FLORIDA
PSYCHOLOGICAL

Florida Psychological Associates, LLC

1903 Island Walkway
Fernandina FL 32034-4797
904-277-0027

1. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information (“PHI”) that identifies you is kept private.
• Give you this notice of my legal duties and privacy practices with respect to health information.
• Follow the terms of the notice that is currently in effect.
• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client’s personal health information without the client’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery

request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.
b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Signature:

Relationship to Client:

Date:

2. Informed Consent for Behavioral Health Services

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

Informed Consent: I give my informed consent to voluntarily participate in Florida Psychological Associates, LLC., behavioral health services and I may decide to end or refuse services at any time. I understand that behavioral health services are not an exact science, and no guarantees are being made relative to the outcome of the services and or recommendations for services. I have the right to refuse services, and to have the consequences of such refusal fully explained to me. I agree to follow all program rules and guidelines, and I understand that failure to do so may result in termination from services. I agree to comply with service/treatment requirements for a medical history, physical examination, laboratory tests, and other behavioral health services. I voluntarily consent to intake and admission to behavioral healthcare services with Florida Psychological Associates, LLC (FPA).

Confidentiality: The law and professional ethics require us to keep client information confidential. This means that, generally, we cannot share your health information without your written authorization and we will strive to protect your privacy.

Limits of Confidentiality:

• If we believe you are threatening serious bodily harm to another, we are required to take protective action. This may include notifying the potential victim, contacting the police, or seeking hospitalization.

• If we believe you are at risk of causing severe harm to yourself, we may be obliged to seek hospitalization for you, or to contact members or others who can help provide protection.

• If we have reasonable suspicion that any child, elderly person, or incompetent person is being abused or neglected, the law requires that we report this to the appropriate county agency.

• If a court of law orders us to release information, we are required to provide that to the court.

• If you are or become involved in any kind of lawsuit or administrative procedure where the issue of your mental health is involved, you may not be able to keep the records private in court.

• In order to provide you with the best treatment, we may seek consultation from another licensed behavioral health professional on our team. In these consultations, we make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential, although the exceptions to confidentiality apply to them as well.

• All services are provided by a licensed professional or supervised by a licensed psychologist, licensed clinical social worker, and/or licensed mental health counselor. I know that I may ask to speak with a supervisor at any time. All team members who are registered interns with the State Department of Health, have earned a field-specific graduate degree, and are working on licensure requirements for the state of Florida. Additionally, all registered interns as previously described, are under the supervision of a licensed professional credentialed as a qualified supervisor by the State of Florida.

• ePrescribe Authorization: ePrecribing is defined as a physician/psychiatrist/ARNP's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare

Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

• Formulary and benefit transactions -Gives the prescriber information about which drugs are covered by the drug benefit plan.

• Medication history transactions - Provides the physician/psychiatrist/ARNP with information about medications the patient is already taking to minimize the number of adverse drug events.

• Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

• Emergencies: If you are experiencing an emergency, please call 911, go to the nearest hospital emergency room, or call 1-800-273-TALK. Please also call us and let us know the nature of your situation as soon as you are able.

Client Signature:

Relationship to Client:

Date:

3. Patient's Bill of Rights and Responsibilities/Consumer Assistance Notice

Section 381.026; 641.511 Florida Statutes

A PATIENT HAS THE RIGHT TO:

•Be treated with courtesy and respect, with appreciation of his/her dignity, and with protection of privacy.

• Receive a prompt and reasonable response to questions and requests.

• Know who is providing medical services and is responsible for his/her care.

• Know what patient support services exist (e.g., interpreter available if the patient does not speak English)

• Know what rules and regulations apply to his/her conduct.

• Be given by the provider information (e.g., diagnosis, planned treatment, alternatives, risks, and prognosis).

• Refuse any treatment, except as otherwise provided by law.

• Be given full information and necessary counseling on the availability of financial resources for care.

• Know whether the provider accepts the Medicare assignment rate, if the patient is covered by Medicare.

• Receive prior to treatment, a reasonable estimate of charges for medical care.

• Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.

• Receive accommodations, regardless of race, national origin, religion, handicap, or source of payment.

• Receive treatment for emergency medical condition that will deteriorate from failure to provide treatment.

• Know if medical treatment is for research and give consent or refusal to participate in research.

• Express complaints regarding any violation of his/her rights.

A PATIENT IS RESPONSIBLE FOR:

• Giving the provider accurate information about present and past illnesses, and any other health information.

