THE ARIZONA SCHWARTZ GROUP, PC

DR. ANDREA MONTOYA, PH.D., PLLC LICENSED PSYCHOLOGIST

1490 SOUTH PRICE ROAD, SUITE 316
CHANDLER, AZ 85286
T 480.899.4077 F 480.718.7737
www.azschwartzgroup.com

PSYCHOLOGICAL SERVICES AGREEMENT

Welcome to my practice! As you consider working with me, it is important that we have a shared understanding of what we can expect from each other. This document contains important information about my professional services and business policies. Please read it carefully and discuss with me any questions you may have at our first meeting. When you sign this document, it will represent an agreement between us, which you may revoke in writing at any time. If you have any questions or concerns while completing the forms, please call the office and one of our helpful staff members will be happy to assist you. I am looking forward to meeting you and your family.

This document (the Agreement) contains important information about the professional services and business policies of Dr. Andrea Montoya, Ph.D., PLLC and The Arizona Schwartz Group, PC. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that Dr. Montoya obtain your signature acknowledging that she has provided you with this information prior to the end of your session.

Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss questions you have about the procedures at any time. When you sign the Psychological Services Consent Form, it will also represent an agreement between us. You may revoke your consent in writing at any time. That revocation will be binding unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy has also shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. In addition, therapy may be experiential at times. Therefore, you may be requested to participate physically. Please notify me of any physical limitations and know that you have the right to refuse. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation process, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, you should discuss them whenever they arise. If your doubts persist, I encourage you to set up a meeting with another mental health professional for a second opinion.

TERMINATION

Termination of psychotherapy is a critical juncture of the psychologist-patient relationship, much like the initiation of the professional relationship. Termination may take place for a variety of reasons and may be initiated by the patient, the psychologist, or as a mutual agreement. Reasons for termination may include; the patient achieves their desired outcome from therapy and no longer feels the need for services, the patient or psychologist

experience a significant life change (e.g., moving out of state), or the psychologist feels that the patient would be better served by a different provider due to the patient's individual needs. At times, financial or time constraints may be an issue for the patient or the family. Due to the importance of processing the end of the therapeutic relationship, I will make adjustments and do my best to ensure that we are able to meet for a final session.

In order to provide you with the best care possible, I ask that you notify me if you are thinking about ending the therapeutic relationship so we can collaborate and determine the best options for you. Since attendance in regularly scheduled sessions is essential to therapeutic progress, I expect that you will discuss any questions or concerns with me as they come up. If you have missed or cancelled several sessions, I will contact you to check in regarding your well-being and your continued interest in services. If I do not receive a response within three weeks of this date, you will be sent a letter notifying you that I am assuming you are no longer interested in services and your case will be considered "closed." I must do this for legal and ethical reasons, however, please be aware that you may communicate your renewed interest in treatment at any time. Additionally, I reserve the right to terminate treatment services for any patient who violates treatment protocol, is generally non-compliant, or who willfully disregards other treatment objectives that could support positive outcomes in therapy.

PATIENT RESPONSIBILITIES

Each patient is responsible for providing accurate contact information as well as billing information. If telephone numbers and/or addresses change, patients must inform Dr. Montoya's business office. Furthermore, the patient understands that the evaluation and treatment provided by Dr. Montoya is limited to outpatient psychology services. This does not necessarily constitute total or definitive psychological care. Further evaluation and treatment may be required in some cases. It is the patient's responsibility to obtain follow up medical care for general health as needed, or when advised to do so by Dr. Montoya.

MEETINGS/SCHEDULING

The initial evaluation period may last from 1 to 3 sessions. During this time, you and Dr. Montoya can decide if she is the best person to provide the services that you need in order to meet your treatment goals. A "therapy hour" is defined as a 45-50 minute session. If you schedule psychological testing, there are specific guidelines that will be discussed upon scheduling these services. Psychological Evaluations typically require 4-6 hours of in office, face-to-face testing with the patient, with a comparable time spent by the psychologist outside the office completing related tasks such as scoring, interpretation, records review, and report writing. An initial consultation meeting will be scheduled prior to testing in order to discuss the referral question(s) and purpose of evaluation, and determine scheduling needs.

