# Acknowledgement Receipt of Notice of Privacy Practices

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

| ______________________________ | ______________________________ |
|---|---|
| Print Patient Name | Patient Signature |
| ______________________________ | ______________ |
| Parent/Guardian Signature (IF UNDER 18) | Date |

THE CHILD & FAMILY COUNSELING GROUP, P.L.C.
*Comprehensive Diagnostic & Therapeutic Services*

# 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.

**Facility Directories** [Optional Language for Inpatient facilities] Our facility directory may list the following information about you: (1) your name, (2) your location in our facility, (3) your general condition without reference to specific medical information, *e.g.*, stable, serious, fair, etc., and (4) your religious affiliation, if any. Our facility directory information may be disclosed to clergymen and, except

for religious affiliation, to other people. You may restrict or prohibit the release of the above information.

**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 12-month 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

John W. Wires, Ph.D.
10521 Rosehaven Street Suite 100 - Fairfax, Virginia 22030
Phone (703) 352-3822 Fax: (703) 385-8353

# Electronic Communication Consent & Release

At Child & Family Counseling Group (CFCG), P.L.C., there are various electronic means of communication used to treat and/or coordinate treatment with you and your family. Electronic communication may include, but is not limited to; Cellular phone calls, Text messages, E-mails, Zoom Conferencing, etc. When I exchange Protected Health Information electronically with a clinician from the CFCG office, I am solely responsible for protecting my own privacy and confidentiality, at my own location.

By signing this form, I acknowledge that I understand it is my responsibility alone to ensure the privacy on my end of any electronic communications. I hold CFCG, P.L.C., my therapist and psychiatrists blameless should any violation of my privacy occur due to my error. I acknowledge that I am informed of CFCG, P.L.C., policy and that CFCG, has on file for me to read and possess a copy if I require, a full list of guidelines and regulations for which CFCG, P.L.C. is compliant.

| | |
|---|---|
| ______________________________ | _________________________ |
| Print Patient Name | Patient Signature |
| ______________________________ | ______________ |
| Parent/Guardian Signature (IF UNDER 18) | Date |

## Internal Release of Information

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 form, 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 use here at Child & Family Counseling Group, P.L.C.

We assure you that all information used and shared will be so judiciously and in the service of providing you better treatment.

______________________________ ______________________________
Print Patient Name Patient Signature

______________________________ ______________
Parent/Guardian Signature (IF UNDER 18) Date

THE CHILD & FAMILY COUNSELING GROUP, P.L.C.
*Comprehensive Diagnostic & Therapeutic Services*

# Release of Information

Patient Name: ___________________________ Date of Birth: _____________

Primary Phone #: _________________________ Email: _______________________

| **Release Purpose:** **(Check all that apply):** | **Person or Organization:** |
|---|---|
| ☐ Release Information<br>☐ Receive Information<br>☐ Verbally or Electronically Exchange Information<br>Child & Family Counseling Group, P.L.C. | Name of Person or Organization: |
| Address: 10521 Rosehaven Street, Suite 100 | Address:_______________________________________ |
| Fairfax, VA 22030 | City, State, Zip:_______________________________ |
| Phone: 703-352-3822 Fax : 703-385-8353 | Phone # _______________ Fax # _______________ |

**Information Category (Check all that apply):**

| | |
|---|---|
| ☐ Billing Information | ☐ Behavioral Report |
| ☐ Education/Academic Records | ☐ Psychological or Neurological Evaluation |
| ☐ Progress Notes | ☐ Psychiatric Records |
| ☐ Teacher's Report | |
| ☐ Other (please specify): | |
| ☐ Entire Medical Record for Specified Date Range:____________________to ______________________ | |

**Purpose of Release**

| | |
|---|---|
| ☐ Legal | ☐ Transfer of care |
| ☐ Continuing Care | ☐ Other (Please Specify): |
| ☐ School | |

**Authorization For General Release of Information**

I authorize Child & Family Counseling Group, P.L.C. to release, receive or exchange information from the above-mentioned patient's medical record as stated. You may amend or revoke this form in writing to Child & Family Counseling Group, P.L.C.

