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

1006 24th Ave., NW, Suite 100, Norman, OK 73069
Phone: (405) 801-2836 Fax: (405) 801-2846

Welcome to my practice. I appreciate you seeking my services 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, couple's 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 one 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 where 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 sometimes require preauthorization. I will attempt to verify this benefit and obtain prior authorization for insurance companies for which I am a provider. **However, it is ultimately your responsibility to know your insurance policy benefits and ensure 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……..	$ 200.00
Individual Therapy	45 minutes……..	$ 150.00
Couples or Family Therapy	45 minutes…….	$ 150.00
Psychological Assessment	Per 60 minutes……..	$ 150.00

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…….	$ 150.00
No Shows or appointments cancelled less than 24 hours ahead of time…….	$ 65.00
Forensic/Court-Related Services Per hour……..	$ 450.00

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 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 Soonercare/Medicaid Tricare

If your insurance company is not listed above, we can usually still file claims with them. Exceptions include but are not limited to 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 circumstances 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 as 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 at 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 the parent(s) 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 parent(s) (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 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 $ 450.00 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 are 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 ensure 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. I will return your call as soon as I possibly can. You can also 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 an independent practitioner 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 administrative staff 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
1006 24th Ave, NW, Suite 100,
Norman, OK 73069-6344.

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

Effective. 08-20-19

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

1006 24th Ave NW, Suite 100, Norman, OK 73069 – P: 405-561-7928 – F: 405-801-2846

Pediatric Intake Form

The information you provide will help staff determine the care you need as well as any further assessments. A patient's individual background and cultural and family surroundings are important factors in her or his response to illness and treatment.

Date: _____

FAMILY AND MEDICAL HISTORY FORM

Patient's Name: _____ Date of Birth: _____
Parent/Legal Guardian name:_____
Home Address: _____City:_____ Zip:_____
Primary Phone: _____(home, cell, other) Secondary Phone: _____(home, cell, other)
E-mail Address: _____
Ethnicity: _____

Pregnancy and Birth History:
Please list all pregnancies in order (including this child, miscarriages, terminations or deceased):

Name of Child	BIRTH WEIGHT	ANY DELIVERY, HEALTH OR DEVELOPMENTAL PROBLEMS	FATHER
1			
2			
3			
4			
5			
6			

Pregnancy complications with this child: Circle all that apply:

Alcohol use
Breathing/Respiratory problems
Diabetes
Failure to Thrive
Genetic condition: _____
Hyperemesis gravidarum
Hypertension (high blood pressure)
Hypoglycemia
Jaundice
Low birth weight
Preterm Delivery
Preterm Labor
Pre-eclampsia
Substance use
Trouble with feeding/eating
Other: _____

Gestational age at time of delivery (or # of weeks early or late):_____
What type of delivery (please circle one)? Vaginal Cesarean Section = elective or emergency
Birth Weight: _____
Was your child in the NICU? Yes NO If so, how long? _____
Please describe any complications that occurred during NICU hospitalization: _____
_____
_____

Medical History:

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint / bone problems (include x-rays, bone scans)	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions (include any EEG's)	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			MRI / CAT scan / Injections	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

Has your child had any difficulties with feeding (i.e., sucking, swallowing, drooling, chewing, choking)? If yes, describe:

_____

_____

Hospitalizations/Surgeries including approximate dates: _____

_____

_____

List the current medications your child is taking, if any (please include any over the counter medications or medications given as needed): _____
_____
_____

Is your child ALLERGIC to any drugs? Yes ___ No ___ If yes, what drugs? _____
_____
Please list reactions to allergy along with severity: _____
_____

Is your child ALLERGIC to any foods? Yes ___ No ___ If yes, what? _____
_____
Please list reactions to allergy along with severity: _____
_____

Does your child use any special equipment for daily activities, such as:

Glasses ____ Hearing Aide _____ Splints _____ Walker _____ Crutches _____ Wheelchair _____
Other: _____

Can your child see and hear well? _____Has vision/hearing been formally evaluated? _____
Date of last evaluation: _____