Once an appointment is scheduled, you will be responsible to pay for that session unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). The business offices are closed on Memorial Day, July 4th, Labor Day, Thanksgiving Holiday (both Thursday and Friday), Christmas Day and New Year's Day. There may be times when we need to contact you by phone. Please inform us if you do not want us to leave a message at any of the phone numbers you provided. We do not accept cancellation or change notices received via email. You must speak to a scheduler to make, change, or cancel appointments.

If you need to cancel or change an appointment, please call 480-899-4077 during regular business office hours of 8:00 am to 5:00 pm Monday through Friday only. Please remember that you will be charged when you do not show for a scheduled appointment.

CONTACTING DR. MONTOYA

You may call and leave a confidential message with one of our receptionists or our office voicemail at any time. I do not return calls on evenings, weekends, and holidays. During business hours, I am often not immediately available by telephone. I typically check my messages several times a day and will return your call within 48 hours unless it is a weekend or holiday, in which case I will return your call on the first business day thereafter. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I have not returned your call within a reasonable time period, please call again because it is likely that something went wrong and I did not receive your message. If you are requesting correspondence over phone that requires more than 10 minutes of my time, I may inform you that charges may apply before this service is provided.

EMERGENCIES
I do not provide 24-hour or emergency therapy services. Although I will make every effort to be available to you if crises arise, you cannot depend on me to be available in emergency situations. If I am out of town or unavailable for an extended period of time, I will provide you with contact information for a colleague so that you may have interim support, if necessary. If you anticipate needing more than very occasional crisis contact with me outside of our sessions, please talk with me about this prior to beginning our work together. In the event that you have an urgent need and cannot reach me, please go to the nearest emergency room or call 911. You may also call the EMPACT psychological crisis line (480)-784-1500 or the Maricopa County Crisis Line (602) 222-9444.

MINORS & PARENTS
For patients under 18 years of age, their parents must review and sign the *Consent for the Provision of Psychological Services to a Minor* form. Consent from both parents, regardless of the custodial arrangement, is the preferred practice of this office. I prefer to see parents and children together as much as possible, as I believe in taking a collaborative approach to therapy. As children enter the teenage years, I tend to spend more time with them individually in therapy. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I strongly encourage teenage children to share treatment information directly with their parents. I will also provide you with general information about treatment status. I will not share specific details without his/her assent, however, if I believe that your child is at serious risk of harming him/herself or another, I will inform you. Examples of serious risk would include a plan to harm self or suicidal ideation which is intensifying.

If you are in a divorce or custody litigation, or involved in the court system in any other manner, you need to understand that my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this disclosure statement, you agree not to call me as a witness in any such litigation. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between a therapist and a patient. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans. I am always happy to write letters to jurisdictions regarding a person's attendance in psychotherapy when requested by the patient.

INDEPENDENT PRACTICE
As you know, I work with a group of independent mental health professionals, under the name The Arizona Schwartz Group, PC. This group is an association of independently practicing professionals which share certain expenses and administrative functions. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

BILLING AND PAYMENTS
Dr. Montoya is a fee-for-service provider. The office does not file insurance claims for you, however, we will provide you with all of the information that you should need to make a claim in the form of a "super bill" invoice. You may receive reimbursement from your insurance provider if you have "out of network" benefits. This has been successful for a number of patients. Of course, plans vary, particularly with regard to mental health coverage, and you will need to discuss reimbursement with your insurance provider if you would like to pursue this option.

Office staff collects full payment at the time of your visit and then your insurance company will reimburse you directly after you submit your claim. Also, if you plan on billing your insurance for reimbursement of your visit, you may need to obtain a prescription from your physician prior to your first appointment (depending on the type of insurance plan you have). If you do not plan on billing insurance, you do not need a prescription. You will be expected to pay for each session at the time it is held at the beginning of your session. When therapy is provided over the telephone during or after office hours, you will be responsible for paying for these therapy services prior to the telephone call. You may choose to have a credit card number kept on file for these appointments if this would be more convenient.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance

company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

PROFESSIONAL FEES

The following are my fees for routine services. If our sessions or other services are shorter or longer than the defined payment schedule, fees will be prorated accordingly. I do not charge for emails or telephone calls to patients, family members, or other care providers that are under 10 minutes.

