Spectrum Behavioral Health Group – OKC, LLC

1006 24th Ave., NW, Suite 100, Norman, OK 73069
Phone: (405) 561-7928 Fax: (405) 801-2846

NEW CLIENT INFORMATION FORM Date of First Appointment: _____

Client Name: _____ Client DOB: _____

Client Address: _____ Client Gender: M F

City: _____ State: _____ Zip Code: _____

Contact Phone Numbers: (h) _____ (cell) _____ (w) _____

Who referred you to my office? _____

List the main reason for seeking services at my office: _____

_____

Please complete the following information if the client is a minor:

Legal Guardian Name(s) _____ Relationship to child: _____

Guardian Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: (h) (cell) (w)

If parents are separated or divorced or you are not the parent, please provide the name of the other parent or legal guardians not listed above and their contact information:

Other Parent/Guardian Name _____ Relationship to child: _____

Other Parent/Guardian Address: _____

Other City: _____ State: _____ Zip Code: _____

Other Phone Numbers: (h) (cell) (w)

All clients must complete the following information:

Please indicate your preferred contact phone number or if you prefer another method of communication:

_____

Please indicate if you do not want our office to leave messages for you on your voicemail (e.g. reminder calls, cancellations, etc.): _____

Primary Insurance Name: _____

ID/Policy Number: _____ Insurance Phone #: _____

Group Number of Policy: _____

Policyholder Name: _____ DOB: _____

Policyholder's Relationship to Client: _____

Policyholder's Address: _____

City: State: Zip Code:

If you have 2 insurance policies, please complete the following information:

Secondary Insurance Name: _____ Insured DOB: _____

ID/Policy Number: _____ Insurance Phone #: _____

Group Number of Policy: _____

Policyholder Name: _____ DOB: _____

Policyholder's Relationship to Client: _____

Policyholder's Address: _____

City: _____ State: _____ Zip Code: _____

Spectrum
Behavioral Health Group

Bryan Ray, Ph.D., BCBA

1006 24th Ave., NW, Suite 100, Norman, OK 73069

Phone: (405) 561-7928 Fax: (405) 801-2846

Welcome to my practice. I appreciate your seeking services at my office and hope that the information and policies contained here answer any questions you have about the services and costs associated with your evaluation or treatment. The following guide explains the policies concerning my qualifications, services, fees, appointments, insurance and confidentiality. ***Although this document is long, it is important that you read it carefully***. You will also need to review the Notice of Privacy Policies document located at my office. If you would like to write down questions you might have, I would be more than happy to discuss them at our next meeting. When you initial and sign this document, it will serve as an agreement between us.

PSYCHOLOGICAL SERVICES AND QUALIFICATIONS

Please arrive 20 minutes early for your first appointment and bring all paperwork and insurance card(s) if we are filing insurance for you or your child.

I am happy to provide a variety of services to children, adolescents and adults. These services include diagnostic evaluations, individual therapy, family therapy, couples therapy and psychological assessment/testing. It is important that you fully understand the service(s) that you or your child will be receiving in my office. I do not provide court-related or forensic services. I do not provide court testimony, forensic assessment, custody evaluations, or other services for court, or legal purposes. My services are limited only to enhancing the health and functioning of my clients. If a child/adolescent presenting for therapy is not in the custody of his/her biological parents, please come prepared with documentation regarding legal guardianship and/or contact information for his/her DHS caseworker.

Psychotherapy: There are many theories and techniques used to define psychotherapy services. How psychotherapy ultimately looks depends upon the psychologist, patient and the particular topics discussed. I generally utilize Cognitive Behavioral Therapy (CBT), but often integrate a variety of methods from other theories to address your specific issues and modes of understanding your world. As a psychotherapist that uses CBT, I believe that our thoughts and behaviors work together to impact the way that we feel.

For psychotherapy, I will typically conduct an initial evaluation session that lasts an hour followed by an additional 1 to 2 sessions of 50-55 minutes to develop a detailed treatment plan. This evaluation typically involves taking a detailed history, including the issues that bring you to psychotherapy and may involve completing testing (such as questionnaires). At the end of the evaluation period, I will be able to offer you some first impressions of what our work will include. If you have questions about my procedures, we should discuss them as they arise.

Psychological Assessment: Psychological assessments are not the same as psychotherapy services, although they are typically conducted to assist in treatment planning, which may include recommendations for certain types of therapeutic interventions. I do not conduct psychological evaluations for forensic or court purposes. Psychological assessments vary in length and cost depending on the type of testing required. Psychological assessments require several hours to complete because of the number of components including interviews, test administration, scoring of tests, interpretation of evaluations and report writing. The amount of time required to complete an assessment varies depending on the goals for the evaluation, but typically ranges from 4 to 12 hours. If you are being referred by another professional for psychological assessment (such as a physician or another mental health professional), it is very helpful to have that professional fax me a brief note indicating the purpose of the evaluation before I see you and/or your child.

Typically, a very young child's first appointment (6 years and younger) is 1 hour in length and my preference is to first meet with the parents alone for the first appointment, a diagnostic interview, during which I gather information about the problems the child is having as well as conduct a thorough Developmental history. Then I will meet with the young child at a separate appointment followed by an additional appointment with the parents where I review my findings and recommendations.

For elementary age children (7 to 12-years-old) and adolescents (13 to 17-years-old), initial appointments take about 1 hour and involve meeting with the child and their parents to conduct a diagnostic interview. A second appointment lasting approximately 1-3 hours will be used for conducting testing with the child and collateral testing regarding the child with the parents. Additional testing may also be scheduled depending on the reasons for the evaluation. For example, testing for learning disabilities requires more testing sessions of various lengths. As with younger children, a separate appointment will also be scheduled when the test results and recommendations will be discussed with the parent and child.

The first testing appointment for an adult is about 3 hours and involves an interview and required testing. Again, additional testing may also be scheduled depending upon the reasons for the evaluation. A separate appointment will be scheduled to review test findings and to make recommendations.

Finally, psychological evaluations are not always covered by insurance at the same benefit as psychotherapy services and often require preauthorization. While I will attempt to verify this benefit and obtain prior authorization for insurance companies for which I am a provider, it is ultimately your responsibility to know your insurance policy benefits and insure that any needed authorizations are obtained prior to my conducting the evaluation.

Initial here to indicate that Psychological Services information was read, understood and agreed upon | |

APPOINTMENTS

For your first appointment, please arrive at least 20 minutes before your scheduled appointment time so that you can check in at the front desk, review the Notice of Privacy Policies and Practices and complete any additional forms. If you are using insurance, please bring your insurance card with you.

When an appointment is made, that time is reserved and cannot be given to another client. It is very important that appointments be kept. If an appointment time needs to be rescheduled or canceled, please call the office so that the time may be made available to others. **ANY MISSED APPOINTMENT** OR LATE CANCELLATION (NOT CANCELLING AT LEAST 24 HOURS IN ADVANCE)**, WILL BE CHARGED A FEE OF $65.00** unless the late cancellation is made necessary by a **genuine emergency**. Appointments may be canceled by leaving a message on my confidential voicemail or letting a receptionist know during regular office hours. Insurance will not pay for missed appointments and the client or their guardian is solely responsible for paying for this fee. Payments for missed appointments are due with the regular fee at the next visit.

If two or more regularly scheduled (i.e. standing) appointments are cancelled, late or missed, I reserve the right to make that appointment time available to other clients without prior notification.

Phone Sessions: A phone session occurs when the therapist and client (or family member) carry on a conversation of a therapeutic, problem-solving or information-exchanging nature. This includes when a client or guardian of a child client agrees for me to conduct a professional consultation with other individuals pertaining to the client's treatment or evaluation (e.g., teacher, physician, therapist, etc.). Short phone calls (under 5 minutes) are not considered sessions. Longer phone calls, however, will be charged as a telephone consultation and will be charged at the rate stated on the fee schedule. The fee for a phone session will be due at the next scheduled visit. Phone sessions will be indicated as such and are not reimbursed by insurance, but are the responsibility of the client or the guardian of the client.

Initial here to indicate that the information about appointments was read, understood and agreed upon | |

PROFESSIONAL FEES

Initial Diagnostic Interview	60 minutes……	$ 185.00
Individual Therapy	45 minutes……	$ 135.00
Couples or Family Therapy	45 minutes……	$ 135.00
Psychological Assessment	Per 60 minutes……	$ 135.00

For each hour spent administering tests, there is typically an additional hour charged to score, interpret and prepare the report.

Telephone Consultations longer than 5 minutes, per quarter hour or any portion thereof……..	$ 33.75
Any additional consultation of services performed on behalf of the client per hour……	$ 135.00
No Shows or appointments cancelled less than 24 hours ahead of time……	$ 65.00
Forensic/Court-Related Services Per hour……	$ 350.00

As noted previously, I do not provide court-related services except when someone has broken this agreement with me and I am compelled by the court to become involved with court related matters (e.g. testifying in court under subpoena, participating in a deposition, preparing for court services, consulting with my personal attorney due to being compelled to be involved in court-related matters.

Please note that your fee may differ slightly from those listed for evaluation, therapy or testing if you are a client with one of the insurance companies with whom Dr. Ray contracts.

Initial here to indicate that the information about professional fees was read, understood and agreed upon ☐

BILLING AND PAYMENTS

You will be expected to pay for each session at the end of each visit, unless other arrangements are made prior to session. I currently accept cash, check, MasterCard, Visa, Debit and Discover Card payments. Please, make checks payable to Bryan Ray, Ph.D., BCBA. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. It is policy that the parent or guardian who initiates services for a child is the party responsible for payment. In cases where parents are divorced and separate appointments are required, payment is expected at the time services are rendered, regardless of which parent accompanies the child/attends the appointment. Shared financial arrangements between parents should be worked out between the parents involved.

Delinquent Accounts: If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon. I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the costs will be included in the claim. In collection situations, the only information I would release is the patient's name/person responsible for payment, the nature of services provided (e.g., family therapy, individual therapy, psychological testing) and the amount due.

Missed Payments: Unless other arrangements are made prior to services, services may be discontinued for missing payments on 2 consecutive sessions. Finance charges are also applicable if you do not make a payment within 30 days. Late charges are computed at 1.5% monthly (18% annually) for any balance over 30 days old. Final payment is expected on behalf of the client before reports, including psychological evaluations, are released, except in the case of emergency. A $ 25.00 charge is added for any returned check or failed credit card transaction.

Initial here to indicate that the information about billing and payment was read, understood and agreed upon ☐

MEDICAL INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate the impact of the resources you have available to pay for treatment or testing services. Services provided are covered under most health insurance policies under outpatient psychiatric treatment or psychological testing. However, some companies reimburse mental health services at a different rate from other medical services. Most policies have annual deductibles by individual, family or health condition. Some companies set annual limits in dollars or number of visits allowed per year. Since benefits are so varied, each client should review his or her policy carefully and be aware of the benefits or limitations involved.

Currently, I am an approved provider for the following insurance companies:

Health Choice, Blue Cross/Blue Shield, Medicaid

If your company is not on this list, we can usually still file claims with them. Exceptions include if you are enrolled in an HMO insurance plan. Typically, HMO's will not reimburse me for services unless I am an HMO provider and you will need to pay for the services. Regardless of whether I am a provider for your insurance, I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of the charges incurred. It is very important that you are aware of exactly what mental health services your insurance policy covers. To do this, you should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about your coverage, call your plan administrator.

Many insurance companies require that you authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in very 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, I 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. I will provide you with a copy of any report I submit, upon your request.

Once you have all of the information about your insurance coverage, we can discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to stop our therapeutic relationship, or if they do not cover services that I deem necessary for me to provide so that therapy or evaluations can be done in the optimal manner. It is important to remember that you always have the right to pay for services yourself instead of submitting to the insurance company.

Initial here to indicate that the information about medical insurance was read, understood and agreed upon _____

CONFIDENTIALITY AND PRIVACY INFORMATION

Records of your service activities are confidential and will not be released without the client's (or guardian's) specific written consent, except under the exceptions listed below. I may use or disclose your Protected Health Information (i.e., information in your health care record that may identify you) for treatment, payment and health care purposes with your consent. You may revoke such consent in writing at any time. You may not revoke an authorization to the extent that (1) we have taken action in reliance on the authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy. Your psychological records will be kept for a minimum of 10 years after your last session. The confidential records will be disposed of in a manner appropriate to maintain confidentiality. The exceptions to confidentiality are:

1. If the therapist suspects that child abuse or neglect has occurred or that a vulnerable adult has been abused or neglected, the law requires that it be reported to the proper authorities. This includes suspected mental or emotional abuse of a child who has witnessed domestic violence.

2. If the therapist believes that you are a clear and imminent danger to yourself or another person, the therapist may notify appropriate others to prevent that occurrence (i.e., statements of suicidal or homicidal intent).
3. If it becomes necessary to contact an attorney or a collection agency, then your name, identifying information about how to reach you and amount owed become available to these agents.
4. In legal proceedings, patient/therapist communications are privileged with the following exceptions. A judge's court order is required for such information to be released or the patient's written release for the information. Examples of when a judge might subpoena your record include, but are not limited to:
    a. If your mental status is an issue for the court;
    b. The judge feels that communications are necessary to the proper administration of justice.

Initial here to indicate that the information about confidentiality and privacy was read, understood and agreed upon | |

PATIENT RIGHTS (in accordance with HIPAA)

(A complete copy of my Privacy Notice is available when you check in at the office.)

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternate Means and at Alternative Locations: You have the right to request and receive confidential communications of Protected Health Information by alternative means or alternative locations (i.e., you may not want a family member to know you are being treated in my practice and may request we send bills to a different address).

Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of your Protected Health Information in my mental health and billing records used to make decisions about you for as long s the information is maintained in the record.

I typically request that the review be conducted in my presence so that I can answer questions that you may have. I may deny your access under certain circumstances (for example, but not limited to: if I believe it isn't in your best interest to review the record; therapy notes are generally not released; information released to me by other providers cannot be released). In some cases, you may have this decision reviewed. A copying charge not to exceed $0.25 per page will apply.

Right to Amend: You have the right to request an amendment of your Personal Health Information for as long as information is in your record. I may deny your request, but will discuss the reasons for such a denial.

Right to an Accounting of Disclosure: You generally have the right to receive an accounting of disclosures of your Personal Health Information.

Psychologist's Duties Under HIPAA: HIPAA requires that you read my Notice of Privacy Practices which is a separate document from this one. Copies of the notice are always located in the binder on the front reception desk so that you can review it at any time. You can also request a copy of that notice for your own records. I, and the staff in my office, are required by law to maintain the privacy of your Personal Health Information and to provide you with a notice of our legal duties and privacy practices with respect to your record. I will abide by the terms in this policy, unless we notify you of changes. You will be provided with copies of new policies or procedures. Further, you should be aware that pursuant to HIPAA and professional ethics codes, I keep professional records containing your Protected Health Information in parts of your file.

Initial here to indicate that the information about HIPAA rights was read, understood and agreed upon | |

MINORS IN TREATMENT

Patients under the age of 18 who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment and evaluation records. Both custodial and non-custodial parents are afforded this right to medical records under Oklahoma law. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I generally recommend that parents consent to give up their access to their child's therapy record. If parents agree to this during therapy, I will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. With young children, I typically do have frequent collateral meetings with parents given that treatment typically involves assistance from their parents (e.g., when behavioral therapy is the primary type of therapy) additional documentation of such meetings are also recorded in the child's medical record. Family meetings may be recommended when I believe that they would be helpful in a child's treatment, too. If I feel that the child, of any age, is in danger or is a danger to someone else, I will notify the parent/guardian of my concern. If I am conducting a psychological evaluation of a child, I typically send the report to the child's parent or legal guardian.

Initial here to indicate that the information about minors in treatment was read, understood and agreed upon ☐

COURT TESTIMONY AND LEGAL INVOLVEMENT

As noted previously, I do not provide court testimony, forensic assessments, custody evaluations, or any other services for court or legal purposes. My services are limited only to enhancing the health and functions of my clients. If you are seeking a psychologist who can testify on your behalf, such as in a custody or criminal case, I will be happy to refer you to other psychologists who do provide those services. By signing this agreement and beginning either your or your child's evaluation or treatment with me, you agree that none of our conversations, treatment, diagnoses, etc. can be used for any legal purposes, and that my records and-or oral testimony cannot be compelled in any case. If a subpoena is issued requiring my appearance or for my records and/or oral testimony, you will then be billed for any attorney fees, costs and/or expenses incurred for the time required to comply with or quash the subpoena and for my time related to dealing with the subpoena. Because of the difficulty of legal involvement, I charge $ 350.00 per hour of time spent in preparation, travel, consultation, appearance, etc. and require that a retainer be paid in advance. These fees are not covered by insurance and is your sole responsibility.

Initial here to indicate that the information about legal involvement was read, understood and agreed upon ☐

IMPAIRMENT FROM ALCOHOL OR OTHER SUBSTANCE

I respectfully request that you be free from alcohol or other intoxicants prior to coming in for an evaluation or therapy session so that we can have the best chance of being successful in our work together. If, during an appointment, I come to believe that you are impaired in some way because of substances, then I will address that concern to determine if we can continue. If in fact you are "intoxicated" for whatever reason, we will stop the session and I will make arrangements for you to get back to your residence "safe and sound." This may involve calling a friend, relative or a cab. Then too, I will request your car keys so that you will not be tempted to continue driving while impaired. If, for some reason, you refuse to cooperate, I could be forced to call the authorities to insure your safety and the safety of others.

Initial here to indicate that the information about impairment from substances was read, understood and agreed upon ☐

EMERGENCIES

If you are experiencing a physical emergency, please call your local emergency numbers. If you are experiencing a psychological emergency, please, call Dr. Ray at his office (405) 561-7928.. If you cannot contact Dr. Ray and it is an emergency, go to your nearest emergency room for assistance. When I am on vacation or otherwise

unavailable, I will leave the name and phone number of the professional covering for me on my voicemail and with the receptionist. My policies will be in effect for that coverage as well.

Initial here to indicate that the information about emergencies was read, understood and agreed upon ☐

PRACTICE STATEMENT

My office is located in the Aurora Professional Center, which also houses several other mental health professionals. We are each independent practitioners who share certain expenses and administrative functions. I assure you that my practice is completely independent from these other professionals in providing you with clinical services and I, alone, am fully responsible for those services. My professional records are separately maintained and no other professional can have access to them without your specific, written permission or in the case of an emergency during my absence which you request. You should be aware that office staff persons are employed to assist with running my practice. In most cases, I need to share protected information with these individuals for administrative purposes (e.g. scheduling and billing). All staff members have been trained about protecting your privacy and have agreed not to release any information without the permission of a professional staff member. I may occasionally find it helpful to consult other health and mental health professionals about a case in order to provide optimal care to my clients. During such consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not always notify you about these consultations unless I feel that it is important to our work together. I will note all consultations in your clinical record.

YOUR SIGNATURE ON THIS FORM INDICATES THAT YOU HAVE READ THE INFORMATION CONTAINED IN DR. RAY'S OUTPATIENT SERVICES CONTRACT AND AGREE TO ABIDE BY THE TERMS WITHIN DURING OUR PROFESSIONAL RELATIONSHIP. THIS ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE REVIEWED THE HIPAA PRIVACY NOTICE DESCRIBED HEREIN. IF YOU ARE THE GUARDIAN OF A MINOR CHILD WHO IS THE CLIENT, YOU ARE GIVING LEGAL CONSENT FOR SERVICES FOR THAT MINOR AND ATTEST THAT YOU HAVE THE LEGAL AUTHORIZATION TO GIVE CONSENT FOR THE CLINICAL EVALUATION OR PSYCHOLOGICAL TREATMENT FOR THAT CHILD.

Client Name: _____
Please Print

Guardian Name (if minor): _____
Please Print

Signature of Adult Client/Guardian:_____ Date:_____

I also give permission for Dr. Ray to release medical Information to my or my child's (if the client is a child) insurance company or a managed care company contracted by the insurance company to manage my or my child's medical care if necessary in order for the insurance company to pay their portion of services provided at this office. I further agree to pay for any part of Dr. Ray's services that the insurance does not pay.

_____	_____	_____
Print Name of Adult Client/Guardian	Signature of Adult Client/Guardian	Date

If you have any questions about your privacy rights or these policies and procedures and outpatient services contract, please direct them to Dr. Bryan Ray at 1006 24th Ave, NW, Suite 100, Norman, OK 73069-6344.

Thank you, and again, welcome to my practice. I look forward to meeting with you.

Spectrum Behavioral Health Group – OKC, LLC

Bryan Ray, Ph.D., BCBA. Licensed Psychologist
1006 24th Ave., NW, Suite 100, Norman, OK 73069
Phone: (405) 561-7928 Fax: (405) 801-2846

OUTPATIENT SERVICES AGREEMENT FOR COLLATERALS IN PSYCHOLOGICAL EVALUATIONS

Introduction
Thank you for assisting in this psychological evaluation. Your participation is important, and is essential to completion of this evaluation. This document is to inform you about the risks, rights and responsibilities of your participation as a collateral participant.

