Psychological and Life Skills Associates, PC

13885 Hedgewood Drive, Suite 245, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124
(703) 490-0336

CHILDREN/ADOLESCENT INTAKE FORM AND DEVELOPMENTAL HISTORY QUESTIONNAIRE

(To be completed by parent(s) about child being brought for counseling)

Referred by:____________________ Today's Date: ___________

Child's Name__________________________Age___Birthdate________Home Phone_______________
Home Address______________________________________City_______________Zip_____________
Mother/Guardian__________________________Employer_______________Occupation____________
Father/Guardian___________________________Employer_______________Occupation____________
Mother/Guardian Phones_____________________Father/Guardian Phones_________________________
Parent's Marital Status: __Married__Single__Divorced__Widowed
Pediatrician/Family Physician____________________________ Physician's Phone__________________
Child's School_________________________________Grade_____Teacher___________
In case of Emergency, Please Contact_______________________________Phone__________________
Social Security Number__________________________

Current Family Structure: (residing in the home)

Name	Age	Relationship	Job/School	Mental Health History	Relationship with Child (positive, conflicted, etc.)

Other Children: (not in home)

Name	Age	Relationship	Job/School	Mental Health History	Relationship with Child (positive, conflicted, etc.)

Current Concerns (Please describe briefly)____
____
____

Prenatal History:

1. Prenatal care:____

2. Mother's health during pregnancy:____

3. Implications, abnormal test results or medical concerns during pregnancy:________________________

4. Fetal exposure to alcohol, cigarettes, or drug use during pregnancy:_____________________________

5. Infant's health/weight at birth:____

6. Unusual aspects to the delivery (e.g. prematurity, lack of oxygen…)____________________________

Early Development:

7. List ages your child reached the following developmental milestones:

Sitting___ Crawling___ Walking___
Using Single Words___ Using sentences___ Toilet Trained___

8. My child's temperament as an infant and toddler were: (check as many as apply)

Easy___ Cautious___ Excitable___
Fussy___ Slow to warm up___ Colicky___
High Energy___ Shy___ Alert___

9. History of articulation problems or regression in language skills:________________________________

10. History of motor problems or regression in motor skills:______________________________________

11. History of social problems or regression in social-relatedness skills:___________________________

Family History:

12. Child's primary caretaker(s) throughout childhood:____

13. Significant family stressors or changes in your child's lifetime (e.g. death, divorce, traumatic event)____
____

Medical History:

14. Medical or mental health conditions:____

15. Previous hospitalizations and dates:____

16. Current Medications: Medication Dose Treating Physician

____

____

____

____

17. History of Psychotherapy: Previous Therapist Dates Issues Addressed

____

____

18. Hearing and/or vision problems: ____

School/Job:

19. Typical grades earned by your child, including any significant or recent chances in grades:____

20. History of learning disability or concerns:____

21. Repeated any grades:____

22. Child's style of interacting with teachers:____

23. Child's style of interacting with peers:____

24. Behavioral concerns at school:____

25. Extracurricular activites:____

For parents/guardians of teenagers:

26. Your goals for your teenager after graduation from high school:______________________________

27. Your teenager's job history:____

Child's Personal Characteristics:

28. Strengths:____

29. Weaknesses:____

30. Hobbies/Interests:____

31. Child's usual mood:____

32. Child's relationship with neighborhood friends:____

33. Types of discipline that are effective with your child:_____________________________________

Current Symptoms: Please check all that apply:

___Irritability
___Aggression
___High activity level
___Staring spells
___Trouble expressing him/herself
___Frequent fatigue
___Low energy level
___Trouble falling asleep
___Trouble getting up in the morning
___Frequent awakenings
___Easily frustrated
___Recent weight gain/loss
___Appetite changes
___Excessive fears/worries
___Social isolation
___Depressed mood
___Mood swings
___Hopelessness
___Anxiety
___Anger/rage
___Guilt
___Grief/mourning
___Coping with pain
___Sexual abuse history
___ Physical abuse history
___Suicidal thoughts/actions
___Desire to hurt someone
___Drug/alcohol use
___Tobacco use
___ Self-harm
___ Problems in thinking
___ Problems with memory

Psychological and Life Skills Associates, PC
13885 Hedgewood Drive, Suite 245, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124
(703) 490-0336

NOTICE OF OUR PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD & INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of Psychological and Life Skills Associates, P.C. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your mental health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your mental health record. You may obtain an accounting of disclosures of your mental health information, request communications of your mental health information by alternative means or at alternative locations, revoke your authorization to use or disclose mental health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: Psychological and Life Skills Associates, P.C. is required to maintain the privacy of your mental health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected mental health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. We will not use or disclose your mental health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

***We will use your mental health information for treatment*:** Information obtained by your therapist will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your mental health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, relevant history, and treatment given.

