Lynn Goya, M.Ed., Psy.D.
100 Kahelu Ave.
Suite 109
Mililani, HI 96789

PEDIATRIC REGISTRATION FORM

Patient's Name: _____
Last First Middle Initial

Date of Birth: _____ Age: _____

Home Address: _____

School: _____

Emergency contact: _____ Relationship to pt: _____

Home ph: _____ Cell ph: _____

If parents are divorced or separated, please bring copy of legal documents on custody arrangements to the first visit.

Marital status of parents: _____

Mother's Name: _____

Place of Employment: _____

Type of Work: _____

Father's Name: _____

Place of Employment: _____

Type of Work: _____

Insurance Coverage:

Primary Insurance Carrier: _____

Subscriber's name: _____ Date of Birth: _____

Subscriber #: _____ Group #: _____

Secondary Insurance Carrier: _____

Subscriber's name: _____ Date of Birth: _____

Subscriber #: _____ Group #: _____

CHILD THERAPY CONTRACT

Lynn K. Goya, Psy.D.
100 Kahelu Ave. #109
Mililani, HI 96789
Ph: (808) 253-9986

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment The information herein is in addition to the information contained in the Patient-Therapist Agreement Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision; however, I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement; you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court; whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad

litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $350 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Signature	Date
Print name	Relationship to child
Signature	Date
Print name	Relationship to child

Lynn K. Goya, M.Ed., Psy.D.
Clinical Psychologist
Mililani Park Plaza 100
Kahelu Ave.
Suite 109
Mililani, HI 96797
Ph: (808) 253-9986

FREQUENTLY ASKED QUESTIONS

Does my health insurance cover treatment?

It is your responsibility to insure that your health insurance plan will cover your treatment. Many plans cover at least part of the cost of mental health services. However, please note that some carriers require pre-authorization for psychological treatment, some have an annual deductible, and some plans have limitations such as a "maximum number of visits per year" clause. This differs with each insurance plan. Please check with your insurance representative regarding the need for pre-authorization and the number of visits you are allowed.

Please be aware that in the unusual instance that your insurance company chooses not to cover part or all of the psychological services rendered, you are financially responsible for payment in full.

Worker's Compensation and No-fault insurance cover the complete cost for preapproved psychological treatment related to conditions caused by an accident or work-related injury.

Professional Fees

My hourly fee is $250 plus tax for the initial evaluation meeting and $200 plus tax for subsequent sessions of the same episode. I also charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $350 plus tax per hour for preparation and attendance at any legal proceeding.

What is the payment procedure?

If you are covered by health insurance, our office will file claim forms with your insurance company. Co-payments and/or allowable portions of treatment fees not

covered by your insurance company will be your responsibility to pay. Co-payments for each session are due at the time of service. A handling charge of $25.00 will be assessed to your account for any returned checks.

What if I miss a session?

Please call us if you cannot make an appointment so we can give your slot to another patient. If you call at least 48 hours in advance of your scheduled appointment, there will be no charge for the missed session. If you cancel an appointment less than 48 hours in advance, you will be charged a fee ranging from $25 to $75 depending on the frequency of your late cancellations. You will be charged $100 for not showing up for an appointment and not calling us to let us know you won't be coming. After the second no-show (not calling and not coming to your appointment), you will be referred to another therapist.

Will any records be kept?

Brief notes are kept to assist in the organization and direction of your treatment. You are entitled to receive a copy of your records, or I can prepare a summary for you. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you view them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

What are my responsibilities in treatment?

Other than discussing with me the various things that are currently happening in your life, the major responsibility you have is to keep me informed of changes that occur with your emotions or behaviors during treatment. While in most instances, treatment will result in a decrease in uncomfortable emotions and undesired behaviors, it is possible that strong feelings of anger, sadness and/or depression may surface for a period of time during the course of treatment. If this occurs for you, it is extremely important that I know about it as soon as possible.

In general, if a situation arises that you believe to be a psychological emergency, you should call me at my office during working hours at 253-9986. If I am not immediately available, call the Suicide and Crisis Hotline at 832-3100, 911, or go to the nearest hospital emergency room.

If a specific situation comes up in which you feel like you want to harm yourself (suicide) or hurt someone else, you must promise to talk to me about the thoughts or plans before acting upon them. Again, if you feel that you cannot wait until the next regular appointment to discuss such thoughts, you must call me, or if I am not available, call 911, the Suicide and Crisis Hotline at 832-3100, or go to the nearest emergency room.

I have read the above and will abide by the stipulations contained herein.

_____ _____

Signature Date

Lynn K. Goya, M.Ed., Psy.D.
Mililani Park Plaza
100 Kahelu Ave.
Suite 109
Mililani, HI 96797
Ph: (808) 253-9986

CONFIDENTIALITY

I understand that the information gathered in the course of Dr. Goya's work with me will remain confidential. However, there are some exceptions to this confidentiality as mandated by law:

1. If information is shared which leads the therapist to believe that I/my minor child would cause injury to another person, Dr. Goya is obligated to contact either that person and/or the police in order to warn of a potential threat.