**NOTE: Please complete form in its entirety, failure to do so may delay or deny processing of your request. Release expires 1 year from date signed unless otherwise stated here: ____________________________________

________________________________ ________________________________
Print Patient Name: Patient Signature:

____________________________________ ______________
Parent/Guardian Signature: (If under 18) Date:

# Informed Consent Overview

Process, Benefits, and Risks of Psychotherapy: Participating in individual psychotherapy may results in several 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, we cannot guarantee such progress. 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. Law in the following circumstances will require disclosure:

- 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. 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.

Availabilities and Emergency Procedures: I have voicemail that I check periodically throughout the day. In addition, we employ an on-call Emergency Answering Service. This service 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 to discuss them with me directly.

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

# Child & Adolescent History Form

**Form completion date: ___________**

***Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.***

## General Information

Name of person completing this form: ______________________ Relation to patient: ____________

Child's Name: _____________________________________________

*First* *Middle* *Last*

D.O.B: _________ Age: __________ Gender: _________________

Home Address: ________________ Phone: ________________

________________ ________________

School: ______________________ Grade: ________________

## Referral Information

How were you referred to CFCG?

____________________________

## Current Concerns

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

How long has this problem(s) existed? ___________ Years _____________Months

What have you been told by others regarding your child's difficulties?__________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

What can we do to help you and your child?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## Who lives in the home?

| Name | Age | Relationship | Education Level | History of Emotional Difficulties |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Mother's Information**

Name: ________________________________ Occupation: ________________________

Health Status:
____________________________________________________________________________

**Mother's Marital History**

| Dates (FROM-TO) | Spouse's Name | How did marriage end? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Father's Information**

Name: ______________________________ Occupation: ___________________________

Health Status:
____________________________________________________________________________

## Father's Marital History

| Dates (FROM-TO) | Spouse's Name | How did marriage end? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**BLENDED, SEPARATED DIVORCED FAMILIES PLEASE COMPLETE THE FOLLOWING**

When did the divorce/separation occur?

______________________________________________

Who is the custodial parent?

______________________________________________

Where is the non-custodial parent?

______________________________________________

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**Mother's Children**

| Name | D.O.B. | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

If not remarried, does mother have significant other? ☐ ☐ Yes ☐ No

If yes, who? ______________________________ How long married? ______________

**Father's Children**

| Name | D.O.B. | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

If not remarried, does father have significant other? ☐ Yes ☐ No

If yes, who? ____________________________________ How long married? _____________

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## Developmental and Health History

Was the child from a planned pregnancy? ☐Yes ☐No

Was the child adopted? ☐ Yes ☐ No If yes, how old was the child at time of adoption? _____

Were there any problems during the pregnancy? (I.e. toxemia, diabetes, high blood pressure, etc.)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Were there any problems during the labor or delivery?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Were there any problems during the first 3 months post-delivery? (I.e. feeding, sleeping, breathing problems, other)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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# Developmental Milestones

*Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.*

| **Milestone** | **Age** |
|---|---|
| Sat Alone | |
| Crawled | |
| Toilet training started | |
| Toilet training ended | |
| Stood Alone | |
| Walked without holding | |
| Rode Tricycle | |

Has the child had any of the following diseases?

| Name | Check yes or write N/A | If yes, what age? |
|---|---|---|
| Measles | | |
| Mumps | | |
| Chicken Pox | | |
| Strep Throat | | |
| Ear Infections | | |

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## Medication History

| Medication Name | Dosage | Directions | Check if presently taking | Start date – End date | Reason for discontinuing |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Has the child had any of the following difficulties? If yes, please explain.