Law enforcement: We may disclose mental health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your mental health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. We will attempt to contact you first to see if you consent to such release.

Child Abuse: If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services. We will discuss this with you as appropriate.

Abuse of Elderly or Incapacitated Adults: When we have reason to suspect that an incapacitated adult (e.g. someone who is not able to advocate for himself or herself) is being abused, neglected or exploited, we are required by law to make a report and provide relevant information to the Virginia Department of Social Services. You will be notified of this action unless your therapist believes that it would put you at risk of serious harm.

Health Oversight: The Virginia Board of Health Professions, including the Boards of Psychology, Social Work, and Counseling, has the power to subpoena relevant records should we be the focus of an inquiry.

Judicial or Administrative Proceedings (Court Orders): If you are involved in a court proceeding and a request is made for information about your treatment, we will not release information without your written authorization. If we receive a Subpoena for your records (of which you have been served, along with the proper notice required by state law) we are required to respond. We will attempt to contact you first to see if you consent to such release. If you object, you may file a motion, with the clerk of the court to move to quash (block) the subpoena. If you pursue this, notify your therapist as soon as possible. We are then required to place your records in a sealed envelope and provide them to the clerk of the court so that the court can determine whether the records should be released.

Serious Threat to Health or Safety of Others: If you communicate to us a specific and immediate threat to cause serious bodily injury or death to an identified or to a readily identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect the threatened person.

Danger to Self: Your therapist can break confidentiality if you (or your child) are in imminent danger of hurting yourself, in order to keep you (or your child) safe. This may include notifying emergency personnel.

Worker's Compensation: If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant PHI to you, your employer, the insurer, or a certified rehabilitation provider.

Debt Collection: Your name can be reported to a collection agency and/or a credit bureau if you fail to pay your bill. You will be notified before such a report is made.

Legal Defense: Disclosure may be made if a therapist must arrange for legal consultation if a patient takes legal action against a therapist.

Effective Date: This notice will be effective on April 14, 2003

Modification & Amendment: This notice may be modified or amended by other documents, upon notification from your healthcare provider.

To obtain more information, or if you have any questions about this form, please contact our privacy officer:

Dr. Christopher T. Haley
13885 Hedgewood Drive #245
Woodbridge, VA 22193
(703)490-0336

Psychological and Life Skills Associates, PC
13885 Hedgewood Drive, Suite 245, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124
(703) 490-0336

Our Financial Policy

Welcome to the office of Psychological and Life Skills Associates, P.C. In order to ensure the efficiency of our practice, we wish to explain our policy with regard to financial responsibility for sessions with the psychotherapists from this office.

All payments are due prior to each session. If we are in network with your insurance carrier, a copay/coinsurance is expected. Our office will then file to your insurance carrier for the remaining amount owed. Benefits quoted by your insurer are not a guarantee of payment. Ultimately, you are responsible for all charges incurred. If we are out of network with your insurance carrier, payment in full is expected. As a courtesy we will file to your insurance. If you have out of network benefits they will reimburse to you directly. During office hour's payment may be given to your psychotherapist or the office staff. After hours, payment is due to your therapist at the time of service. With so many insurance carriers, policies, and various benefit packages available, we will help you with your insurance filing but we cannot guarantee payment or accept responsibility for negotiating your claim(s). It is important that you understand the provisions of your insurance policy.

Our Late Cancellation/No-Show Policy

If you are unable to keep a scheduled appointment, you are required to give us at least a 24-hour notice. Late cancellations (with less than 24 hours notice) and No Shows (missing a scheduled appointment) are charged $75 each time, regardless of the reason. For all group sessions, you will be charged $25 for the first and $50 for all subsequent appointments. This fee cannot be billed to insurance.