- Individual Therapy (In-office): $175/50-minute session; $250/90-minute Initial Parent Consultation/Intake

- Psychological Assessment: Variable, and dependent on age of child, referral question(s), case complexity, and other factors such as the child's ability level, attention, and motivation for assessment tasks. Please contact the office for more information.

- Other Services and Administrative tasks: $175/hour, prorated to 15-minute (.25 hour) increments – includes email, telephone conversations with you or professionals whom you have authorized me to speak with on your behalf, and/or any other tasks that you ask of me outside of our scheduled therapy sessions. Other services include report or letter writing, telephone conversations lasting longer than 10 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. *Please note that services related to legal involvement (e.g. consultations with attorneys) will be billed at a higher rate.

Payment schedules for other professional services, such as psychotherapy performed out of office, will be discussed and agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. Please note that the above listed fees are subject to change.

PROFESSIONAL RECORDS

I maintain an electronic record keeping system. I will make progress notes in your chart after each session. These notes will be brief and will only convey general information that communicates the progress you are making. If another physician referred your case to me and you have provided written consent for care coordination, your progress will be communicated to the physician in writing or by phone. When written consent is obtained I can share information about you with whoever you wish. Otherwise, our communication will be confidential between us. Clinical data and psychotherapy notes, along with your financial records and all related information about your case, are stored on a server which is kept locked. This server is backed up and on line in a secured and encrypted server. By signing the consent for treatment, you hereby give me permission to destroy the original of any document that you provide to me, and to retain such documents only in an electronic imaged format. After termination of our professional relationship, I will likely only retain an electronic copy of your file for the minimum period required by law. The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your (or your child's) records, I recommend that you review them in my presence so that we can discuss the contents.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

EMAIL COMMUNICATIONS AND TEXT MESSAGING
I use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with my office should be limited to things like questions regarding services, appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. Please do not text message me unless we have made other arrangements.

SOCIAL MEDIA
I do not communicate with, or contact, any of my patients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I believe that any communications with patients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

WEBSITES AND WEB SEARCHES
I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment. Recently it has become fashionable for patients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews, please share it with me so we can discuss it and its potential impact on your therapy.

CONFIDENTIALITY POLICIES
The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I am professionally and ethically required to consult with other psychologists regularly. Such consultations are bound by the same confidentiality as are individual sessions. Should I decide to consult about your case, I will omit identifying information from such consultations to protect your privacy. If you object to my consulting with colleagues about your situation, please inform me so that I can understand your concerns. I will note all consultations in your file to further protect the privacy of your information.
- If you use health insurance to pay for any portion of your treatment, I may be required to release some treatment details to your insurance company.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- Generally, if you are involved in a court proceeding, I cannot disclose any information about you without your written consent or a court order. In the event that I am court ordered to disclose your information, I am legally obligated to do so.
- If a government agency requests information for health oversight activities, I may be required to comply.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to respond to the complaint.
- If a client files a worker's compensation claim, I may be required to comply with legal requests. This may include disclosure of your record to parties involved in the claim.

Certain Federal and Arizona laws require that I take action that I believe is necessary to attempt to protect others from harm. These situations include:

- If I have cause to suspect that you or someone you know is or may be abusing or neglecting a child, an elderly person, or an otherwise impaired or disabled person, I am required by law to report this to the proper authorities.
- If I believe that you present an imminent danger to the health and safety of yourself or someone else, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to only what is necessary.

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.

