

Detail of Informed Consent

Process, Benefits, and Risks of Psychotherapy: Participating in individual psychotherapy may result in a number of benefits including a reduction of problematic behaviors, a greater understanding of the child's strengths and weaknesses, improved awareness of emotional issues, improved self-esteem, and increased availability within the learning environment. However, such progress cannot be guaranteed. Working towards these goals requires efforts from the patient and support from the family is essential.

Confidentiality: The laws and standards for mental health professionals require that records be kept regarding the treatment of your child. All information disclosed within sessions and the written records pertaining to those sessions are completely confidential and cannot be revealed to anyone without your written permission, except where disclosure is required by law. Disclosure is required by law in the following circumstances:

- When there is reasonable suspicion of child or elder abuse or neglect
- Where the client presents a danger to him/herself or to others
- When disclosure is court-ordered

The reason for such requirements is that mental health professionals have legal and ethical responsibility to take action to protect endangered individuals from harm when there is indication that such a danger exists. Such actions may include notifying the parent/guardian, notifying the potential victim, contacting the police, or seeking hospitalization for the child.

When working with children, the issue of confidentiality is often complicated. In order for children to relate well to the mental health professional and thereby address their social, emotional, and behavioral goals, children must feel a sense of privacy about the information they decide to share. However, mental health professionals understand and acknowledge that there may be types of information that would be important for the parent or guardian to know, even if it does not fall under the categories listed above.

In addition, children are made aware from the onset of treatment that regular communication with the parent/guardian will occur. They are told that relevant themes and issues will be shared with the parent/guardian, when it seems in their best interest to do so.

Availability and Emergency Procedures: I have voicemail that I check periodically throughout the day. In addition, I carry an emergency pager throughout the day and after hours. This pager is for emergencies only, e.g. if the child is experiencing an emotional or behavioral crisis and you feel that he or she is out of your control and at risk of hurting him/herself or someone else. In the event of a life threatening emergency and I cannot be reached, **the parent should immediately call 911 or immediately proceed to the nearest emergency room.**

If you have any questions or concerns regarding your Informed Consent, please feel free to discuss them with us directly.

The Clinical Staff
The Child and Family Counseling Group, P.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or Guardian of the Patient acknowledges that he or she personally received a copy of The Child and Family Counseling Group's Notice of Privacy Policies on the date indicated below.

Signature of Patient/Guardian

Date

Patient Name (Printed)

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information (“PHI”) private in accordance with this Notice of Privacy Practices (“Notice”), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

Treatment. Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.

Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.

Health Care Operations. Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers’ compensation or similar laws, public health laws,

court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer.

We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Us

Privacy Officer: John W. Wires, Ph.D.
 3959 Pender Drive, #320
 Fairfax, Virginia 22020
 (703) 352-3822

AUTHORIZATION FOR RELEASE OF INFORMATION

The Child & Family Counseling Group, P.L.C. is an outpatient mental health facility which has an interdisciplinary staff. Occasionally, staff members need to consult with each other in order to provide the best possible care for their clients. This may necessitate the sharing of client information. When this pertains to you, we require your written permission. By signing this page you will be authorizing us to exchange both verbally and in written form any information we have obtained from you and which we have available to us here at the Child & Family Counseling Group, P.L.C. We assure you that all information used and shared will be done so judiciously and in the service of providing you better treatment.

Date

Signature

Witness

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____

DOB: _____

I authorize: _____

The Child & Family Counseling Group, P.L.C.
3959 Pender Drive, Suite 320
Fairfax, Virginia 22030

_____ to exchange information with

_____ to release to

_____ to receive from

NAME OF PERSON, ORGANIZATION, OR INSTITUTION

ADDRESS

The following information:

_____ Medical Records

_____ Education/Academic Records

_____ Psychiatric Records

_____ Psychological Evaluation

_____ Neurological Evaluation

_____ Behavioral Report

_____ Teacher's Report

_____ Verbal Exchange

_____ Other Information

Approximate Dates of Service: _____

For the Purpose of: _____

SIGNATURE

DATE

WITNESS

DATE

RELEASE IS VALID FOR:

ONE YEAR

TERMINATION OF TREATMENT

REVOKED

(Please circle one)

NEW PATIENT INFORMATION

Patient Name: _____

Patient Date of Birth: _____

Responsible Party: _____

Billing Address: _____

Home Phone Number: _____

Work Phone Number: _____

Parent Work Phone Number: _____

Psychiatrist Name: _____

Therapist Name: _____

Primary Care M.D. Name: _____

Whom May We Thank
for Referring You: _____

If your clinician does not participate with your insurance plan, please stop here.
If your clinician does participate with your insurance plan, please complete the following.

Insurance Name: _____

Insurance Telephone Number: _____

Insurance Claims Address: _____

Name of Insured: _____

Social Security Number of Insured: _____

Relationship of Insured to Patient: _____

ID Number: _____

Group Number: _____

Plan Number: _____

Authorization Number: _____

PATIENT HISTORY ADULT

This form is to be completed by the named individual. If you have any problems with the form, please discuss them with your therapist.

Name: _____ Date of birth: _____

Date form completed: _____

Reason for seeking treatment: _____

How long has this problem existed? 1-3 mos. 6-12 mos. 1-2 yrs. 2-5 yrs. 10+ yrs. (circle one)

Prior therapy: Yes No (circle one)

If Yes: What was the duration?

Brief

Long-term (circle one)

In what environment?

Periodic Sessions

Day Treatment

Inpatient (circle one)

Was it:

Helpful

Not Helpful

Not Sure (circle one)

Current marital status: _____

Current primary physician: _____

Occupation: _____

Current employment: _____

High School graduate: Yes No GED (circle one)

College graduate: Yes No (circle one)

If Yes: Degree(s) or number of credits: _____

Field of study: _____

Occupational training (please explain): _____

Military service: _____

Religious affiliation: _____

Recreation (list some usual activities): _____

Have you ever been married? Yes No (circle one)

If Yes: How many times? _____

How long did the marriage(s) last? _____

Please explain: _____

List all of those with whom you reside, and designate the relationship(s) and age(s)
(e.g., Mary Doe, Wife, 40):

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Do you have children who do not live with you? Yes No (circle one)
If Yes, please provide the name(s) and age(s):

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Have there been deaths in your family or among your friends? Yes No (circle one)
If Yes: Who: When:

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Have you moved recently: No Yes (circle one)
If Yes: When:

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Have you moved often: No Yes (circle one)
If Yes, please explain:

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Do you plan a move in the near future? No Yes (circle one)
If Yes, please explain:

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WORK HISTORY FOR THE PAST 10 YEARS

| | <u>Employer</u> | <u>Job Title</u> | <u>Date Started</u> | <u>Date Left</u> | <u>Reason for Leaving</u> |
|----|-----------------|------------------|---------------------|------------------|---------------------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |

Your Family of Origin

Please provide data on your mother, father, siblings, and any step or half-family members.

| <u>Name and Relationship</u> | <u>Age</u> | <u>Health Status</u> | <u>Occupation</u> | <u>Where Resides</u> | <u>Frequency of Contacts</u> |
|--------------------------------------|------------|----------------------|-------------------|----------------------|------------------------------|
| <i>(Example: May Doe, mother</i> | <i>60</i> | <i>Heart Problem</i> | <i>Housewife</i> | <i>Oregon</i> | <i>Once/year</i> |

Have you ever been separated from family members for a prolonged period? No Yes (circle one)

Were there any separations from your family or either parent when you were a child (e.g., mother hospitalized for 3 weeks when you were 5)? No Yes (circle one)

If Yes, please explain: _____

Is there any history of mental, emotional, or psychiatric problems in your family? No Yes (circle one) If Yes, please explain: _____

Health History

List any medications taken...

On a Regular Basis Now

Previously

| | |
|-------|-------|
| | |
| | |
| | |
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| | |

Hospitalizations:

Date

Medical or Psychiatric

Purpose

Outcome

| | | | |
|-------|-------|-------|-------|
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Please provide a history of each pregnancy, miscarriages or abortion,

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Please list any chronic health conditions (e.g., Asthma, high blood pressure).

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Please list any serious accidents or illnesses for which did not require hospitalization.

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What is your current general state of health?

Symptoms and Behaviors Checklist

Please answer every question, even if the response is "No". Indicate the severity of the symptom, if known, for the past year.

| <u>SYMPTOM</u> | <u>SEVERITY</u> | | | |
|--|-----------------|-------------|-----------------|---------------|
| | <u>No</u> | <u>Mild</u> | <u>Moderate</u> | <u>Severe</u> |
| Depression | | | | |
| Tearfulness | | | | |
| Feeling lonely | | | | |
| Feeling sad | | | | |
| Withdrawn | | | | |
| Spending more time alone | | | | |
| Moody | | | | |
| Avoiding friends | | | | |
| Concerned about injury | | | | |
| Eating more | | | | |
| Eating less | | | | |
| Weight change | | | | |
| More exercise | | | | |
| Less exercise | | | | |
| Decreased interest in sex | | | | |
| Decreased interest in usual activities | | | | |
| Tired | | | | |
| Sleeping more | | | | |
| Sleeping less | | | | |
| Waking during the night | | | | |
| Waking early in the morning | | | | |
| Sleepwalking | | | | |
| Nightmares/Bad dreams | | | | |
| Headaches | | | | |
| Careless about dress/hygiene | | | | |
| Having trouble concentrating | | | | |
| Confused | | | | |
| Distractable | | | | |
| Impulsive | | | | |
| Disorganized | | | | |
| Hearing things others don't hear | | | | |
| Seeing things others don't see | | | | |
| Trouble following directions | | | | |
| Perfectionistic | | | | |
| Anxious | | | | |
| Worrying | | | | |
| Feeling panicky | | | | |
| Obsessive/ritualistic behaviors | | | | |
| Critical of others | | | | |
| Have few friends | | | | |
| Low self-esteem | | | | |
| Disappointed in appearance | | | | |
| Disappointed in achievements | | | | |
| Disappointed in social life | | | | |
| Legal problems | | | | |
| Problems at work | | | | |

| <u>SYMPTOM</u> | <u>SEVERITY</u> | | | |
|------------------------------|-----------------|-------------|-----------------|---------------|
| | <u>No</u> | <u>Mild</u> | <u>Moderate</u> | <u>Severe</u> |
| Problems in daily life | | | | |
| Arguing | | | | |
| Defiant | | | | |
| Destroying/damaging property | | | | |
| Irritable | | | | |
| Angry | | | | |
| Easily frustrated | | | | |
| Giving away belongings | | | | |
| Threats to oneself | | | | |
| Wishes to be dead | | | | |
| Suicidal thoughts | | | | |
| Suicidal intent | | | | |
| Homicidal thoughts | | | | |