Statement Fee

All payments are due at the time of service. If a balance is owed and a statement is mailed to you, you will be charged a $5.00 statement fee for each statement sent to you.

Collections Services

We are contracted with collection services to recover any money owed to Psychological and Life Skills Associates.

Outstanding Balance Policy

Payment is due at the time of session. Account balances that exceed $250 must make payment before further appointments can be scheduled.

Returned Checks

The return of a check (electronic or paper) issued to Psychological and Life Skills will result in a $25.00 returned check fee being placed on the account of the patient, or individual, on whose behalf the check was presented for each returned check, no matter the reason.

The undersigned has read, understands, and agrees to the above terms and conditions.

____ ________________________
Signature of Person Financially Responsible Date

____________________________________ ________________________________
Address (if other than patient's) Signature of Therapist/Witness

____
Date of birth of financially responsible party

Insurance Information

Ins. Co. (Name/Addr):____

Policy Holders Name:________________________________DOB:__________ SSN and Insurance ID:___________

If Military (Active/Retired):____

Any secondary insurance?(if so, name of company)__________________________

Policy Holders Name (if different from above):_________________DOB:________

SSN and Insurance ID:____

NOTE: Tricare Options Standard please alert your therapist if you have used any of your mental health benefits since October 1.

All Payments are Due at the Time of Your Appointment
And You Must Agree to One of the Following (please initial one):

____
Initial here

I agree to pay my session fee/co-pay in full at the time of service using one of the methods below.

1. BY CASH: We will gladly accept cash payments and will provide you with a receipt of payment.
2. BY CREDIT: We accept all major carriers. We can also accept credit card payments by phone. You can reach our office staff Monday-Friday from 10 am to 5 pm by calling 703-490-0336 x 0.
3. BY CHECK: Please make checks payable to ***Psychological and Life Skills Associates, PC***. You may give the check to your therapist or the office staff.
4. BY PAYPAL: Visit our website, Psychlife.net, and click on "Make a Payment." Then, follow the Paypal prompt.

____
Initial here

I request that my credit or debit card be charged for each session at the time of service. (please complete below)

NAME OF CLIENT ____
Card # ____
Exp date ____
Sec code ____
Billing zip ____
Name of Cardholder ___________________________________
Signature ____
Address (if different than above)
____
____

Psychological and Life Skills Associates, PC
13885 Hedgewood Drive, Suite 233, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124

Child/Adolescent Therapy Contract

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

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

Therapy is most effective when a trusting relationship exists between the psychotherapist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions.

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

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to pay me a $6000 retainer and reimburse me $400 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

____ ______________________
Signature of Responsible party (Parent/Legal guardian) Date

____
Printed name of Responsible party (Parent/Legal guardian)

____ ______________________
Signature of Therapist Date

Psychological and Life Skills Associates, PC
13885 Hedgewood Drive, Suite 245, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124
(703) 490-0336

Consent for Release and Use of Confidential Information

And

Acknowledgement of Notice of Privacy Practices

I,____hereby
(Name of Patient or Authorized Agent)
give my consent to Psychological and Life Skills Associates, P.C. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of:_____________________________.

I acknowledge the review and/or receipt of the Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to my therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my mental health information. Written revocation of consent must be sent to our office.

I understand that I have the right to request that the practice restricts how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed:____Date:_______________

If you are not the patient, please specify your relationship to the patient_________.

Psychological and Life Skills Associates, PC
13885 Hedgewood Drive, Suite 245, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124
(703) 490-0336

Charges for Ancillary Services

Please be aware that it is our policy to charge for non-clinical services. Such services include, but are not limited to, telephone consultations with other providers or schools, writing letter on behalf of clients, completing paperwork at the request of clients (eg. filling out disability paperwork), and fielding emergency calls. Charges will reflect the time needed to complete the service and is billed in 15 minute increments at a rate of $135/hour.
***Please note that advance notification will be sent before additional charges are applied.**

For example:

15 minutes = $33.75

30 minutes = $67.50

45 minutes = $101.25

60 minutes = $135.00

Charges for Medical Records

Searching and Handling Fee - $10
Pages 1 - 50: $0.50 per page
Pages 51+: $0.25 per page

I have read, understand, and agree to the above office policy.

____________________________________ ____________________
Signature of Patient, Parent, or Guardian Date