2. In cases where child abuse is communicated to the therapist. Dr. Goya is mandated to contact Child Protective Services.

3. If it is felt that I am/my minor child is actively suicidal, Dr. Goya would attempt to take all reasonable precautions to protect me/my minor child from harm, and this may include divulging information to others.

In all cases where there is a need to reveal information to others, the situation will be discussed with me in order to help me understand the need to report and in the hope of securing my consent.

In addition to the legally required limits on confidentiality, insurance companies and managed care company employees may request the following information to assist in processing claims for therapy services received: medical records and information necessary for the filing of claims and the authorization process which may include information relating to drug and alcohol use. I understand that I am/my minor child is protected by Federal law from secondary release of information by the insurance carrier.

I understand the statement of confidentiality and limits on confidentiality given above.

Signed	Date
Witnessed	Date

Lynn Goya, M.Ed., Psy.D.
100 Kahelu Ave. Ste. 109
Mililani, HI 96789

CHILD/ADOLESCENT QUESTIONNAIRE

Child's name: _____

School: _____ Grade: _____

Date of Birth: _____

PRESENT ILLNESS AND HISTORY:

Please give a brief summary of your child's problem: _____
_____
_____

When did the problem start? _____

How severe has the problem become? Is the problem affecting school and home? If so, please explain how it is affecting it. _____
_____
_____
_____

What do you believe is the cause of the problem? _____
_____
_____
_____
_____

PAST HISTORY

Has help been sought in the past for this or any other problems? _____
_____

Please circle problems your child/adolescent has experienced in the past:

Suicidal thoughts/attempts
Feelings of anxiety or worry
School/academic problems
Substance abuse
Sleep disturbances
Family problems
Obsessions or compulsions
Feelings of depression
Behavioral problems
Peer relationship problems
Impulse control
Legal problems
Physical/emotional/sexual abuse
Bizarre behaviors

FAMILY PSYCHIATRIC HISTORY

Circle any problem(s) relatives of your child/adolescent have experienced (including parents, grandparents, aunts, uncles, cousins, etc.)

Nervous breakdown	Mental retardation	Hallucinations
Psychiatric hospitalization	Depression	Mania
Delusions	Paranoia	Eating disorder
Fears/Phobias	Panic attacks	Suicide attempts
ADHD/"hyper"	Arrests/Legal problems	Alcohol/drug abuse

PAST AND CURRENT MEDICAL IINFORMATION

Who is your child's/teen's current pediatrician? _____
Was your child/teen referred by your pediatrician? _____
If so, may I contact your pediatrician? _____

Is your child/adolescent on any medication at this time?

Medication	Dosage	Treatment for what	Prescribed by

Any allergies? _____ If so, please elaborate. _____
_____

Any serious illnesses, injuries or hospitalizations? If so, please give child's age when these occurred:
_____
_____

Any ongoing physical complaints made by your child/adolescent? _____ If so, please elaborate. _____
_____
_____

Please circle problems your child/adolescent may have experienced:

Head injury	Recurrent vomiting	Stomachaches
Loss of consciousness	Diarrhea with dehydration	Hernia
Convulsions or seizures	Poison ingestion	Fainting spells
Odd movements or sounds	Undescended testicles	Double vision
Difficulty breathing	Urinary tract infections	Sleep problems
Meningitis or encephalitis	Asthma or bronchitis	Tremors
Chronic ear infections	Nervous twitches or tics	Heart disorder

Has your child/adolescent missed any immunizations? _____ If so, please elaborate.

_____

_____

Any irregular dental visits or dental problems? _____ If so, please elaborate. _____

_____

_____

Any use of drugs or alcohol? _____ If so, please elaborate. _____

Any smoking/chewing of tobacco? _____ If so, please elaborate. _____

_____

_____

Any consumption of caffeine drinks? _____ If so, please elaborate. _____

Is your adolescent sexually active? _____ If so, please elaborate. _____

_____

_____

Any problems with hearing? _____ vision? _____ If so, please elaborate. _____

_____

_____

Any problems with appetite or weight? _____ If so, please elaborate. _____

_____

_____

FOR FEMALES ONLY

Has menses begun? _____ If so, when? _____ Are they regular? ____
Any past or current pregnancies? _____ If so, please elaborate. _____

_____

_____

FAMILY MEDICAL HISTORY

Has anyone in the child's/adolescent's family had medical problems? _____ If so, please Elaborate. _____

_____

_____

Circle those that apply to child's/adolescent's family:

Birth defects
Thyroid/endocrine problems
Inherited diseases
Seizures/neurological problems
Tourettes/Tic Disorder
Other:

DEVELOPMENTAL HISTORY

Pregnancy. Please circle all that apply.