| | Check yes or write N/A | If yes, please explain |
|---|---|---|
| Accidents/Fractures | | |
| High Fever | | |
| Seizures | | |
| Food Poisoning | | |
| Lead Ingestion | | |
| Bedwetting or Soiling | | |

| | Check yes or write N/A | If yes, please explain |
|---|---|---|
| Constipation | | |
| Vision Problems | | |
| Hearing Problems | | |
| Speech Problems | | |
| Speaking Excessively Loud | | |
| Memory Problems | | |
| Allergies | | |
| Aggressive Behavior | | |
| Unusual Fears | | |
| Sleeping Difficulties | | |
| Head Banging | | |

| | Check yes or write N/A | If yes, please explain |
|---|---|---|
| Rocking | | |
| Temper Tantrums | | |
| Discipline Problems | | |
| Other | | |

**Adolescent**

***(12-18 years of age)***

| *(Please check all that apply)* | Yes | No | N/A | Additional Information |
|---|---|---|---|---|
| Have menses begun? | | | | Onset age? |
| Does he/she date? | | | | |
| Is he/she sexually active? | | | | |
| Has she been pregnant | | | | If yes, results of pregnancy? |
| Does he/she drive? | | | | |
| Does he/she work? | | | | Where & Hours worked per week? |

**Extracurricular Activities**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

_____________________________________________

_____________________________________________

Does he or she have a group of close friends? ☐ Yes ☐ No

How does he/she relate to authority?

______________________________________________

______________________________________________

______________________________________________

Any of the following?

Drugs ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

Tobacco ☐ Yes ☐ No

Has he/she ever run away? ☐ Yes ☐ No

If yes, when?

______________________________________________

______________________________________________

Where did they run away to? ____________________ For how long? ____________________

Has he/she been hospitalized for emotional problems? ☐ Yes ☐ No

**Please list all psychiatric hospitalizations evaluations**

| Type of Evaluation | Date (s) | Hospital/Facility | Treating Doctor |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Has he/she ever been suspended/expelled from school? ☐ Yes ☐ No

If yes, when: ________________________________

Why? ________________________________________

Any legal problems? ☐ Yes ☐ No

If yes, what were the circumstances?

______________________________________________________________________

______________________________________________________________________

Any suicidal language, gestures, or attempts? ☐ Yes ☐ No

If yes, please describe:

______________________________________________________________________

## Academic History

| Name of School | City/State | Grade(s) | Problems (if any) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Has your child been retained? ☐ Yes ☐ No

Has your child been tested? ☐ Yes ☐ No

**Please list any previous evaluations (i.e. Psychological, Educations, etc.)**

| Place of Evaluation | Type | Address | Date |
|---|---|---|---|
| | | | |

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

Has your child ever been is a special class placement, received remedial help, or had tutoring?
Yes ☐ No ☐

If yes, please specify

______________________________________________________________

______________________________________________________________

Relationship with Teachers (please check one)

☐ Excellent

☐ Average

☐ Poor

Relationship with Peers (please check one)

☐ Excellent

☐ Average

☐ Poor

***Please bring copies of all Psychological, Educational, or other evaluations to your upcoming appointment.***

## Activities

What things does your child like to do?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

What things does your child do well?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

What things present difficulty for your child?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Does your child recognize dangerous situations? ☐ Yes ☐ No

Give detailed description of an average day:

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Other comments:

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

## Symptoms Checklist

*(please check yes or no)*

| Symptom | Yes | No |
|---|---|---|
| Difficulty falling asleep | | |
| Trouble remaining sleep | | |
| Loss of Appetite | | |
| Excessive Appetite | | |
| Binge Eating | | |
| Excessive Exercising | | |
| Trouble Concentrating | | |
| Trouble Sitting Still | | |
| Feelings of Sadness | | |
| Tearfulness | | |
| Irritability | | |
| Trouble Controlling Aggression | | |
| Trouble Making Friends | | |
| Trouble with the Law | | |
| Ever been arrested | | |
| Uses drugs | | |
| Uses Alcohol | | |
| Smokes Cigarettes | | |
| Runs away from home | | |
| Hears voices | | |
| Sees visions | | |
| Oppositional to authority | | |
| Gets in fights | | |
| Has been sexually abused | | |
| Sexually molested other children | | |
| Takes medication at this time | | |

Please elaborate on symptoms marked yes: