Child & Family Psychological Associates

Today's Date: _____

Child's Name: _____ Birthdate/Age: _____/_____

Sex: _____

Address: _____

_____/_____
Zip Code

Phone: _____ (H) _____(W)

Cell Phone: _____ Messages may be left at ____ H ____ W ____ Cell

Parents' E-Mail Address _____
Use for Scheduling? ___Y General Information? ___Y
Use for Billing? ___Y ___N

Check Current Status of Natural Parents:
_____ Married (Date of Marriage _____)
_____ Separated (Date of Separation _____)
_____ Divorced (Date of Divorce _____)
_____ Never Married Legal Custodian:_____

Parents Occupation(s): _____

Family Members (please list all adults and children living in the home)

Name	Birthdate	Relationship	Name	Birthdate	Relationship

School/District: _____ Present Grade: _____

Has child - Repeated a grade? Yes _____ Grade _____ No _____

Received Special Education/Tutoring? Yes _____ Type _____

Current academic grades in school: _____

Previous Mental Health Services for Child or Family Members?: Yes _____ No _____

Who: _____ Where: _____ Year: _____

Who referred you to this practice?: _____

Insurance Company: _____ Insured's Name _____/_____
Relationship to Client

Insurance ID #: **Please provide card for copying** Insured's Birthdate: _____

Child & Family Psychological Associates
MEDICAL HISTORY

Child's Name: _____ Birthdate/Age: _____/_____

1) Does your child have a family physician? Yes _____ No _____

Name of Physician: _____

Address: _____

2) Date last treated by physician: _____
Explain nature of the treatment and results: _____

_____

3) Any current medical problems? Yes _____ No _____

If yes, please explain the nature of the problem(s): _____

_____

4) Current medications (prescribed and over-the-counter). Please state name, how often taken, dosage,

and purpose: _____

_____

5) Please check any of the following which are now or have been a problem for your child:

_____ High or prolonged fever	_____ Shortness of breath	_____ Congestion
_____ Convulsions	_____ Low blood pressure	_____ Head injury
_____ Unconsciousness	_____ Ulcers	_____ Diarrhea
_____ Bedwetting	_____ Underweight	_____ Nightmares
_____ Insomnia	_____ Epilepsy	_____ Vomiting
_____ High blood pressure	_____ Menstrual problems	_____ Dizziness
_____ Vision problems	_____ Headaches	_____ Soiling
_____ Stomach problems	_____ Constipation	_____ Tobacco Dependence

_____ Other (Please specify) _____

Comments/Explanations (if needed): _____

_____

Allergies? _____ No _____ Yes Details _____

_____

Child's Name: _____ DOB: _____

6) Family health history (blood relatives only). Please check any of the following that have occurred in your family (including your child) and identify which family member(s):

	Family Member(s)
---------- Learning disabilities	_____
---------- Drug abuse	_____
---------- Suicide	_____
---------- Alcoholism	_____
---------- Intellectual Disability	_____
---------- Psychiatric hospitalization	_____
---------- Depression	_____
---------- Attention deficit disorder or hyperactivity	_____

7) Does your child have or have you had a problem with drugs or alcohol? Yes _____ No _____

If yes, please state which substances: _____

_____

8) List any major illnesses, injuries, and/or surgeries your child has had (include age at the time):

None: _____ _____

_____

9) Please note any concerns with pregnancy, birth and early childhood development (e.g., walking, talking, toilet training, play with other children, physical growth, etc.): _____

_____

_____

10) Has your child ever been a victim of physical, sexual, or emotional abuse?: Yes _____ No _____

11) Please list any past or current stressors or life events that you feel have caused problems for your child/family that have been difficult to overcome: _____

_____

_____

CHILD & FAMILY PSYCHOLOGICAL ASSOCIATES (CFPA LLC)
822 Portage Trail ~ Cuyahoga Falls, OH 44221
330-923-9344~ 866-248-1103 (f)
www.childandfamilypsychologists.com

Practice Orientation

Welcome to Child & Family Psychological Associates. The following document outlines some key CFPA LLC policies that we want to make sure you are aware of. Please review the following items and discuss them with your provider. You will be asked to sign this document indicating that you have read and understand each of the items discussed below. You will be offered a copy of this document and a copy will be kept on file.