Who Is A Collateral?
A collateral is usually a spouse, parent, family member or friend who participates in evaluations to assist the identified client. The collateral is not considered to be a client and is not the subject of the evaluation. Psychologists have certain legal and ethical responsibilities to clients and the privacy of the relationship is given legal protection. My primary responsibility is to my client and I must place their interests first. You also have limited privacy protection.

The Role Of Collaterals In Evaluations
The role of collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the client, to provide information to the psychologist and never attend another session. In another case a collateral, such as a parent, might attend all of the patient's testing/evaluation sessions and his/her relationship with the client may be a focus of the evaluation. We will discuss your specific role in the evaluation at our first meeting and at other appropriate times.

Medical Records
No record or chart will be maintained on you in your role as a collateral. However, notes about you and the information you provide about the patent will be entered into the identified client's chart. The client may have a right to access the chart and the material contained therein, particularly if they are an adult. It is sometimes possible to maintain the privacy of our communications. If that is your wish, we should discuss it before any information is communicated. You have no right to access the client's chart without the express written consent of the identified client if they are an adult.

Confidentiality
The confidentiality of information in the client's chart, including the information that you provide me, is protected by both federal and state law. It can only be released if the identified client is an adult and specifically authorizes me to release it. However, if the client is a minor, this information will be part of the child's medical record. Under Oklahoma law, both custodial and non-custodial parents have a right to examine their child's medical records unless a court specifically denies such access. Exceptions to confidentiality include:

- If I suspect you or another person are abusing or neglecting a child or a vulnerable adult, I am required to file a report with the appropriate agency.
- If I believe that you are a danger to yourself (e.g., suicidal) I will take actions to protect your life even if I must reveal your identity to do so.
- If you threaten serious bodily harm to another I will take necessary actions to protect that person even if I must reveal your identity to do so.
- If you, or the client, is involved in a lawsuit, and a court requires that I submit information or testify, I must comply.

- If insurance is used to pay for the treatment, the client's insurance company may require me to submit information about the treatment for claims processing purposes or for utilization review.

Clinical Evaluations
This evaluation is a clinical evaluation and is typically being conducted in order to assist in treatment planning for the client being evaluated. By signing this agreement, you are agreeing that it is not being conducted for forensic or court-related purposes. If the evaluation is for a minor child and their parents are divorced or separated, I want both parents to participate in the child's evaluation and I will assist with having both parents participate to the extent that I am able to do so. In this case, I also need your agreement that your and my involvement in this process 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 child.

In my evaluation of both adults and children, this agreement indicates that you agree that in any court proceedings you will not 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 reimburse me at the rate of $350 per hour for time spent traveling, preparing reports, testifying, being in attendance and any other case-related costs, including any legal fees I incur if I need to obtain legal consultation from my personal attorney.

Summary
If you have questions about the nature of this clinical evaluation, my procedures, or your role in this process, please discuss them with me. Remember that the best way to assure quality and ethical treatment is to keep communication open and direct with your clinician. By signing below you indicate that you have read and understood this document.

Print Client's Name	Your Relationship To The Client
Print Your Name	
Your Signature	Date

Spectrum Behavioral Health Group – OKC, LLC

Bryan Ray, Ph.D., BCBA. Licensed Psychologist
1006 24th Ave., NW, Suite 100, Norman, OK 73069
Phone: (405) 561-7928 Fax: (405) 801-2846

Background Information Form

Client Name: _____ Interview Date: _____

REFERRAL INFORMATION

1. **What led you to seek an evaluation for your child at this time?**

2. **Please provide a brief history of your child's symptoms over the course of his or her life.**

When would you say these symptoms began? ☐ 0-7 years old ☐ 8-12 years old ☐ 13-15 years old ☐ 16-21 years old ☐ 22 years to present

3. **Are you currently involved in a law suit, or in a situation that will likely lead to a law suit being filed?**
☐ Yes ☐ No
If Yes, please describe:

DEVELOPMENTAL HISTORY

Prenatal History

4. **How was your health during pregnancy?**
Good ☐ Fair ☐ Poor ☐ DK ☐

5. **How old was the mother when the child was born?** Under 20 ☐ 20-24 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐ 40-44 ☐ Over 44 ☐ DK ☐

Do you recall using any of the following substances or medications during pregnancy?

6. **Beer or Wine**
☐ Never ☐ 10-19 times
☐ Once or twice ☐ 20-39 times
☐ 3-9 times ☐ 40+ times

7. **Hard Liquor**
☐ Never ☐ 10-19 times
☐ Once or twice ☐ 20-39 times
☐ 3-9 times ☐ 40+ times

8. **Coffee or other caffeine (Cokes, etc.)**
Taken together, how many times?
☐ Never ☐ 10-19 times
☐ Once or twice ☐ 20-39 times
☐ 3-9 times ☐ 40+ times

9. **Cigarettes**
☐ Never ☐ 10-19 times
☐ Once or twice ☐ 20-39 times
☐ 3-9 times ☐ 40+ times

10. **Did you ingest any of the following substances?**
☐ Valium (Librium, Xanax)
☐ Tranquilizers
☐ Anti-seizure medications (Dilantin)
☐ Treatment for diabetes
☐ Antibiotics (for viral infections)
☐ Sleeping pills
☐ Other:

Perinatal History

11. **Did you have toxemia or eclampsia?** No ☐ Yes ☐ DK ☐
12. **Was there Rh Factor incompatibility?** No ☐ Yes ☐ DK ☐
13. **Was (s)he born on schedule?** 8 mos or earlier ☐ Term 8-10 mos ☐ 10 months ☐ DK ☐
14. **What was the duration of labor?**
Under 6 hours ☐ 7-12 hours ☐ 13-18 hours ☐ 19-24 hours ☐ Over 24 hours ☐ DK ☐

15. Were you given any drugs to ease the pain during labor? No ☐ Yes ☐ DK ☐
Name:

16. Were there indications of fetal distress during labor or during birth? No ☐ Yes ☐ DK ☐

17. Was Delivery Normal? ☐ Breech? ☐ Caesarian? ☐ Forceps? ☐ Induced? ☐ DK ☐

18. What was the child's birth weight? Less than 2 lbs ☐ 2 – 3 lb. 15 oz ☐ 4 – 5 lb. 15 oz ☐
6 – 7 lb 15 oz ☐ 8 – 9 lb 15 oz ☐ 10 – 11 lb 15 oz ☐ 12 lbs or over ☐ DK ☐

19. Were there any health complications following birth? No ☐ Yes ☐ DK ☐
If Yes, specify:

Postnatal Period and Infancy

20. Were there early infancy feeding problems?
No ☐
Yes ☐

21. Was the child colicky?
No ☐
Yes ☐

22. Were there early infancy sleep pattern difficulties?
No ☐
Yes ☐

23. Were there problems with the infant's responsiveness (alertness)?
No ☐
Yes ☐

24. Did the child experience any health problems during infancy?
No ☐
Yes ☐

25. Did the child have any congenital problems?
No ☐
Yes ☐

26. Was the child an easy baby? Did (s)he cry a lot? Did (s)he follow a schedule well?
Very easy ☐
Easy ☐
Average ☐
Difficult ☐
Very difficult ☐

27. How did the baby behave with other people?
More sociable than average ☐
Average sociability ☐
More unsociable than average ☐

28. When (s)he wanted something, how insistent was (s)he?
Very insistent ☐
Pretty insistent ☐
Average ☐
Not very insistent ☐
Not at all insistent ☐

29. How would you rate the activity level of the child as an infant/toddler?
Very active ☐
Active ☐
Average ☐
Less active ☐
Not active ☐

Developmental Milestones

30. At what age did (s)he sit up?
3-6 months ☐
7-12 months ☐
Over 12 months ☐
Don't Know ☐

31. At what age did (s)he crawl?
6-12 months ☐
13-18 months ☐
Over 18 months ☐
Don't Know ☐

32. At what age did (s)he walk?
- Under 1 year ☐
- 1-2 years ☐
- 2-3 years ☐
- Don't Know ☐

33. At what age did (s)he speak single words (other than "mama" or "dada")?
- 9-13 months ☐
- 14-18 months ☐
- 19-24 months ☐
- 25-36 months ☐
- 37-48 months ☐
- Don't Know ☐

34. At want age did (s)he string two or more words together?
- 9-13 months ☐
- 14-18 months ☐
- 19-24 months ☐
- 25-36 months ☐
- 37-48 months ☐
- Don't Know ☐

35. At what age was (s)he toilet-trained? (Bladder control)
- Under 1 year ☐
- 1-2 years ☐
- 2-3 years ☐
- 3-4 years ☐
- Over 4 years ☐
- Don't Know ☐

36. At what age was (s)he toilet trained (Bowel control)
- Under 1 year ☐
- 1-2 years ☐
- 2-3 years ☐
- 3-4 years ☐
- Over 4 years ☐
- Don't Know ☐

37. Approximately how much time did toilet training take from start to finish?
If still having problems, tell what type, when happens and how often:
- Less than 1 month ☐
- 1-2 months ☐
- 2-3 months ☐
- 3-4 months ☐
- Still working on it ☐

MEDICAL HISTORY

38. How would you describe his/her health now?
If poor explain:
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐
- Very Poor ☐

39. How is her/his hearing?
If poor explain:
- Good ☐
- Fair ☐
- Poor ☐

40. How is his/her vision?
If poor explain:
- Good ☐
- Fair ☐
- Poor ☐

41. How is her/his gross motor coordination?
If poor explain:
- Good ☐
- Fair ☐
- Poor ☐

42. How is his/her fine motor coordination?
If poor explain:
- Good ☐
- Fair ☐
- Poor ☐

43. How is her/his speech articulation?
If poor explain:
- Good ☐
- Fair ☐
- Poor ☐

44. Has (s)he had any chronic health problems? (asthma, diabetes, etc.)
    If yes, explain:

    When was the onset of the chronic illness?

- ☐ No
- ☐ Yes
- ☐ Birth
- ☐ 0-1 year
- ☐ 1-2 years
- ☐ 2-3 years
- ☐ Over 3 years

45. Which of these illnesses has your child had?
    If any, please tell when or list any others:

- ☐ Mumps
- ☐ Chicken Pox
- ☐ Measles
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Pneumonia
- ☐ Encephalitis
- ☐ Otitis Media
- ☐ Lead Poisoning
- ☐ Seizures

46. Has the child had any accidents resulting in:
    If any, please tell when or list any others:

- ☐ Broken Bones
- ☐ Severe Lacerations
- ☐ Head Injury
- ☐ Severe Bruises
- ☐ Stomach Pumped
- ☐ Eye Injury
- ☐ Lost Teeth
- ☐ Sutures (stitches)

47. Has (s)he ever had surgery for any of these:
    If yes, explain and tell duration of hospital stay:
    If other surgery please list:

- ☐ Tonsillitis
- ☐ Adenoids
- ☐ Hernia
- ☐ Appendicitis
- ☐ Eye, Ear, Nose & Throat
- ☐ Digestive Disorder
- ☐ Urinary Tract
- ☐ Leg or Arm
- ☐ Burns

48. Is there any suspicion of alcohol or drug abuse?
    If yes, explain:

- ☐ No
- ☐ Yes
- ☐ Don't Know

49. Is there any history of physical/sexual abuse?
    If yes, explain:

- ☐ No
- ☐ Yes
- ☐ Don't Know

50. Are there a history of sleeping problems?
    If yes, explain:

- ☐ None
- ☐ Difficulty Falling Asleep
- ☐ Wakes Up During Night
- ☐ Wakes Up Early Morning

51. Is the person a restless sleeper?
    If yes, explain

- ☐ No
- ☐ Yes
- ☐ Don't Know

52. Are there appetite control problems?
    If yes, explain:

- ☐ Overeats
- ☐ Average
- ☐ Under eats

TREATMENT HISTORY

53. Have these ever been prescribed?
    If yes, what was duration of use? If others please list and tell duration:

- ☐ Ritalin/Stimulants
- ☐ Tranquilizers
- ☐ Dexedrine
- ☐ Cylert
- ☐ Anticonvulsants
- ☐ Antihistamines

54. Have there been psychological treatments?
If yes, when, with whom and where was it?

- ☐ Individual Psychotherapy
- ☐ Group Psychotherapy
- ☐ Family Therapy
- ☐ Inpatient Evaluation
- ☐ Residential Treatment

SCHOOL HISTORY

55. Preschool:

56. Kindergarten:

57. Grades 1 – 3:

58. Grades 4 – 6:

59. Grades 7 – 9:

60. Grades 10 – 12:

61. Post High School Schooling: - How many years of school have been completed?

62. Ever in any type of special education program?
If yes, how long and who was teacher?

- ☐ Learning Disabilities Class
- ☐ Behavioral/Emotional Disorders Class
- ☐ Resource Room
- ☐ Speech & Language Therapy
- ☐ Gifted & Talented Classes
- ☐ Advanced Placement Classes
- ☐ Other (specify):

63. Has ever been:
If yes, number of times, when and for how long?

- ☐ Suspended from school
- ☐ Expelled from school
- ☐ Retained in grade

64. Have other instructional modifications been attempted?

- ☐ None
- ☐ Behavior Modification Program
- ☐ Daily/weekly report card
- ☐ Other (specify)

SOCIAL HISTORY

65. Gets along with siblings?

- ☐ Doesn't have any
- ☐ Better than average
- ☐ Average
- ☐ Don't Know

66. Makes friends?

- ☐ Easier than average
- ☐ Average
- ☐ Worse than average
- ☐ Don't Know

67. On the average, how long do friendships last?

- Less than 6 months ☐
- 6 months – 1 year ☐
- More than 1 year ☐
- Don't Know ☐

FAMILY HISTORY

Past/Present History of:	Client	Client's Children	Client's Siblings	Client's Mother	Client's Father	Extended (Maternal)	Extended (Paternal)
ADHD Symptoms							
Alcohol Abuse							
Anxiety Disorders							
Depression							
Legal Difficulties							
Manic-Depression							
Mental Retardation							
Obsessive-Compulsive							
Schizophrenia/Psychosis							
Seizures/Epilepsy							
Suicide/Suicide Attempts							
Substance Abuse							
Tics/Tourettes Syndrome							
Inpatient Psych Services							
Outpatient Psych Services							
Other Medical Diagnoses							

68. Is/was the client
If yes, explain:

- Adopted ☐
- In Foster Care ☐
- In DHS Custody ☐
- In OJA Custody ☐

69. Are client's parents married/still together?
If no, explain client's age at split/divorce, number of marriages, step-siblings, half-siblings and custody/visitation arrangements.

- Yes ☐
- No ☐

CURRENT BEHAVIORAL CONCERNS

70. Primary Concerns

71. Other (related concerns)

72. What strategies have been implemented to address problems?

- Verbal reprimand ☐
- Time Out (isolation) ☐
- Removal of privileges ☐
- Rewards ☐
- Physical punishment ☐
- Acquiescence to child ☐
- Avoidance of child ☐

73. On the average, what percentage of the time does your child comply with initial commands?
- ☐ 0-20%
- ☐ 20-40%
- ☐ 40-60%
- ☐ 60-80%
- ☐ 80-100%

74. On the average, what percentage of the time does your child eventually comply with commands?
- ☐ 0-20%
- ☐ 20-40%
- ☐ 40-60%
- ☐ 60-80%
- ☐ 80-100%

75. To what extent the child's parents/caretakers consistent with Respect to disciplinary strategies?
- ☐ Most of the time
- ☐ Some of the time
- ☐ Very seldom

76. Have any of the following stress events occurred within the past 12 months?
- ☐ Parents divorced or separated
- ☐ Family accident or illness
- ☐ Death in family
- ☐ Parent changed job
- ☐ Changed schools
- ☐ Family moved
- ☐ Family financial problems
- ☐ Other (specify)

77. Which of the following are considered to be a significant problem at the present time?
- ☐ Fidgets
- ☐ Difficulty remaining seated
- ☐ Easily Distracted
- ☐ Difficulty awaiting turn
- ☐ Often blurts out answers to questions before they are completed
- ☐ Difficulty following instructions
- ☐ Difficulty sustaining attention
- ☐ Shifts from one activity to another
- ☐ Difficulty playing quietly
- ☐ Often talks excessively
- ☐ Often interrupts or intrudes on others
- ☐ Often does not listen
- ☐ Often loses things
- ☐ Often engages in physically dangerous activities

78. When did these problems begin? (specify age): _____

79. Which of the following are considered to be a significant problem at the present time?
- ☐ Often loses temper
- ☐ Often argues with adults
- ☐ Often actively defies or refuses adult requests or rules
- ☐ Often deliberately does things that annoy other people.
- ☐ Often blames others for own mistakes
- ☐ Is often touchy or easily annoyed by others
- ☐ Is often angry or resentful
- ☐ Is often spiteful or vindictive
- ☐ Often swears or uses Obscene language

80. When did these problems begin? (specify age): _____

81. Which of the following are considered to be a significant problem at the present time?

- ☐ Stolen without confrontation
- ☐ Lies often
- ☐ Run away from home overnight at least twice
- ☐ Deliberate fire-setting
- ☐ Forces someone else into sexual activity
- ☐ Often truant
- ☐ Breaking and entering
- ☐ Destroyed others' property
- ☐ Cruel to animals
- ☐ Used a weapon in a fight
- ☐ Often initiates physical fights
- ☐ Stolen with confrontation
- ☐ Physically cruel to people

82. When did these problems begin? (specify age): _____

83. Which of the following are considered to be a significant problem at the present time?

- ☐ Persistent school refusal
- ☐ Persistent refusal to sleep alone
- ☐ Unrealistic & persistent worry about possible harm to parents
- ☐ Persistent avoidance of being alone
- ☐ Unrealistic & persistent worry that an event will separate child from parents
- ☐ Repeated nightmares re: separation
- ☐ Somatic complaints
- ☐ Excessive distress in anticipation of separation from parents
- ☐ Excessive distress when separated from home or parents

84. When did these problems begin? (specify age): _____

85. Which of the following are considered to be a significant problem at the present time?

- ☐ Unrealistic worry about future events
- ☐ Unrealistic concern about competence
- ☐ Unrealistic concern about Appropriateness of past behavior
- ☐ Somatic complaints
- ☐ Marked self-consciousness
- ☐ Excessive need for reassurance
- ☐ Marked inability to relax

86. When did these problems begin? (specify age): _____

87. Which of the following are considered to be a significant problem at the present time?

- ☐ Less pleasure in activities
- ☐ Insomnia or hypersomnia often
- ☐ Depressed or irritable mood most of day nearly every day
- ☐ Moves quickly or slowly
- ☐ Feelings of worthlessness or excessive inappropriate guilt
- ☐ Fatigue or loss of energy
- ☐ Decrease or increase in appetite
- ☐ Diminished ability to concentrate
- ☐ Suicidal ideation or attempt

88. When did these problems begin? (specify age): _____

89. Which of the following are considered to be a significant problem at the present time?

- ☐ Poor appetite or overeating
- ☐ Insomnia or hypersomnia
- ☐ Depressed or irritable mood for most of the day for a year.
- ☐ Low energy or fatigue
- ☐ Poor concentration or difficulty making decisions
- ☐ Low self-esteem
- ☐ Feelings of hopelessness
- ☐ Never without symptoms for more than 2 months in the last year

90. When did these problems begin? (specify age): _____

OTHER CONCERNS

91. Has the client exhibited any of the following symptoms?

- ☐ Stereotyped mannerisms
- ☐ Odd postures
- ☐ Excessive or under reaction to sounds around
- ☐ Overreaction to touch
- ☐ Compulsive rituals
- ☐ Motor Tics
- ☐ Vocal Tics

92. Has the client exhibited any of the following symptoms?

- ☐ Loose thinking (tangential ideas circumstantial speech, etc.)
- ☐ Bizarre ideas (e.g. odd fascinations, Delusions, hallucinations)
- ☐ Incoherent speech (mumbles jargon)
- ☐ Disoriented, confused, staring or being "spacey"

93. Has the client exhibited any of the following symptoms?

- ☐ Unusual fears
- ☐ Strange aversions
- ☐ Excessive lability without reference to environment
- ☐ Panic attacks
- ☐ Explosive temper with minimal provocation
- ☐ Excessively constricted or bland affect
- ☐ Situationally inappropriate emotions
- ☐ Excessive clinging, attachment or dependence on adults

94. Has the client exhibited any of the following?

- ☐ Little or no interest in peers
- ☐ Significantly indiscreet remarks
- ☐ Initiates or terminates interactions inappropriately
- ☐ Abnormalities of speech
- ☐ Qualitatively abnormal social behavior
- ☐ Self-mutilation
- ☐ Excessive reaction to changes in routine