In compliance with the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), The Arizona Schwartz Group PC and Dr. Andrea Montoya, Ph.D. PLLC have established privacy policies and procedures relating to the protected health information of our patients. Protected health information is information related to your past, present, or future physical or mental health or condition, or payment for such, in which you personally could be identified. HIPPA requires that providers must maintain the privacy of protected health information, provide a notice of their legal duties and privacy practices, and abide by the terms of the privacy notice currently in effect.

If you have any questions about our privacy practices or any of the information contained in this Notice of Privacy Practices for Protected Health Information ("Notice"), or wish to register any complaints related to our privacy practices, you should contact:

DR. ANDREA MONTOYA, PH.D. PLLC.
1490 S PRICE ROAD, SUITE 316
CHANDLER, AZ 85286

We will supply a written copy of this Notice to any person requesting it, whether or not they are a current patient. All patients will be given a copy of this Notice at the time of the first service provided to them following the effective date listed above. This Notice will be posted prominently and copies will be made available in our office. We reserve the right to make changes to our Notice and have any new provisions become effective for all protected health information we maintain. If we make any material changes to the uses or disclosures of protected health information, the individual's rights, our legal duties, or other privacy practices stated in this Notice, this Notice will be revised. The revised Notice will be posted prominently in our office, and we will make the revised Notice available to anyone who requests a copy. The Notice is also available at www.AZSchwartzGroup.com.

The "Privacy Rule" protects all individual identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information 'protected health information (PHI).' Individual identifiable health information' is information, for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number, etc...)."

YOUR RIGHTS AS A PATIENT

With respect to your protected health information, you have the right to:

- Have full and complete knowledge of your therapist's qualifications, training, and licenses.
- Be fully informed regarding proposed evaluation and treatment.
- Discuss your therapy with anyone you choose, including another therapist or mental health provider.
- Refuse treatment entirely, or any component of any proposed treatment arrangement.
- Request that information from your treatment be shared with another therapist or organization, provided that appropriate consent forms have been signed.
- Question your therapist's competence. Should you become displeased with services, you are encouraged to talk to me to see if the matter can be resolved. If you feel unable to address these concerns with me, you may address these concerns with another therapist or pertinent or legal bodies.
- Request copies of ethical principles or other guidelines that govern my practice.

THE ARIZONA SCHWARTZ GROUP, PC

CONSENT FOR PSYCHOLOGICAL SERVICES

1490 SOUTH PRICE ROAD, SUITE 316
CHANDLER, AZ 85286
T 480.899.4077 F 480.718.7737
www.azschwartzgroup.com

ACKNOWLEDGMENT OF PATIENT RIGHTS, PRIVACY POLICY, LIMITS TO CONFIDENTIALITY, AND OFFICE POLICIES	
Please initial to indicate your understanding of the following:	
____ / ____*	I understand that psychotherapy can have benefits and risks, and since therapy often involves discussing unpleasant aspects of my life, uncomfortable feelings may be experienced.
____ / ____*	I understand that I can end treatment at any time I wish and that I can refuse any requests or suggestions made by my psychologist.
____ / ____*	I understand that Federal and Arizona state laws require that psychologists report all cases in which there is a danger to self or others, as well as any information that might be related to child or elder abuse.
____ / ____*	I understand that my medical records will be held or released in accordance with the state & federal laws (*HIPPA*) regarding confidentiality of such records, as outlined in the *Notice of Privacy Practices.*
____ / ____*	I agree that I will be responsible for the payment of all professional fees associated with the services provided.
____ / ____*	I understand the policy for missed appointments and that I may be responsible for my usual service fee if I do not provide 24 hour notice of cancellation.

*** (If patient is under age 18 and biological/adoptive parents are divorced, both parents must initial and sign this document)**

OPTIONAL AUTHORIZATION FOR CONSULTATION AND/OR COORDINATION OF CARE

Dr. Montoya is an independent contractor with the Arizona Schwartz Group, PC. In order to provide the highest level of care, psychologists often consult with other clinicians and physicians to discuss clinical impressions and treatment plans. You have the option of giving authorization for Dr. Montoya to consult and coordinate care with colleagues at the Arizona Schwartz Group, PC. This authorization is completely voluntary and can be revoked at any time by giving written notice.