• Reporting unexpected changes in his/her condition to the health care provider.

• Reporting to the provider whether they understands a planned course of action and what is expected.

• Following the treatment plan recommended by the health care provider.

• Keeping appointments and, when unable to do so, notifying the health care provider or facility.

• Their actions if treatment is refused or if the patient does not follow the health care provider’s instructions.

• Making sure financial responsibilities are carried out.

• Following health care facility conduct rules and regulations.

FILING COMPLAINTS:

FPA is committed to quality services for all. We are happy to provide a copy of our grievance policies upon request. If you have a concern about a health care professional you may call or submit a complaint to:

FLORIDA AGENGY FOR HEALTHCARE ADMINISTRATION CONSUMER SERVICES UNIT

P.O. Box 14000 Tallahassee FL 32317-4000

Monday – Friday 8 am - 5 pm (EST) 1-888-419-3456 (Press 2)

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

200 East Gaines Street, Tallahassee FL 32399

Monday – Friday 8 am - 5 pm (EST); 1-877-MY-FL-CFO (1-877-693-5236)

Signature:

Relationship to Client:

Date:

4. Medication Management Contract

I have been prescribed a controlled substance for the treatment of symptoms related to a psychiatric disorder. Controlled substances are tightly regulated by state and federal law because of a high risk for abuse. Therefore, the prescription will be written for a one month supply, with or without refills, per the discretion of the prescriber. The prescriber does not replace lost, stolen or damaged prescriptions. This means that the prescription generally will not be rewritten before the 30 day renewal period, regardless of the reason for an early refill request. I acknowledge that I am responsible for protecting my medications from being lost, stolen, or misused by others. It is both illegal and potentially very dangerous to share or sell prescription medications with another person. I understand it is a FELONY to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, or to give or sell these medications to others for any reason.I agree that my previous prescribing clinician, if applicable, may be notified that my prescriptions are now going to be written by a new prescriber. I agree that my previous prescribing clinician may disclose my prescription history to my new prescriber.I will NOT seek to have duplicate prescriptions written for the same, similar, or commonly misused medications. Commonly misused medications include, but are not limited to, gabapentin (Neurontin), bupropion (Wellbutrin, Zyban), quetiapine (Seroquel), and phentermine (diet pills). I understand my pharmacy records can be requested and reviewed if deemed necessary.I agree to consistently update my concurrent medication list with all of my providers. I agree to inform my current prescriber immediately if I am prescribed any pain pills from another prescriber (such as from primary care physician or the ER) as this can be dangerous or deadly in combination with other controlled substances, especially benzodiazepines.Because mixing benzodiazepine/stimulant medications with drugs, alcohol and pain pills can be unsafe (possibly result in injury or death), and in order to ensure the safe and proper use of controlled substance prescriptions, a urine drug screen or pill count may periodically be required prior to renewing a prescription. I pledge to be cooperative with this request within 48 hours.My prescribing clinician requires medication follow-up visits regularly until the dose of medication is stable. If appointments are not kept, my prescriptions may not be renewed. Prescription renewal requiring an appointment will be provided during a scheduled appointment and not on a walk-in basis. Once the dose of medication is stabilized, then I may be allowed to have visits less often.

I acknowledge that violation of these policies concerning controlled substances will result in immediate termination of my prescription for those substances, which may require me to seek treatment for withdrawal at an ER or other capable facility.I have read and understand this contract and I agree to comply. I have received a copy of this document.*

Signature:

5. Late Cancellation/No Show Policy

1. Patients will be held responsible for any scheduled appointment time they make with the organization. In the event of cancellation of an appointment with less than a 24-hour notice the following fees will be assessed:

Therapy appointment late cancel: $35.00

Therapy appointment no show: $100.00

Psychological Evaluation late cancel: $100.00

Psychological Evaluation no show: $200.00

The exception to this policy is Medicaid clients. Medicaid recipients cannot be charged for missed or cancelled appointments.

* Patients who cancel with more than a 24-hour notice will not be charged a fee.

2. This policy may be waived due to certain exceptions which are listed: Illness, with documentation from patient as required; death in family; or other extenuating circumstances. It is the policy of this organization that a patient may request a No-Show/Late Cancel Fee Wavier but the no-show fee may only be waived once in a 12-month period.

3. Authority to charge for no-show fees is held by front office staff upon cancellation received within approved policy guidelines or true no-show for scheduled appointment.