Previous evaluations/services: *Who* *Where* *When*
Occupational Therapist _____
Physical Therapist _____
Speech Therapist _____
Psychologist _____
Other _____

HAS YOUR CHILD HAD ANY THERAPY THIS CALENDAR YEAR HERE OR AT ANOTHER FACILITY? YES ____ NO ____

Nutritional

Please answer the following questions regarding your child's nutritional status.	**Yes**	**No**	**N/A**
My child has chewing or swallowing problems that make it difficult to eat. If yes, please explain:			
My child has had significant unexplained weight loss or gain in the past three months.			
My child has an open non-healing wound.			

Does your child have intolerances or dislikes of major food groups such as grains, fruits, starches, milk, protein, etc? If so, please describe: _____
_____

Developmental history:
We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you cannot recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE	GOOD/FAIR	POOR
Speech/Language Milestones: Smiled						
Said first words / names single objects						
Combine words (i.e., me go, dad shoe)						
Use simple questions (i.e., where's mom?)						
Followed simple 1 step directions						
Said 2-3 phrases						
Counted to 5						
Knew alphabet						
Motor Milestones: Held head up						
Rolled over						
Sat unsupported						
Crawled on hands and knees						
Stood alone						
Walked by self						
Threw objects actively						
Ran by self						
Pedal a tricycle						
Feeds self: (finger feed / eats with spoon / fork)						
Drink from: (bottle / spouted or special cup / regular cup)						
Brush teeth: (tolerates from parent / independent)						
Dressed self						
Manipulates buttons, zippers, shoelaces						
Bladder trained - days						
Bladder trained - nights						
Bowel trained						
Sleeps through the night						
Shows a hand preference (which?)						
Cut paper with scissors						
Scribble with a crayon						

Has your child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Masturbation	
11			Fire play or cruelty to animals	
12			Major mood swings	
13			Under or over reactive to sounds	
14			Under or over reactive to clothing	
15			Under or over reactive to taste	
16			Under or over reactive to smell	
17			Any unusual fears?	

General Information:

Father's Name:_____ Date of birth:_____
Occupation:_____ Highest Educational Level:_____
Religion:_____ Relationship to child: (please circle): Biological Adoptive Step Foster Other

Mother's Name:_____ Date of birth:_____
Occupation:_____ Highest Educational Level:_____
Religion:_____ Relationship to child: (please circle): Biological Adoptive Step Foster Other

Brother's and Sisters (please include ages):_____
If both primary caregivers work, who cares for the child? _____
History of abuse/trauma: Yes_____ No_____

FAMILY STRESSORS (please note/explain if any of the following stressful events happened in the last 12 months):

ITEM	NO	YES	EVENT	EXPLANATION
1			Marital separations/divorce	
2			Death in the family	
3			Financial crisis	
4			Job change/difficulties	
5			School problems	
6			Legal problems	
7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event	

Social

Is your child in school? Yes _____ No _____ If yes, where? _____
What grade? _____ Is he/she in any special classes or have special needs?_____
Has your child missed any school because of this condition? _____ If yes, how much? _____
How much, if any, have the current symptoms interfered with your child's social activities? _____
_____
Is your child on an IEP or 504 plan? Yes _____ No_____
Describe your current support system at home for your child's treatment: _____
_____

Reason for visit:

Briefly state the reason your child is being evaluated (include reasons for each evaluation if receiving more than one):
_____
_____
_____

When did you first notice the problem(s)? _____
What were your initial concerns? _____

How does your child usually communicate (gestures, single words, short phrases, sentences)?
_____
How does your child feel about their current condition? _____

Child / Family concerns and goals

Please describe the major concerns and / or goals you have in seeking help for your child. List your concerns in order of their importance to you.

1. _____
2. _____
3. _____
4. _____
5. _____

Other

Were you referred for the evaluation? YES/NO Name of Referral:_____
Who is your child's Pediatrician or Family Doctor? _____
Address: _____
Phone #:_____

Parent Signature: _____ ***Date:*** _____