By checking the below box(es), I hereby authorize Dr. Andrea Montoya, Ph.D., PLLC to discuss, send and/or receive medical information to/from:

☐	Dr. Marc Schwartz, DO and Board Certified Child, Adolescent, & Adult Psychiatrist for the purpose of care coordination and professional consultation.
☐	Kim Leight, RN, MSN, PSYNP for the purpose of care coordination and professional consultation.
☐	Dr. Allison Solomon, Psy.D., PLLC. for the purpose of care coordination and professional consultation.
☐	I *DO NOT* wish to authorize Dr. Montoya to consult with other providers at this time.

Your signature below indicates that you have read and understand the information detailed in Dr. Montoya's *Psychological Services Agreement*, agree to abide by its terms, and consent to participate in treatment. For parents/guardians of patients under 18 years of age, the *Consent for Provision of Psychological Services to a Minor* form must also be completed.

Patient Name		Patient Signature (age 18 yrs. and older)	Date
Parent/Guardian Signature (if patient is under age 18)	Date	Second Parent/Guardian Signature (if required)	Date

THE ARIZONA SCHWARTZ GROUP, PC

CONSENT FOR PROVISION OF PSYCHOLOGICAL SERVICES TO A MINOR

1490 South Price Road, Suite 316
Chandler, AZ 85286
Tel: 480.899.4077
www.azschwartzgroup.com

Patient Name		Date of Birth		Age	

Please select the custodial arrangement that applies to your current situation:

☐ Biological or adoptive parents residing together	☐ One parent/guardian has SOLE legal custody	☐ Joint custody arrangement
*This consent form may be completed by one or both parents	*This consent form MUST be completed by the parent/guardian with legal custody	*This consent form MUST be completed by BOTH parents

If legal documents exist regarding custodial agreements, it is required that a copy be on file with my office. Please bring these documents to your first appointment

Please initial each area below indicating your understanding:

_____ / _____	Parents are encouraged to respect their minor child's right to confidentiality. The specifics of therapy conversations with children will be kept private. Parents can be assured that the child will be encouraged to share critical information and that the parents will be given information regarding therapy themes and treatment progress. Laws regarding disclosure as specified previously also apply to minor patients. Children of divorce must have permission from the custodial parent to attend therapy. ***Permission from both parents, regardless of the custodial arrangement, is a required practice of this office.*** A copy of the decree must be included in the patient's file indicating the custodial arrangement. In any custodial arrangement, both parents have the right to contact the psychologist and inquire regarding their child's treatment progress (unless legally indicated by the court).
_____ / _____	I understand that the psychologist is not conducting a custody or visitation evaluation for my child. I agree not to involve the psychologist in any custody or visitation disputes, as I understand that would not be in the best interest of my child's relationship with the psychologist and would be counterproductive to the therapeutic process. I agree not to involve the psychologist in court proceedings regarding any treatment of my child now or in the future.

I / We the undersigned parent(s) or guardian(s) of the herein identified minor: _____, do hereby give my/our written consent for said minor to be entered into counseling/psychological services at The Arizona Schwartz Group, PC with Dr. Andrea Montoya, Ph.D., PLLC.

My signature below also verifies that I am a legal parent or guardian of the above identified minor and have the legal right to consent for said minor to receive treatment from Dr. Montoya. It is understood that this consent is subject to revocation by the undersigned at any time except to the extent that action has already been taken on that consent.