4. Patients with authorized credit cards on file will be charged within 48 hours of the missed appointment. Patients without a card on file will be reminded of their no-show fees and be required to pay at their next appointment along with their other existing fees.

Client Signature:

Relationship to Client:

Date:

6. Intake Information

How did you hear about us?:

Why are you seeking services?:

Are there any Court documents related to you seeking services? If yes, please describe below. You must bring to the first session.:

- [ ] FPA is committed to improving best practice mental health services; this includes data collection that is kept anonymous by FPA and is not distributed to any third party. Please check here if FPA may use de-identified information to inform and improve services?

What medications are you currently using?:

Anything else you want the doctor to know?:

7. Informed Consent for Telehealth Services

We are fortunate to be able to provide video-conferencing services to reduce interruptions in your care. Prior to providing these services, it is important to discuss the additional information provided below. There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.

• Confidentiality still applies for telehealth services (e.g. nobody will ever record the therapy session without the explicit permission from the others person(s)).

• Telehealth sessions are conducted on a secure platform that conforms to HIPPA regulations. We agree to use the video-conferencing platform selected for our virtual sessions and the mental health provider will explain how to use it.

• You need to use a computer equipped with a webcam or a smartphone during the session.

• It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.

• We will confirm with you that your physical location conforms to FPA policies.

• It is important to use a secure internet connection rather than public/free Wi-Fi.

• It is important to be on time. To cancel or change your tele-appointment, you must notify FPA 24 hours in advance.

• We will attempt to use the phone number on file as a back-up to restart the session or to reschedule it, in the event of technical problems.

• FPA recognizes the importance of ongoing suicide risk assessment for all clients. If participating in telehealth your risk assessment must include at least one emergency contact and the closest ER to your location in the event of a crisis situation.

• If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.

• You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

• Certain circumstances may arise in which telehealth is no longer appropriate. At that time your provider will work with you to ensure appropriate continuation of any needed services including resuming your in-person sessions.

Signature:

8. Insurance 1

Do you have behavioral health insurance?

- [ ] Yes
- [ ] No

If no, Please contact our office for self pay rates unless otherwise discussed.

Primary Insurance::

Effective Date::

Member ID # ::

Subscriber Name:

Relationship to Subscriber:

Behavioral Health Provider Phone Number::

Secondary Insurance::

Effective Date ::

Member ID #::

Behavioral Health Provider Phone Number ::

9. Credit/Debit Payment Authorization Form

(Card holder) Name on card if different than client:

Card Number:

CVV (Numbers on back):

Expiration Date:

Billing Zip Code:

I authorize Florida Psychological Associates to charge my credit/debit/health account card for professional services. If I do not cancel before 24 hours, I recognize that FPA will charge my card as a late cancel or no show if I do not show up for the appointment. These fees are subject to the type of appointment with our office.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature:

The Mental Illness Needs Detection (MIND) Screener - Child Version

This measure is only intended for clients under the age of 18. If you are the parent and/or legal guardian, please allow your child to answer these questions on their own.

Name:

Date:

Instructions
Please think about your thoughts and feelings over the last month. Select the answer(s) that best describes how you have been feeling most of the time.

1. Do you get upset a lot?:

2. Check any feelings that bother you a lot:

- [ ] Angry
- [ ] Irritated
- [ ] Frustrated
- [ ] Nervous
- [ ] Afraid
- [ ] Hopeless
- [ ] Lonely
- [ ] Sad
- [ ] None of these feelings bother me a lot

3. Do you worry all the time?:

4. Are you unable to get a scary thought out of your head?:

5. Do you have less fun than you used to?:

6. Do you feel like crying a lot?:

7. Do you get into fights a lot?:

8. Do you lose your temper a lot?:

9. Do you have trouble sitting still most of the time?:

10. Do you have a hard time paying attention to most things?:

11. Do you have thoughts that others think are strange?:

12. Do you hear or see strange things that other people don't?:

13. Do you eat a whole lot more than other people?:

14. Do you eat a whole lot less than other people?:

15. Do you get enough sleep at night?:

16. Do you hurt yourself on purpose?:

17. Have you thought of killing yourself?:

18. Do you have a hard time deciding on things?:

19. Do you dread going to school?:

20. Are you bullied most days?:

21. Do you get in trouble a lot?:

22. Do you always break the rules?:

23. Do you usually feel restless?:

24. Are you always tired?:

25. Do you have at least one close friend?:

26. Do you have trouble getting along with most people?:

Think about all your answers so far...
27. Do these things cause problems for you at school?:

28. Do these things cause problems for you at home?:

29. Do these things cause problems with your friends or family?:

THANK YOU FOR COMPLETING THIS MEASURE

Pediatric Symptom Checklist - Youth Report (Y-PSC)

For each item, please select the best option that best fits you. This measure is intended for clients under the age of 18. If you are the parent and/or legal guardian, please allow your child to answer these questions on their own.