MEMORANDUM OF UNDERSTANDING

1). **Notice of Privacy Practices:** I acknowledge that I have been given access to the *Notice of Privacy Practices* document (website address located in header) that outlines the appropriate use and disclosure of my Protected Health Information (PHI).
2). **Emergencies:** I understand that CFPA is not an emergency facility. If I have an emergency, I will call 911 or go to the nearest Emergency Department.
3). **Contacting My Provider:** I acknowledge that, in addition to the address/phone number/fax number listed on this document, my provider has told me the best way to contact him/her. I understand that email is not a secure form of communication and that it cannot be used in emergencies.
4). **Insurance Claims:** I authorize the release of any medical information deemed necessary to process my insurance claims. I understand that I am responsible for knowing my insurance benefits and that I will be responsible for any and all charges not covered by my insurance provider.
5). **Copays:** I understand that I am responsible for any copays or deductibles required by my insurance provider. I understand that copays will be collected at the time of service and that the amount of my copay may be found on the back of my insurance card or by contacting my insurance carrier.
6). **Payments:** I understand that payments for copays or balance due can be made via check, credit card, or cash. I also understand that I will be charged late fees for outstanding balances greater than 90 days.
7). **No Shows/Cancellations:** I understand that I may be billed for a missed appointment (No Show/Cancellation without advance notice). I further understand that the cost of the missed session will be billed to me and not the insurance company.
8). **Diagnosis:** I understand that, in order to submit an insurance claim, a diagnosis must be given. I recognize that this will be done thoughtfully and will be based on the information available at the time of the appointment. I also understand that it may be modified as additional information becomes available.
9). **Mandated Reporter:** I understand that the providers at CFPA are mandated reporters and, as such, that they are legally bound to report even suspicions of abuse related to a child, marital partner, elder, or an individual with a developmental delay. Furthermore, I understand that they are required to make a report any time they are concerned about me harming myself or others.
10). **Release of Information/Limits of Confidentiality:** I understand that the information given to my provider, written or oral, will not be disclosed without my expressed written authorization. I also understand that there are some uncommon circumstances (outlined in the *Notice of Privacy Practices* document on the website) that may require part or all of my record to be released.
11). **Scope of Practice:** I understand that this practice does not participate in forensic activities (e.g., parenting fitness evaluations, child custody evaluations, or other related forensic activities). I further understand that, if called to testify in a legal case of any kind, my provider will; a) only provide information related to the stated presenting concerns/treatment goals, attendance, and general level of participation and b) will be paid at a rate of 200% of their hourly rate (for a minimum of 3 hours). I understand that this amount is designed to cover lost wages, travel, and other expenses.

12) **Electronic Communication:** In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we 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 our 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/Texting Communication: We use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with our office

should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email us about clinical matters because email is not a secure way to contact us. Email should not be used to contact a clinician for emergencies as there may be a delay in reading your message. The recipient of any CFPA email should check the email and attachments for the presence of viruses. CFPA accepts no liability for any damage caused by any virus transmitted in company email. Permission is granted to forward any CFPA email unless otherwise stated in the body of the message. If you need to discuss a clinical matter, please feel free to call your psychologist or wait to discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. Texting may be used on a very limited basis and only related to setting and changing appointments.

Social Media: We do not communicate with, or contact, any of our clients through social media platforms like Twitter and Facebook. In addition, if any of our staff discover that they have accidentally established an online relationship with you, we will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. We may participate on various social networks, but not in a professional capacity. If you have an online presence, there is a possibility that you may encounter CFPA staff by accident. If that occurs, please discuss it with your psychologist. We believe that any communication with clients online has a high potential to compromise the professional relationship. In addition, please do not try to contact any staff in this way as we will not respond and will terminate any online contact, no matter how accidental.

Websites: CFPA has a website that you are free to access. We use it for professional reasons to provide information to others about the practice. You are welcome to access and review the information that we have on our website and, if you have questions about it, it should discuss this during your sessions.

Web Searches: We will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather information about us 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 any CFPA staff through web searches, or in any other fashion for that matter, please discuss this with your psychologist so that we can deal with it and its potential impact on your treatment. Recently it has become fashionable for clients 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 of CFPA staff, please share it so we can discuss it and its potential impact on your treatment. Please do not rate our work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

I have read and understand this document and have been given the opportunity to ask questions related to anything mentioned within. My signature authorizes evaluation and/or treatment services for the identified client below.

Parent/Guardian or Client's Signature:_____ Date:_____

Client's Name: _____
(PRINT)