_____ Parent/Guardian Printed Name

_____ Parent/Guardian Signature

_____ Date

_____ Parent/Guardian Printed Name (if required)

_____ Parent/Guardian Signature

_____ Date

THE ARIZONA SCHWARTZ GROUP, PC

APPOINTMENT REMINDER PREFERENCES/UPDATE

1490 South Price Road, Suite 316
Chandler, AZ 85286
Tel: 480.899.4077
www.azschwartzgroup.com

Patient Name		Date of Birth	

Contact Information (If under 18 Parent/Guardian information) Please check box if okay to leave a detailed message ↓

Name		Phone #(H)	☐
Complete Address		(Cell)	☐
	Email		

Emergency Contact Information

Name		Phone #(s)	
Relationship			

Pharmacy Information (only for patients of Marc Schwartz, DO & Kim Leight, RN, MSN, PsyNP)

Pharmacy		Phone #	

Appointment Reminders
The Arizona Schwartz Group can now send appointment reminders via text, email and automated phone message. If you wish to receive these reminders we require your consent**. Please initial** to indicate your understanding of the following:

____	Reminder messages are generated using a secure service. I understand that they are transmitted over a public network onto a personal telephone and/or computer and as such may not be secure. The practice will not transmit any information which would enable an individual patient to be identified.
____	I acknowledge that appointment reminders are a courtesy and that I am responsible for keeping track of my appointments. Circumstances may occur where the Arizona Schwartz Group is unable to send reminders, or we are unable to reach you, and the responsibility of attending appointments or cancelling them still rests with me. **I understand that if I cancel or reschedule an appointment with less than 24 business hours' notice, I will be charged for the full amount of the appointment.**
____	Messaging options can be cancelled at any time. Text messaging rates may apply. I agree to advise the practice of any changes to my phone numbers or email address.

You can elect to receive a text message *and* email *or* automated phone message reminders. If you do not elect a text message, you will receive only one appointment reminder (either an automated message OR an email). By checking the below box(es), I hereby authorize members of the Arizona Schwartz Group to leave appointment reminders at the provided number(s) and/or email address:

☐ Mobile # (for text msgs)		**Or**: (please choose **one**)	☐ Phone # (for automated msgs)	
☐ Email			☐ Email	

This update applies to the following provider(s):

☐ Marc Schwartz, DO
☐ Kim Leight, RN, MSN, PsyNP
☐ Allison Solomon, PsyD
☐ Andrea Montoya, PhD

_____ _____
Patient or Parent/Guardian Signature Date

Acknowledgement of Independent Contractor Status

This documents is to advise you that Dr. Andrea Montoya, PH.D., PLLC is not an employee or agent of this office. Your signature below acknowledges that Dr. Andrea Montoya, PH.D., PLLC is an independent contractor. It further acknowledges that Dr. Marc Schwartz, DO PC or the Arizona Schwartz Group, PC will not be responsible for the actions or the services provided Dr. Andrea Montoya, PH.D. All services performed on behalf of Dr. Andrea Montoya, PH.D. are done as an accommodation.

Acknowledged and agreed.

Client's Name Printed:_____

Client's Signature: _____ Date: _____/____/

Parent/guardian/personal representative (if applicable)

Name Printed:_____

Signature: _____ Date: _____/____/

Witness (if client is unable to sign)

Name Printed: _____

Signature: _____ Date: _____/____/

THE ARIZONA SCHWARTZ GROUP, PC

CHILD & ADOLESCENT INTAKE FORM

1490 SOUTH PRICE ROAD, SUITE 316
CHANDLER, AZ 85286
Tel: 480.899.4077
www.azschwartzgroup.com

Thank you for taking the time to complete this form! All of the information will help us provide a thorough and comprehensive assessment

Identifying Information

Patient Information

Patient Name		Date of Birth		Age	
Ethnicity		Primary Language		Gender	
School		Teacher (K-6 only)		Grade	

Parent/Guardian Information

Name		Age		Occupation	
Phone #(s)		Email			

Name		Age		Occupation	
Phone #(s)		Email			

How did you hear about the AZ Schwartz Group?	

Family Structure

What is your current marital status?					
☐ married	☐ unmarried but residing together	☐ unmarried	☐ divorced/ separated*	☐ widowed	☐ other
* If divorced or separated from biological parent, what are the custody arrangements?					
please provide documentation at first appointment					

Please list the name and ages of child's siblings, and any other individuals residing in the home			
Name	Age	Name	Age

Current Concerns

Please briefly describe your reason for seeking treatment for your child at this time.