Mother had prior difficulties w/ pregnancies
Unplanned pregnancy
Mother w/ fevers, illnesses or other infections
Mother exposed to medications or x-rays
Mother used alcohol, tobacco, or drugs
Mother had diabetes, toxemia or high blood pressure
Miscarriage(s)
Gap in prenatal care
Premature
Overdue
Mother bled during pregnancy

Labor and Delivery. Please circle all that apply.

Unusual or difficult labor
Concerns of baby at birth
Mother with infections
Baby needed special care
Baby in hospital longer than mother
Mother had post-partum depression

Infancy and Early Childhood. Please circle all that apply.

Infant breast fed
Infant cried a lot
Attachment problems
Infant difficult to care for
Feeding problems
Other:

Developmental Milestones. Please circle all that apply.

Physical development
Dressing independently
Toileting
Fears
Speech and language
Eating independently
Peer interactions
Other:

SOCIAL DEVELOPMENT

Is your child involved in outside activities?

Activity	Program	Age started	How often

Please rate your child's/adolescent's temperament on this scale by circling a number on this five-point scale.

Mellow	1	2	3	4	5	Intense
Cautious	1	2	3	4	5	Adventurous
Happy	1	2	3	4	5	Sad
Social/outgoing	1	2	3	4	5	Isolates/Shy
Adapts easily	1	2	3	4	5	Never warms up
Calm	1	2	3	4	5	Hyperactive
Dependent	1	2	3	4	5	Independent
High self-esteem	1	2	3	4	5	Low self-esteem

Please circle all that apply.

Difficulty making friends
Breaks the law
Fights with others
Bullies others
Other:

Difficulty keeping friends
Promiscuity
Is picked on by others
"Wrong kind of friends"

What are your child's/adolescent's interests and hobbies? _____

What your child's/adolescent's strengths?_____

What do you like most about your child/adolescent? _____

What do you like least? _____

FAMILY ENVIRONMENT

Who lives in the home?

Name _____ Relationship _____ Age _____ Employment _____

Significant Others (e.g. siblings, caretakers) who live away from home

Name Relationship Where lives

Who is involved with disciplining the child/adolescent? _____

What disciplining methods are used? _____

Do these individuals agree or disagree on approaches? _____

MARITAL STATUS OF BIOLOGICAL PARENTS

Married/Living with from (date) _____ to _____

What is the current relationship like between these parents? _____

Mother's prior marriages and/or significant relationships:
Married to/living with from (date) _____ to _____

Father's prior marriages and significant relationships:
Married to/living with from (date) _____ to _____

SIGNIFICANT EVENTS

Has your child/adolescent ever been placed outside the family home?

When Where Reason

EDUCATIONAL HISTORY

School Dates Grades/Marks Why left

Please circle all that apply.

Significant change in grades
Truant
In special education classes
Suspensions/detentions
Doesn't complete work
Special services/classes
Repeated grade(s)
Excessive tardies
Receives extra help
Dislikes school
Resists going to school

Please explain: _____

_____

_____

Any other comments: _____

_____

_____

ADDENDUM TO CHILD THERAPY CONTRACT

Lynn K. Goya, M.Ed., Psy.D.
Clinical Psychologist
100 Kahelu Ave., Suite 109
Mililani, HI 96789
Ph: (808) 253-9986

This addendum to my "Child Therapy Contract" clarifies details of the agreement in the complex situation which exists when the parents or guardians of a child or teen who is seeking my services, are divorcing, divorced, separating, or separated. Under those conditions, I ask you to agree to the following:

Consent to Treatment: In cases where parents/guardians have joint legal custody, I will require written consent from both parents/guardians for me to work with their child/teen. Signing this addendum will represent such consent. I will also require, prior to the first meeting, a copy of that portion of the divorce decree/court document describing the custody of the child/teen.

Confidentiality: To assist their child/teen in establishing a trusting and therapeutic relationship with me, parents/guardians are willing to waive their right to access their child's/teen's therapeutic information, including their child's statements made during therapy, except when the child's/teen's physical health and safety are in imminent jeopardy. Parents/guardians attest to this waiver by signing this addendum.

Forensic Matters: Parents/guardians understand that my role is to be their child's/teen's therapist. Unless ordered to do so by a court order signed by a judge, I will not provide information to a court or attorney, either orally or in writing, as this may compromise my therapeutic role. I may consider discussing information with a court- appointed professional who is functioning in the role of a custody evaluator or guardian- ad-litem, if that professional is obtaining information from a variety of sources. It is NOT part of my role as therapist to recommend any change in custody or visitation.

Dual Role: If I am your child's/teen's therapist, I will NOT take on a second role, such as parent therapist, court evaluator, mediator, or expert witness for one parent.

Financial: The parent/guardian who brings/accompanies the child/teen to their session with me, or, if not in attendance, who scheduled that appointment, will be responsible for the copayment or payment of my fee, whichever is appropriate for that visit.

Your signature below indicates that you understand and agree to the conditions specified in this Addendum.

_____ _____

Signature Date

_____ _____

Signature Date