will be free. There may be a charge for more frequent lists. In such a case, I will notify you of the cost involved and you may choose to change or withdraw your request before any costs are incurred.

Right to request Confidential Communications: You have the right to request that I communicate with you about health/mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing. Please specify how or where you wish to be contacted. I will accommodate all reasonable requests.

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

Complaints:

If you think that your privacy rights have been violated you may contact me at 619.325.1136 or you may file a complaint with the Secretary of the United States Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Client's Name: _____Date of Birth: _____

Parent/Guardian's Name (if client is a minor):_____

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Signature of Client (Parent or Guardian if client is a minor) Date

CONSENT FOR TREATMENT OF A MINOR

The undersigned person and/or responsible party hereby authorizes and requests that:

Claudia Rhodes, Licensed Clinical Social Worker (LCSW)

License Number: LCS14930:

provide counseling/therapy to _____ ,
(minor's name)

my _____. This agreement may be revoked by me at any time.
(relationship of minor to me)

I understand that the content of clinical social work sessions is bound by the laws of confidentiality so that Claudia Rhodes, LCSW, may not reveal the content of any of my child's sessions unless Claudia Rhodes, LCSW suspects that a child or elder adult is being abused or my child becomes a danger to self or others or a Court Judge orders information to be revealed. I understand that if Claudia Rhodes, LCSW wishes to reveal information to anyone about my child's sessions, Claudia Rhodes, LCSW must obtain written consent from me to do so.

Both parents must consent for treatment unless the treatment is court ordered.

Signature of Parent/Guardian :_____ Date:_____

Signature of Parent/Guardian :_____ Date:_____

Signature of Minor :_____ Date:_____

Signature of Witness :_____ Date:_____

7/16/07