Pregnancy & Childbirth

Pregnancy

Were there any complications during pregnancy?	☐ No	☐ Yes:

Length of Pregnancy (in weeks; full-term = 40 weeks)		Length of Labor (in hours)		Birth Weight	

If your child was adopted, please answer the following questions. Otherwise, skip to the next question.		
Does your child know of the adoption?	☐ No	☐ Yes
At what age was the child placed in your home?		

Delivery

Were there any complications during delivery?	☐ No	☐ Yes:

At birth, did the baby experience any problems?	☐ No	☐ Yes:

Early Developmental History

Motor/Physical Development

Skill	Early/On Time	Delayed (Age)
Sit up (6-9 mo.)	☐	☐ ____
Walk (12-18 mo.)	☐	☐ ____
Pedal a bicycle without training wheels (5-6 yrs.)	☐	☐ ____

Do you *currently* have any of the following concerns about your child's motor development?		
☐ low muscle tone	☐ gross motor deficits (e.g., throwing, catching, running, etc.)	☐ fine motor deficits (e.g., handwriting, buttoning, etc.)
☐ poor coordination	☐ other:	☐ none

Has your child ever participated in physical or occupational therapy?	☐ No	☐ Yes

Toilet Training

Time	Bladder Control	Bowel Control
Daytime	☐ Typical ☐ Delayed ☐ Still Working	☐ Typical ☐ Delayed ☐ Still Working
Nighttime	☐ Typical ☐ Delayed ☐ Still Working	☐ Typical ☐ Delayed ☐ Still Working

Language/Communication Development

Skill	Early/On Time	Delayed (Age)
Uses single words (12-18 mo.)	☐	☐ ____
Uses 2-3 word sentences/phrases (18-24 mo.)	☐	☐ ____
Points to things when named (18-24 mo.)	☐	☐ ____
Follows simple instructions (18-24 mo.)	☐	☐ ____
Talks so strangers can understand most of the time (24-36 mo.)	☐	☐ ____

Do you *currently* have any of the following concerns about your child's language/communication?		
☐ unconnected thoughts	☐ unclear speech	☐ stuttering
☐ repetitive speech	☐ trouble understanding others	☐ trouble expressing thoughts
☐ other:		☐ none

Has your child ever lost language or regressed?	☐ No	☐ Yes

Has your child ever participated in speech therapy?	☐ No	☐ Yes

Social/Emotional Development

A child's temperament describes the way in which he/she approaches and reacts to the world. How would you describe your child's temperament? (May check more than one)		
☐ Easy or Flexible (tend to be happy, regular in sleeping and eating habits, adaptable, calm, and not easily upset)	☐ Difficult (may be fussy, irregular in feeding and sleeping habits, fearful of new people and situations, easily upset by noise and stimulation, and intense in their reactions)	☐ Slow to Warm/Cautious (may be less active; may withdraw or react negatively to new situations; over time, they may become more comfortable with repeated exposure to a new person, object, or situation)

Do you *currently* have any concerns about your child's social/emotional development?		
☐ limited emotions	☐ extreme emotional reactions	☐ poor friendship skills
☐ limited interest in peers	☐ doesn't respond to people	☐ doesn't play pretend games
☐ other:		☐ none

Cognitive Development

Did your child learn pre-academic skills (such as numbers, colors, shapes, etc.) at the same time as other children his/her age?	☐ Yes	☐ No

Do you *currently* have any of the following concerns about your child's cognitive development?		
☐ can't brush teeth, get undressed without help	☐ struggles to follow multistep directions	☐ doesn't talk about daily activities or experiences
☐ seems forgetful	☐ can't give first and last name	☐ seems easily distracted
☐ other:		☐ none

Medical History

Typical Daily Functioning

How would you describe your child's:					
Overall physical health	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent
Appetite	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent
Energy/Activity Level	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent
Sleep	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent

Hearing & Vision

Do you have any concerns about your child's hearing?	☐ No	☐ Yes:

Does your child wear glasses?	☐ No	☐ Yes:

