Center for Psychological Health and Wellness, LLC

Child/Teen Initial Paperwork (For Ages Under 18)

Please tell us about your child or teenager...

Today's Date___________________________

Name of Child/Teen____Date of Birth____________________________

Address (Street Address, City, State, Zip)____

____

If Child Lives in Another Home Part of the Week, Please Provide Address, Person to Contact at that Location, Relationship to the Child/Teen, and Phone Number

____

____

Home Phone___________________________Mom's Cell or Other Phone_____________________________________

Dad's Cell or Other Phone__________________________ Email Address______________________________________

Mom's Occupation and Employer____

Dad's Occupation and Employer____

Are there specific custody arrangements? Y or N. If yes, please describe._________________________________

Who Referred You to Heidi Ramsbottom PhD.?____

Where Do You Go to School? What Grade?____

Social Security Number of Responsible Party____

In the Event of An Emergency, Who Should We Contact? Phone?___________________________

____

Family Doctor or Pediatrician?____

May We Contact This Doctor To Consult On Care Issues?(check one)_______Yes________No

If You Plan to Use Insurance, Please Indicate Insurance Company__________________________

Is the Insurance Through (check one) Mom_____Dad _____ Other_______, Relationship and Person's Full

Name____

Please Provide the Date of Birth For The Person That Carries the Insurance________________

That Parent's Employer is_____________________________________

Is the Child/Teen Taking Any Medications? (Please list)

____

____

Has the Child Ever Had Psychological Care?(check one)______Yes________No

If Yes, Please Tell Us the Name of the Therapist, Dates of Service, and Nature of Difficulty.

____

____

What is the Nature of the Concern You Wish to Address with Therapy for Your Child/Teen?

____

____

Center for Psychological Health and Wellness, LLC

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and the staff of Center for Psychological Health and Wellness, LLC. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at , (484) 509-0499, and a copy will be posted in the waiting room of our office.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer, Heidi Ramsbottom PhD. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_________________________________ ________________

Signature of client age 14 and over Date

____

Printed name of client age 14 and over

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Signature of parent/legal guardian

Center for Psychological Health and Wellness, LLC

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the designated staff of Center for Psychological Health and Wellness, LLC. I understand that developing a treatment plan with the staff member and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the staff of Center for Psychological Health and Wellness, LLC.

I am aware that I may stop my treatment at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 days) before the time of the appointment. If I do not cancel and do not show up, I will be charged the full fee for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, Center for Psychological Health and Wellness, LLC may stop my treatment.

If a staff member at Center for Psychological Health and Wellness, LLC has reason to suspect, on the basis of his/her professional judgment, that a child is or has been abused, that staff member is required to report suspicions to the authority or government agency vested to conduct child abuse investigations. The staff member is required to make such reports even if s/he does not see the child in a professional capacity.

The staff of Center for Psychological Health and Wellness, LLC is mandated to report suspected child abuse if anyone aged 14 or older reports that s/he committed child abuse, even if the victim is no longer in danger.

The staff member is also mandated to report suspected child abuse if anyone says that he or she knows of any child who is currently being abused.

My signature below shows that I understand and agree with all of these statements.

_______________________________________ ______________________

Signature of client (or person acting for client) Date

_______________________________________ ______________________

Printed name Relationship to client (if necessary)