

# 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)

Email: \_\_\_\_\_ Referred by: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_ Birthdate \_\_\_\_\_ Gender: \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Mother/Guardian Phone \_\_\_\_\_ Father/Guardian Phone \_\_\_\_\_

Parent's Marital Status:  Single  Married  Divorced  Widowed

Pediatrician/Family Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Child's School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

In case of Emergency, Please Contact \_\_\_\_\_ Phone \_\_\_\_\_

### Current Family Structure: (residing in the home)

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

### Other Children: (not in home)

Name	Age	Relationship	Job/School	Mental Health History	Relationship w/ 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)

- |                                      |  |                                    |
|--------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Easy        | <input type="checkbox"/> Cautious        | <input type="checkbox"/> Excitable |
| <input type="checkbox"/> Fussy       | <input type="checkbox"/> Slow to warm up | <input type="checkbox"/> Colicky   |
| <input type="checkbox"/> High Energy | <input type="checkbox"/> Shy             | <input type="checkbox"/> 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 changes 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 activities:\_\_\_\_\_

**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:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Irritability                         | <input type="checkbox"/> Recent weight gain/loss | <input type="checkbox"/> Sexual abuse history     |
| <input type="checkbox"/> Aggression                           | <input type="checkbox"/> Appetite changes        | <input type="checkbox"/> Physical abuse history   |
| <input type="checkbox"/> High activity level                  | <input type="checkbox"/> Excessive fears/worries | <input type="checkbox"/> Suicide thoughts/actions |
| <input type="checkbox"/> Staring spells                       | <input type="checkbox"/> Social isolation        | <input type="checkbox"/> Desire to hurt someone   |
| <input type="checkbox"/> Trouble expressing<br>Him/herself    | <input type="checkbox"/> Depressed mood          | <input type="checkbox"/> Drug/alcohol use         |
| <input type="checkbox"/> Frequent fatigue                     | <input type="checkbox"/> Mood swings             | <input type="checkbox"/> Tobacco use              |
| <input type="checkbox"/> Low energy level                     | <input type="checkbox"/> Hopelessness            | <input type="checkbox"/> Self-harm                |
| <input type="checkbox"/> Trouble falling asleep               | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Problems in thinking     |
| <input type="checkbox"/> Trouble getting up<br>in the morning | <input type="checkbox"/> Anger/rage              | <input type="checkbox"/> Problems with memory     |
| <input type="checkbox"/> Easily frustrated                    | <input type="checkbox"/> Guilt                   | <input type="checkbox"/> Grief/morning            |
|   | <input type="checkbox"/> Coping with Pain        | <input type="checkbox"/> Frequent awakenings      |

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## **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 hour 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. This fee cannot be billed to insurance. \_\_\_\_\_(Initials)

### **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.

Consent for Release and Use of Confidential Information

I, \_\_\_\_\_ hereby give my consent to Psychological and Life Skills

Associates, P.C. to use for the purpose of payment, all information contained in the patient record

of: \_\_\_\_\_.

**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)

\_\_\_\_\_  
Date of birth of financially responsible party

# Our Financial Policy

## **Insurance Information**

Ins. Co. (Name/Address): \_\_\_\_\_

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: \_\_\_\_\_

***All Payments are Due at the Time of Your Appointment Using Your Credit/Debit Card on File.  
Our company policy is to require a credit/debit card on file to be charged.***

\_\_\_\_\_  
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) \_\_\_\_\_

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## **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 participate in any court-related activities, 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)

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**Consent for Release and Use of Confidential Information and  
Acknowledgement of Notice of Privacy Policy**

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 that I may review the Privacy Policy found on Psychlife.net. The Notice of Privacy Policy 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\_\_\_\_\_.



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In order to comply with the No Surprise Act of 2020, we are providing you with a list of our fees. This Good Faith Estimate explains our rates for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

### **Charges for Psychotherapy Services**

Initial Intake \$175  
Individual/Family/Marital sessions \$155  
Group sessions \$75

### **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 \$155/hour. For example:

15 minutes = \$38.75  
30 minutes = \$77.50  
45 minutes = \$116.25  
60 minutes = \$155.00

### **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.

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Signature of Patient, Parent, or Guardian

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Date

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## **Electronic Record and Signature Disclosure**

From time to time, Psychological and Life Skills Associates, PC, may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically via email. The words "the Company," "we," "us," and "our" refer to Psychological and Life Skills Associates, PC. The words "you and "your" mean you, the individual(s) identified on this intake form. "Communication" means any client agreement, amendments, disclosures, notices, responses, transaction history, privacy policies and all other information related to the service, including but not limited to information that we are required by law to provide to you in writing. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the "I agree" button at the bottom of this document.

### **Communications in Writing.**

All Communications, either electronic or paper format, from us to you will be considered "in writing." You should print or download for your records a copy of this intake form and disclosure that you deem important.

### **Federal E-Sign Consent**

You acknowledge and agree that your consent to electronic Communications is being provided in connection with a intake form and with a transaction that is subject to federal Electronic Signatures in National Commerce Act, and that you and we both intend that the Act apply to the fullest extent possible to validate our ability to conduct services as a business with you electronically.

### **Acknowledging your access and consent to receive materials electronically.**

To confirm to us that you can access this information electronically, which will be similar to other electronic Communications that we will provide to you, please verify that you were able to read this electronic disclosure and that you are also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving Communications exclusively in electronic format on the terms and conditions described above, please let us know by clicking the "I agree" button below.

By clicking the 'I agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC RECORD AND SIGNATURE DISCLOSURES document; and
- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and
- Until or unless I notify Psychological and Life Skills Associates, PC, as described above, I consent to receive electronic means all notices, disclosures, authorizations, acknowledges, and other documents that are required to be provided or made available to me by Psychological and Life Skills Associates, PC during the course of my relationship with you.

I AGREE

\_\_\_\_\_  
PRINT NAME (Patient, Parent, or Guardian)

\_\_\_\_\_  
DATE