Medical Conditions

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

Is there a family history of heart disease or sudden death?	☐ No	☐ Yes:

Medication History

Current Medication(s)	Start Date	Side Effects

Family History of Mental Health Conditions

Please indicate if any of the following mental health conditions are present or suspected in the child's immediate or extended family history. (Please include individual's relationship to child)	
Condition	Family Member(s)
☐ Alcohol Abuse/Dependence/Heavy Drinking	
☐ Anger Problems/ Behavior/Conduct Problems	
☐ Anxiety or Obsessive Compulsive Disorder (OCD)	
☐ Attention Deficit Hyperactivity Disorder (ADHD)	
☐ Autism Spectrum Disorder/Asperger's	
☐ Bipolar Disorder/Mood Disorder/Schizophrenia	
☐ Depression	
☐ Developmental Delays	
☐ Eating Disorders	
☐ Intellectual Disability	
☐ Learning Disorders (e.g., dyslexia, or reading/math/writing problems)	
☐ Suicide - Attempts	
☐ Suicide - Completed	
☐ Substance Abuse	
☐ Other:	
☐ Other:	

Educational History for School Aged Children

Does your child receive special education services?	☐ No	☐ Yes*

* Type: ☐ 504 Plan (e.g., accommodations for ADHD, asthma, etc.)
☐ Individualized Education Plan (IEP)
Primary Category of Eligibility: _____

Please bring a copy of the latest IEP document to the session, if possible. Thank You!

Has your child ever been held back a grade level?	☐ No	☐ Yes:

Has your child ever been written up for behavior, suspended or expelled?	☐ No	☐ Yes*
*Please describe:		

Please comment about any academic strengths and/or weaknesses you have observed:

Please indicate whether any of the following issues describe your child:		
☐ can't seem to get started with homework	☐ battles or argues about doing school work	☐ forgets to bring home needed materials
☐ forgets to turn in completed assignments	☐ struggles to understand work	☐ takes longer than others to complete work
☐ needs parents to provide significant support to complete work	☐ is easily distracted during homework time	☐ rushes through work, resulting in poor quality
☐ school materials are disorganized (i.e., messy backpack or binder)	☐ is dishonest about assigned work	☐ turns in incomplete assignments
☐ loses assignments or classroom materials	☐ other:	☐ no problems

Social, Emotional, & Behavioral Functioning

Interests

What are your child's strengths? What does he/she enjoy doing for fun? (i.e., games, activities, interests, etc.)

Social Skills

Please indicate which items best describe your child's social functioning:		
☐ makes friends easily	☐ has a best friend	☐ plays well with others
☐ shares easily	☐ follows rules	☐ enjoys team sports
☐ helps others	☐ leads other children	☐ follows other children
☐ prefers adults over peers	☐ is easily influenced	☐ prefers to be alone
☐ fights more than others	☐ bullies others	☐ does not have many friends

Mood & Behavior

How would you describe your child's typical mood?
What stressors typically trigger your child's negative moods and behavior?
How does your child show that he/she is upset?
What helps your child calm down after they have become upset?

Critical Items

Has your child ever experienced any potentially traumatic events? (e.g., physical or sexual abuse, neglect, victimization by peers, major losses, the witnessing of violence done to others, accidents, injuries, natural disasters, etc.)	☐ No	☐ Yes*
Has your child ever intentionally harmed him/herself, or talked about doing this?	☐ No	☐ Yes*
Has your child ever said they could see or hear things that others could not?	☐ No	☐ Yes*
Has your child ever been hospitalized due to an inability to be safe with self or others?	☐ No	☐ Yes*
Does your child currently, or has he/she ever used illegal substances?	☐ No	☐ Yes*
Has your child ever been involved with the juvenile justice system?	☐ No	☐ Yes*

Is the family currently, or have you ever, been involved in a case with Child Protective Services (CPS)?		
☐ Current Involvement*	☐ Past Involvement *	☐ No History
*Please describe:		

* Please explain "Yes" responses

Please feel free to provide any additional information not covered in this form that you think is helpful and important

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

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