Name:

Date:

1. Complain of aches or pains.:

2. Spend more time alone.:

3. Tire easily, little energy.:

4. Fidgety, unable to sit still.:

5. Have trouble with teacher.:

6. Less interested in school.:

7. Act as if driven by motor.:

8. Daydream too much.:

9. Distract easily.:

10. Are afraid of new situations.:

11. Feel sad, unhappy.:

12. Are irritable, angry.:

13. Feel hopeless.:

14. Have trouble concentrating.:

15. Less interested in friends.:

16. Fight with other children.:

17. Absent from school.:

18. School grades dropping.:

19. Down on yourself.:

20. Visit doctor with doctor finding nothing wrong.:

21. Have trouble sleeping.:

22. Worry a lot.:

23. Want to be with parent more than before.:

24. Feel that you are bad.:

25. Take unnecessary risks.:

26. Get hurt frequently.:

27. Seem to be having less fun.:

28. Act younger than children your age.:

29. Do not listen to rules.:

30. Do not show feelings.:

31. Do not understand other people's feelings.:

32. Tease others.:

33. Blame others for your troubles.:

34. Take things that do not belong to you.:

35. Refuse to share.:

15. SDQ

Strengths and Difficulties Questionnaire

For each item, please select either "Not True," "Somewhat True," or "Certainly True." It would help us if you answered all items as best as you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

This measure is intended for clients under the age of 18. If you are the parent and/or legal guardian, please allow your child to answer these questions on their own.

Name:

Date:

1. I get a lot of headaches, stomachaches, or sickness.:

2. I worry a lot.:

3. I am often unhappy, depressed, or tearful.:

4. I am nervous in new situations. I easily lose confidence.:

5. I have many fears. I am easily scared.:

6. I get very angry and often lose my temper.:

7. I usually do as I am told.:

8. I fight a lot. I can make other people do what I want.:

9. I am often accused of lying or cheating.:

10. I take things that are not mine from home, school, or elsewhere.:

11. I am restless. I cannot stay still for long.:

12. I am constantly fidgeting or squirming.:

13. I am easily distracted. I find it difficult to concentrate.:

14. I think before I do things.:

15. I finish the work I'm doing. My attention is good.:

16. I would rather be alone than with people of my age.:

17. I have at least one good friend or more.:

18. Other people my age generally like me.:

19. Other children or young people pick on me or bully me.:

20. I get along better with adults than with people my own age.:

21. I try to be nice to other people. I care about their feelings.:

22. I usually share with others, for example: CDs, games, or food.:

23. I am helpful if someone is hurt, upset, or feeling ill.:

24. I am kind to younger children.:

25. I often offer to help others (parents, teachers, children).:

Overall, do you think you have difficulties in any of the following areas?
26. Emotions, concentration, behavior, or being able to get on with other people:

If you have answered "Yes," please answer the following questions about these difficulties:
A. How long have these difficulties been present?:

B. Do the difficulties upset or distress you?:

C. Do the difficulties interfere with your everyday life in the following areas?
1. HOME LIFE:

2. FRIENDSHIPS:

3. CLASSROOM LEARNING:

4. LEISURE ACTIVITIES:

D. Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?:

Thank you very much for your help!

0. Authorization for Release of Confidential Information 1

Florida Psychological Associates, LLC 1903 Island WalkwayFernandina Beach, FL 32034Phone: (904) 277-0027Fax: (904) 775-4480

Client Name:

Client's Date of Birth:

Please read and check the following statement:

- [ ] I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I, as a client or legal representative, authorize Florida Psychological to release and/or receive the following:

- [ ] Diagnostic Evaluation Results
- [ ] Treatment Plan/Summary
- [ ] Discharge Reports
- [ ] Recommendations

Other: :

The above information is only to be released to and/or from, the following party:

Name and/or Agency:

Phone :

Fax:

This information is to be used for::

For the purpose of::

This authorization shall remain in effect until one year from date of signature at which time it shall expire and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

Date:

Print Name (if person filling this form out is not the client):

Relationship to Client: