Carol Terry Psychological Services, P.C.
Carol Terry, Ph.D., Licensed Psychologist
1006 24th Ave N.W., Suite 100
Norman, OK 73069
Phone: (405) 321-0303 Fax: (405) 801-2846

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: M / F / Other
Address: _____
City_____ State: _____ Zip: _____
Preferred Contact Number: _____ Other: _____ Ok to leave a voicemail? Y / N
Ok to send text visit reminders? Y / N Preferred Number to text: _____
Email: _____ Would you like to receive secure emailed appointment reminders? Y / N
Emergency Contact: _____ Phone: _____ Relationship to patient:_____

Who referred you to my office: _____
Please list the main reasons for seeking psychological services:

IF PATIENT IS A MINOR, PLEASE COMPLETE THE SECTION BELOW:

Legal Guardian Name(s)_____ Relationship to child: _____
Legal Guardian Mailing Address: _____
City_____ State: _____ Zip Code_____
Preferred Contact Number: _____ Other: _____ Ok to leave a voicemail? Y / N

If parents are separated or divorced, OR you are not the parent, please provide the name of the other parent/guardian(s) not listed above and their contact information:
Name: _____ Relationship to child: _____
Address: _____ City: _____ State: ___ Zip: _____
Preferred Contact Number: _____ Other: _____ Ok to leave a voicemail? Y / N

****

BILLING INFORMATION

Person responsible for payment: _____
Address: _____ City: _____ State: ___ Zip: _____
Preferred Contact Number: _____ Other: _____ Ok to leave a voicemail? Y / N

Insurance Company: _____ Phone Number: _____
Insurance ID#: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ___ Zip: _____

PLEASE COMPLETE SECTION BELOW FOR ANY *SECONDARY* INSURANCE

Insurance Company: _____ Phone Number: _____
Insurance ID#: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ___ Zip: _____

Carol Terry Psychological Services, P.C.
Carol Terry, Ph.D., Licensed Psychologist
Aurora Professional Center
1006 24th Ave, NW, Suite 100, Norman, OK 73069
Phone:(405) 321-0303 Fax: (405) 801-2846
www.normanpsychology.com

Psychologist-Client Services Agreement
Business Policies and Procedures (07/01/2021)

Welcome to my practice. I appreciate your seeking services at my office and hope that this policy answers your questions about the services, policies, and costs associated with your evaluation or treatment here. The following guide explains the policies concerning my qualifications, services, fees, appointments, insurance, and confidentiality. Please review it carefully. If you have any questions, please discuss them with Dr. Terry. In addition to this document, you also need to review the Notice of Privacy Policies Document located at the front entry of my office and on the website.

Please arrive 10 minutes early for your first appointment so we can verify we have received your completed intake forms and make a copy of any insurance card(s) if we are filing with insurance for you or your child.

We have a small waiting room. Please don't bring more than 2 family members with you in addition to the patient who is scheduled.

Services and Qualifications
A variety of services are provided at this practice, including Clinical Diagnostic Evaluations, Individual, Family, and Couples Therapy, and Clinical Psychological Testing for adults, adolescents, and children. It is important that you understand what service you or your child will be receiving at my office. I do not provide court-related or forensic services. *I do not provide court testimony, forensic assessment, custody evaluations, letters to attorneys, or any other services for court or legal purposes.* My services are limited only to enhancing the health and functioning of my clients.

I earned my doctorate in Clinical Psychology from the University of North Carolina at Chapel Hill in 1988 and I have been a Licensed Psychologist since 1990. I am a member of the American Psychological Association as well as a variety of other professional organizations. I also teach in the Psychology Department at the University of Oklahoma and have served on a variety of board of directors for several professional organizations and community agencies.

Psychotherapy Services
If you are seeking psychotherapy services for yourself or a family member, I typically conduct an initial evaluation session that lasts an hour followed by about 1 to 2 additional 55-minute sessions to develop a treatment plan and to decide if I can provide the services that you or your child requires. This evaluation typically involves taking a detailed history, including the current difficulties that brought you here. Sometimes, I will also recommend psychological testing. During the initial evaluation period, we can both decide if I am the best person to provide the services you or your child needs to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 55-minute session per week at a time we agree on, although sessions may be longer or less frequent, depending on patient needs. Further, I want you to be aware there are both risks and benefits associated with psychotherapy. While the goal of psychotherapy generally is to find solutions to problems and reductions in feelings of distress, the process of psychotherapy also can involve the experience of uncomfortable feelings like sadness, guilt, anger, or frustration. But there are no guarantees of what will be experienced in therapy. By the end of the initial evaluation period, I will offer you some initial impressions of what our work together will include if you decide to proceed with therapy. Sometimes, patients may take a break from therapy for various reasons. If this occurs and I have no contact from you for 60 days, I will close your chart and you will not be considered a current patient. Of course, if you seek future services, we will decide whether I am available and can resume therapy with you again. If you have questions about my procedures, we should discuss them whenever they arise.

Clinical Psychological Evaluation/Testing Services
Clinical psychological evaluations 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. They are clinical in nature in that they may assist with diagnostic evaluation and treatment planning. I do not conduct psychological evaluations for forensic or court purposes. Psychological evaluations vary in length and cost depending on the type of testing required. Given that psychological evaluations involve several components that include interviews, test administration, scoring and interpretation of tests, and written reports, they require several hours to complete. The amount of time needed to complete an evaluation 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 a psychological evaluation (such as a physician or therapist), it is very helpful to have that professional fax me a brief note indicating what the purpose of the evaluation is before I see you or your child.

Typically, for a very young child's first appointment (6 years and younger), 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 when I review my findings and recommendations.

For elementary age children (6 to 12 years old) and adolescents (13 to 17), I will meet first with the parent(s) and child for a one-hour interview and then for a separate appointment for about 2 to 4 hours to conduct the testing. Additional testing may also be scheduled depending on the reasons for the evaluation. For example, testing for learning disabilities may require more than one testing session. After the testing is completed, a separate feedback appointment will also be scheduled to review the test results and recommendations. A written report of testing findings and recommendations will be prepared.

An adult's first testing appointment is an hour interview. A separate appointment to conduct the testing can range from about 2 to 4 hours, depending on the nature of the testing. After the testing is completed, a separate feedback appointment will also be scheduled to review the test results and recommendations. A written report of testing findings and recommendations will be prepared.

Finally, psychological evaluations are not always covered by insurance at the same benefit as psychotherapy services. Sometimes testing is subject to an insurance deductible or occasionally insurance requires preauthorization. While my billing company will attempt to check this benefit and we will assist

with authorizations if required, 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.

Fees and Payment Procedures
A current fee schedule is listed in this policy guide. However, fees may vary, depending on your insurance plan. Payments are due at each visit unless other arrangements are made beforehand. Please make checks payable to "Carol Terry Psychological Services, PC." Credit Cards and Debit Cards are also accepted for payment.

For minors, it is my policy that the parent or guardian who initiates therapy or testing for a child is the party responsible for payment at the time that services are rendered. Shared financial arrangements between parents should be worked out between the parents involved. If parents are divorced and I am seeing their child, I typically require both parents to sign a business policy and consent for treatment by the first appointment.

Medical Insurance
Services provided are covered under most health insurance policies under outpatient psychiatric treatment, behavioral health, or psychological testing. However, some companies reimburse mental health services at a different rate from other medical services. Some policies have annual deductibles to be met by individuals or the family; some set annual limits in dollars or numbers 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. We will also have our billing service (JCarman Billing and Consulting) check your benefits upon scheduling your first appointment. ***These benefit checks, however, are not a guarantee of payment by your insurance company and you may be responsible for more or less of the cost.*** In addition, we will file insurance claims for you, unless otherwise directed by you.

Insurance Plans for which I am an in-network provider:

1. Blue Cross Blue Shield PPO Plans 2. Healthchoice 3. Coventry/First-Health

If you have one of the insurance plans listed above, your company could possibly reimburse me at a higher rate than if you go to an out-of-network provider. If your company is not on this list, we can usually still file claims with them and will check your insurance's out-of-network benefit for you. Exceptions to this are if your insurance plan does not have any out of network benefits, is Soonercare, Tricare, or an HMO; these policies will not reimburse me for services; you certainly have the option to self-pay for services.

Appointments and New Patient Forms

For your first appointment, please complete the new patient forms issued to you via my patient portal through Therapy Notes®. These forms are completed online and sent back electronically.

When an appointment is made, that time is set aside and cannot be given to any other 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 someone else. There will be a charge of **$ 75.00** for **any missed appointment** unless notice of cancellation is received **24 hours in advance** or unless the last-minute cancellation is made necessary by a **genuine emergency**. Insurance will not pay for missed appointments and the client or their guardian is solely responsible for paying this fee. Appointments may be canceled by leaving a message on my confidential voicemail or letting my secretaries know during regular office hours**. Payments for missed appointments are due with the regular fee at the *next* visit.**

Phone Sessions and Other Methods of Communication
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 or when an adult client or the guardian of a child client agrees for me to conduct a professional consultation with other individuals pertinent to treatment or evaluations (e.g., teacher, physician). 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 for individual therapy. 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.
I do not communicate with patients via text or email except for emailing appointment reminders and administrative paperwork. This is primarily to ensure your privacy and to plan ample time for communications. I also do not communicate with patients over social media.

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. We may use or disclose your Protected Health Information (i.e., information in your health care record that may identify you) for treatment, payment and healthcare operations 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 already acted, 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.

The exceptions to confidentiality are listed below:

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. (Examples, statements of suicidal or homicidal intent).
3. If it becomes necessary to contact an attorney or a collection agency typically due to nonpayment of bills, then your name, identifying information about how to reach you, and amount owed will 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:
A. If your mental status is an issue for any legal proceedings;
B. The judge feels that communications are necessary to the proper administration of justice.

MINORS AND PARENTS
Patients under 18 years of age 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 noncustodial parents are accorded this right to medical records under Oklahoma law. Please note that written information shared with me by a parent concerning their child becomes part of the child's medical record. 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 behavior therapy is the primary type of therapy) and 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 beneficial in a child's treatment too. If I feel that the child 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 parents or legal guardian.

COURT TESTIMONY AND LEGAL INVOLVEMENT
As noted above, I do not provide court testimony, forensic assessment, custody evaluations, letters to attorneys, or any other services for court or legal purposes. My services are limited only to enhancing the health and functioning 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 that service. 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 difficulties inherent of legal involvement, I charge $400.00 per hour of time spent in preparation, travel, consultation, appearance, etc. and require that a retainer be paid in advance.

Psychologist's Duties under HIPAA
You are required under HIPAA to review my Notice of Privacy Practices which is a document in addition to this one. This notice is always located in the binder on the front reception desk so that you can review it at any time and on my website www.normanpsychology.com You can also request a copy of that Notice in writing from my secretaries. We 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. We 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 code, I keep professional records containing your Protected Health Information in parts of your file.

Impairment from Alcohol or Other Substances
I respectfully request that you be free of alcohol or other intoxicants prior to coming in for an evaluation or therapy so that we can have the best chance of being successful in our work together. If, during a session, 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, then 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 taxi. 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, then I could be forced to call the authorities to ensure your safety and the safety of others. While such a circumstance has only happened one time in my years of practice, you need to be informed about what could happen if you were to come to therapy "impaired" in this way.

Emergencies: Please call Dr. Terry on her cellular phone at (405) 202-3323 in case of an emergency or in the case of a life-threatening emergency call 911 or proceed to the nearest emergency room. Please do not text me. If it is before 5 p.m., first call my office (321-0303); leave a message with the secretary or on the voicemail if there is no answer. If your call is not returned promptly during business hours, you can call Dr. Terry's cellular phone number. 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 my secretary. My policies will be in effect for that coverage as well.

FEE SCHEDULE**
Initial Diagnostic Interview, 60 minutes.....$200.00

Individual Therapy, per 55-minute session.....$175.00

Couples or Family Therapy, per 55-minute session.....$175.00

Psychological Evaluation, per hour.....$ 175.00 (estimates can vary based on service). 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.....$40.00

Any additional consultation or services
performed on behalf of the client *other than* court-related/legal matters, per hour.....$175.00

No Shows or appointments cancelled less than 24 hours ahead of time.....$75.00

Forensic/Court-Related Services (As noted above, I don't do 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) Fee per hour....$ 400.00
** Please note that if you are a client with one of the insurance companies Dr. Terry contracts with, your fee may differ slightly from those listed for evaluation, therapy or testing services.

LATE CANCELLATIONS, MISSED APPOINTMENTS, and PAYMENTS: If you are unable to keep an appointment kindly give us 24 hours notice, otherwise a charge of $**75.00** will be due. Insurance will not pay this fee. The client or their guardian is responsible for the payment of this fee.

Unless other arrangements are made beforehand, services will be discontinued for missing payments with no notice or for no payment on 2 consecutive sessions. Payments are collected on the day of services unless prior arrangements are made with our office. Finance charges are also typically added 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. Accounts that are over 90 days past due are turned over to a collection agency. A $25.00 charge is added for any returned checks.

Practice Statement: My office is in the Aurora Professional Center, a building with several other mental health professionals. This group is an association of independently practicing professionals, which shares certain expenses and administrative functions. While the members share office space and expenses, I want you to know that my practice is completely independent in providing you with clinical services and I am fully responsible for those services. My professional records are separately maintained, and no member of the group can have access to them without your specific, written permission or in the case of emergency coverage during my absence which you request. You should be aware that I employ office staff to assist me with running my practice and I also contract with a billing service to provide billing services. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and billing. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member. I may occasionally find it helpful to consult with other health and mental health professionals about a case for me to provide optimal care to my patients. During such consultations, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your clinical record.

Breach Notification Addendum to Policies and Procedures: As Required under the 9/2013 Privacy Rule of HIPAA, I must notify you of the following Breach Notification Policy. A "breach" is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule.

1. When the Practice becomes aware of or suspects a breach in your PHI, the Practice will conduct a Risk Assessment and will keep a written record of that Risk Assessment. This will include reviewing the nature and extent of the PHI involved, to whom the PHI may have been disclosed, whether the PHI was in fact acquired or viewed, and the extent to which the risk to the PHI has been mitigated.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the practice will give notice of the breach as described in the breach notification overview in my Privacy Notice.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

Your signature on this form indicates that you have read the information in this agreement and agree to its terms. This also serves as an acknowledgement that you have reviewed the HIPAA Privacy Notice form described herein. If you are the guardian of a minor child who is the patient, 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 treatment for that child.

X_____ _____ _____
Signature of Adult Patient/Guardian Print Name of Adult Patient/Guardian Date

_____ Date of Birth of Child: _____
Print Name of Minor of Patient
if Patient is a Child

I also give permission for Dr. Terry, her staff, or her medical billing company to release medical information to my or my child's (if the patient is a child) insurance company or a managed care company contracted by my insurance company to manage my or my child's medical care, if necessary. I understand this allows the insurance company to pay their portion of services provided at this office. I further agree to pay for any services that the insurance will not pay for.

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

If you have any questions about your privacy rights or this business policy and agreement, please direct them to:
Dr. Carol Terry
1006 24th^{h} Ave, NW, Suite 100, Norman, OK 73069.
405-321-0303.

Carol Terry Psychological Services, P.C.
Carol Terry, Ph.D., Licensed Psychologist
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OUTPATIENT SERVICES AGREEMENT FOR COLLATERALS IN PSYCHOTHERAPY

INTRODUCTION
I want to thank you for assisting in the psychotherapeutic treatment of my patient. Your participation is important, and may be essential to the success of the treatment. 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, other family member, or friend, who participates in therapy to assist the identified patient. The collateral is not considered to be a patient and is not the subject of the treatment. Psychologists have certain legal and ethical responsibilities to patients, and the privacy of the patient-therapist relationship is given legal protection. My primary responsibility is to my patient and I must place their interests first. You also have less privacy protection.

THE ROLE OF COLLATERALS IN THERAPY
The role of a collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the patient, to provide information to the therapist and never attend another session. In another case a collateral, such as a parent of a young child, might attend all of the patient's therapy sessions and his/her relationship with the patient may be a focus of the treatment. We will discuss your specific role in the treatment at our first meeting and at other appropriate times.

BENEFITS AND RISKS
Psychotherapy often engenders intense emotional experiences, and your participation may engender strong anxiety or emotional distress. It may also expose or create tension in your relationship with the patient. While your participation can result in better understanding of the patient or an improved relationship, or may even help in your own growth and development, there is no guarantee that this will be the case. Psychotherapy is a positive experience for many, but it is not helpful to all people.

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 patient will be entered into the identified patient's chart. The patient 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 that chart without the written consent of the identified patient if they are an adult.

CONFIDENTIALITY
The confidentiality of information in the patient'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 patient is an adult and specifically authorizes me to release it. However, if the patient is a minor, this information will be part of the child's medical record. Under Oklahoma law, both custodial and noncustodial 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 patient, 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 PURPOSES OF TREATMENT
Psychotherapy at my office is a clinical service and is not intended for forensic or court-related purposes. If therapy is for a minor child and their parents are divorced or separated, I want both parents to participate in the child's therapy as collaterals and I will assist with having both parents participate to the extent that I am able to do so. When parents are involved in

treatment as collaterals, 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 parent will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your 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 regarding my treatment of a minor, 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 $300 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.

PARENTS AS COLLATERALS

Clinicians specializing in the treatment of children have long recognized the need to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members, is common and often recommended. Parents in particular have more rights and responsibilities in their role as a collateral than in other treatment situations where the identified patient is not a minor.

- In treatment involving children and their parents, access to information is an important and sometimes contentious topic. Particularly for older children, trust and privacy are crucial to treatment success. But parents also need to know certain information about the treatment. For this reason, we need to discuss and agree about what information will be shared and what information will remain private. I generally require a written contract signed by both you and your child/children concerning access to a child's record and once that contract is made, I will treat it as legally binding, although it sometimes may be overridden by a judge. In general, I believe that parents should be informed about the goals of treatment and how the treatment is going and whether the child comes to his/her appointments. At the end of treatment, I prepare a summary for the parents upon request. In addition, I will always inform you if I think that your child is in danger or if he/she is endangering others. One of our first tasks is to discuss and agree on our shared definition of dangerousness so we are all clear about what will be disclosed, particularly if your child is an adolescent.

- If you are participating in therapy with your child, you should expect the clinician to request that you examine your own attitudes and behaviors to determine if you can make positive changes that will be of benefit to your child.

SUMMARY

If you have questions about therapy, 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 your have read and understood this document.

_____ _____

Print **Your Name** State Your Relationship to the patient

_____

Print the **Patient's Name**

_____ _____

Your Signature Date

Carol Terry Psychological Services, P.C.
Carol Terry, Ph.D., Licensed Psychologist
1006 24th Ave N.W., Suite 100
Norman, OK 73069
Phone: (405) 321-0303 Fax: (405) 801-2846

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CHILD AND FAMILY INFORMATION

In order for me to serve you and your child better, please answer the following questions and return this form prior to your next appointment if possible or bring it to the next appointment. Please feel free to add any extra comments on a separate page.

Today's Date: _____

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

School: _____ Grade: _____ Teacher: _____

Parent (*mother*) name: _____ Age: _____ Education: _____

Place of employment: _____ Occupation: _____

Parent (*father*) name: _____ Age: _____ Education: _____

Place of employment: _____ Occupation: _____

Does the child have step-parent(s): Yes / No If Yes, please complete the following:

Step-parent Name: _____ Age: _____ No. of years known child: _____

Step-parent Name: _____ Age: _____ No. of years known child: _____

If parents are divorced or separated, what is the current visitation schedule with each parent?

_____

If parents are divorced, what is the legal custody agreement in terms of primary or joint custody AND rights to give medical consent for the child's treatment: _____

_____

Is the child adopted: Yes / No If Yes, at what age: _____

CONCERNS AND GOALS

A. What are the main concerns you have about your child? _____

_____

_____

B. Please describe your main GOALS for this evaluation or treatment:

_____

_____

_____

C. How long has this concern been a problem? _____
D. When did you first notice the problem? _____
E. What have you personally done to address the problem? _____
_____
_____
F. What seems to help the most? _____

Please list all persons currently living in the home(s) with the child:

Name	Age	Relationship to child

Please list other siblings or parents whom the child does *NOT* live with:

Name	Age	Relationship to child

Please check all events which have occurred for the child IN THE PAST YEAR:

_____ Moved to a new home
_____ Changed Schools
_____ Academic Failure
_____ Birth of sibling
_____ Death of relative/friend
_____ Parents' divorce/separation
_____ Family financial problems
_____ Teased/bullied
_____ Traumatic Experience

Other (please explain): _____

Please check all events which have EVER occurred for the child AND caused the child significant distress:

_____ Moved to a new home
_____ *When?*
_____ Changed Schools
_____ *When*
_____ Academic Failure
_____ *When?*
_____ Birth of sibling
_____ *When?*
_____ Death of relative/friend
_____ *When?*
_____ Parents' divorce/separation
_____ *When?*
_____ Family financial problem
_____ *When?*
_____ Teased/bullied
_____ *When?*
_____ Traumatic Experience
_____ *When?*

Other (please explain): _____

_____

DEVELOPMENTAL AND MEDICAL HISTORY

Pregnancy and Delivery

Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.): _____
Length of delivery (number of hours from initial labor pains to birth): _____
Mother's age at child's birth: _____ Child's birth weight: _____lbs. _____oz.

Did any of the following conditions occur during pregnancy/delivery?

1. Bleeding	Yes / No
2. Excessive weight gain (more than 30 lbs.)	Yes / No
3. Toxemia/Preeclampsia	Yes / No
4. Rh factor incompatibility	Yes / No
5. Frequent Nausea/Vomiting	Yes / No
6. Serious Illness or Injury	Yes / No
7. Took Prescription Medications: If Yes, Name(s) of Med(s):	Yes / No
8. Took Street Drugs:	Yes / No
9. Used alcoholic beverage If Yes, approx. # of drinks per week:	Yes / No
10. Smoked Cigarettes. If Yes, approx.. # per day: _____	Yes / No
11. Was given medication to ease labor pains? If yes, name of medication:	Yes / No
12. Delivery was induced	Yes / No
13. Forceps were used during delivery	Yes / No
14. Had a breech delivery	Yes / No
15. Had a C-Section delivery	
16. Other problems Please describe: _____	Yes / No

Did any of the following conditions affect your child during the delivery or within the first few weeks after birth?

1. Injured during delivery	Yes / No
2. Cardiopulmonary destress during delivery	Yes / No
3. Delivered with cord around the neck	Yes / No
4. Trouble breathing following delivery	Yes / No
5. Needed Oxygen	Yes / No
6. Was cyanotic, turned blue	Yes / No
7. Was jaundiced, turned yellow	Yes / No
8. Had an infection	Yes / No
9. Had seizures	Yes / No
10. Was given medications	Yes / No
11. Born with congenital defect	Yes / No
12. In hospital more than 7 days	Yes / No

INFANT HEALTH AND TEMPERAMENT

During the first 12 months was your child:

1. Difficult to feed	Yes / No
2. Difficult to get to sleep	Yes / No
3. Colicky	Yes / No
4. Difficult to put on a schedule	Yes / No
5 Alert	Yes / No
6. Cheerful	Yes / No
7. Affectionate	Yes / No
8. Sociable	Yes / No
9. Easy to comfort	Yes / No
10. Difficult to keep busy	Yes / No
11. Overactive, in constant motion	Yes / No
12. Very stubborn, challenging	Yes / No

EARLY DEVELOPMENT MILESTONES

At what age did your child first accomplish the following:

1. Sitting without help
2. Crawling
3. Walking alone, without assistance
4. Using single words (e.g., Mama, Dada, ball, etc.)
5. Putting two or more words together
6. Bowel training, day and night
7. Bladder training, day and night

HEALTH HISTORY

Date of child's last physical exam: _____ **Doctor's Name:** _____

At any time has your child had the following:

1. Asthma	Never	Past	Present
2. Allergies	Never	Past	Present
3. Diabetes, arthritis, or other chronic illness(es). Please specify:	Never	Past	Present
4. Epilepsy or seizure disorder	Never	Past	Present
5. Febrile seizures	Never	Past	Present
6. Chicken Pox, Strep or other common childhood illnesses	Never	Past	Present
7. Heart or blood pressure problems	Never	Past	Present
8. High fevers (over 103 degrees)	Never	Past	Present
9. Broken bones	Never	Past	Present
10. Severe cuts requiring stitches	Never	Past	Present
11. Head injury with loss of consciousness(describe)	Never	Past	Present
12. Lead poisoning	Never	Past	Present
13. Surgery (describe)	Never	Past	Present
14. Lengthy hospitalization	Never	Past	Present
15. Speech or language problems	Never	Past	Present
16. Chronic ear infections	Never	Past	Present
17. Hearing difficulties	Never	Past	Present
18. Eye or vision problems	Never	Past	Present
19. Fine motor/handwriting problems	Never	Past	Present
20. Gross motor difficulties, clumsiness	Never	Past	Present
21. Appetite problems (overeating or undereating)	Never	Past	Present
22. Sleep problems (falling asleep, staying asleep)	Never	Past	Present
23. Soiling problems	Never	Past	Present
24. Wetting problems	Never	Past	Present
25. Snoring	Never	Past	Present
26. Other health difficulties. Please describe	Never	Past	Present
27. SENSORY SENSITIVITIES (e.g., Upset, Bothered, Very Sensitive)			
a. Sensitive to textures	Never	Past	Present
b. Sensitive to sounds	Never	Past	Present
c. Sensitive to tastes	Never	Past	Present
d. Sensitive to smells	Never	Past	Present
e. Sensitive to lights, how things look	Never	Past	Present
28. Habits (e.g., nail biting, picking)	Never	Past	Present

29. Repetitive Behaviors	Never	Past	Present
a. Walking on toes repeatedly	Never	Past	Present
b. Walking in circles or pacing back and forth	Never	Past	Present
c. Flapping hands repeatedly	Never	Past	Present
d. Lining up objects repeatedly	Never	Past	Present
30. Becomes upset by changes in schedules or plans	Never	Past	Present
31. History of abuse or neglect. Please describe:	Never	Past	Present

SCHOOL HISTORY QUESTIONNAIRE

1. Please list the schools your child has attended in chronological order beginning with any preschool experiences

SCHOOL	Grades Attended	Years Attended	City

2. Please summarize your child's progress including strengths and weaknesses in academic and social adjustment within each of these grade levels (attach additional sheets as necessary)

Preschool: _____

_____

Kindergarten: _____

_____

Grades 1 & 2: _____

_____

Grades 3 through 5: _____

_____

Grades 6 through 8: _____

_____

Grades 9 through 12: _____

_____

_____

3. To the best of your knowledge, describe any problems and strengths your child currently has in the following academic areas (attach additional pages if necessary):

Subject	Current Problems	Grade problems began	Strengths
Reading (phonics)			
Reading (comprehension)			
Spelling			
Writing			
Math			
Oral Expression skills			
Listening Comprehension Skills			
Science			
Social Studies			

4. Has your child ever repeated a grade? If so, please explain

5. Describe any special education or tutoring services your child received and when they received them (e.g., speech therapy: 1st grade to present)

6. Is homework a problem? If so, please check all that apply:

___ Can't get started
___ Forgets to bring home materials
___ Doesn't understand the work
___ Distracted by radio, TV or anything
___ Battles or argues about doing work
___ Needs you there constantly
___ No place to work
___ Forgets assignments
___ Doesn't anticipate deadlines
___ Takes too long
___ The most stressful time of day
___ Doesn't care / no motivation

7. Is your child's work made more difficult by problems with:

	Not at all	Somewhat	A lot
Poor concentration			
Giving up too easily			
Inconsistent performance			
Poor motivation			
Disorganization			
Spacing out or daydreaming			
Not finishing things			
Having low frustration tolerance			
Sadness			
Poor handwriting			
Rapidly shifting from one thing to another			
Being easily distracted			
Impulsiveness			
Anxious			

SOCIAL HISTORY

1. Does your child get along well with others? In what areas to you notice difficulties? Please check Yes, No or Sometimes to the following questions. You may add comments.

	Yes	No	Sometimes	Comments
Makes friends easily				
Has a best friend				
Plays well with others				
Shares easily				
Follows rules				
Enjoys team sports				
Leads other children				
Helps others				
Easily influenced				
Prefers to be alone				
Is extremely social				
Is extremely shy				
Bullies others				
Fights others				
Insists on having his own way				

Please list any previous treatment or evaluations your child has received for behavioral, emotional or academic problems. (Also include substance abuse problems, if any.)

Treatment (therapy/counseling):

From _____ to _____ Reason for treatment _____

Who saw your child / location: _____

From _____ to _____ Reason for treatment _____

Who saw your child / location: _____

From _____ to _____ Reason for treatment _____

Who saw your child / location: _____

Evaluations (e.g., testing at school):

Date of testing: _____ Person/place who did the testing: _____

Do you know the results of the testing? _____ If "YES", please describe: _____

_____

_____

MEDICATIONS

Please list any medications (prescription and over-the-counter) the child currently takes.

Name of Medication	Date Began	Reason	Prescribing Doctor

DISCIPLINE STRATEGIES

Please check all discipline strategies used for this child:

_____ Verbal Reprimands ____ Yelling ____ Spanking ____ Time out

_____ Loss of privileges ____ Reasoning____ ____ Rewards for Good Behavior

_____ Other (Please explain): _____

FAMILY HISTORY

Please check all behavioral, emotional, psychiatric or substance abuse problems present in the child's family and indicate all members for whom the problem(s) existed:

_____ *Depression*	_____ *Anxiety*	_____ *Learning Problems*	_____ *ADHD/ADD*
__ Mother	__ Mother	__ Mother	__ Mother
__ Father	__ Father	__ Father	__ Father
__ Sibling(s)	__ Sibling(s)	__ Sibling(s)	__ Sibling(s)
__ Grandparent	__ Grandparent	__ Grandparent	__ Grandparent
__ Aunt/Uncle	__ Aunt/Uncle	__ Aunt/Uncle	__ Aunt/Uncle
__ Cousin	__ Cousin	__ Cousin	__ Cousin

Family History continued on next page

____ *Schizophrenia (or psychosis)*	_____ *Bipolar Disorder (Manic Depression)*	_____ *Alcohol/drug*	*Other:* _____ *(e.g., Autism, OCD)*
__ Mother	__ Mother	__ Mother	__ Mother
__ Father	__ Father	__ Father	__ Father
__ Sibling(s)	__ Sibling(s)	__ Sibling(s)	__ Sibling(s)
__ Grandparent	__ Grandparent	__ Grandparent	__ Grandparent
__ Aunt/Uncle	__ Aunt/Uncle	__ Aunt/Uncle	__ Aunt/Uncle
__ Cousin	__ Cousin	__ Cousin	__ Cousin

DISRUPTIVE BEHAVIOR DISORDERS RATING SCALE – PARENT FORM (FORM 4)

Form completed by: _____ **Relationship to child:** _____

Circle the number that *best describes* your child's behavior at home over the past 6 months

		Never or rarely	Some-times	Often	Very often
1	Fails to give close attention to details or makes careless mistakes in schoolwork	0	1	2	3
2	Has difficulty sustaining attention in tasks or play activities	0	1	2	3
3	Does not seem to listen when spoken to directly	0	1	2	3
4	Does not follow through on instructions and fails to finish work	0	1	2	3
5	Has difficulty organizing tasks and activities	0	1	2	3
6	Avoids tasks (e.g., schoolwork, homework) that require mental effort	0	1	2	3
7	Loses things necessary for tasks or activities	0	1	2	3
8	Is easily distracted	0	1	2	3
9	Is forgetful in daily activities	0	1	2	3
10	Fidgets with hands or feet or squirms in seat	0	1	2	3
11	Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
12	Runs about or climbs excessively in situations where not appropriate	0	1	2	3
13	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14	Is "on the go" or acts as if "driven by a motor"	0	1	2	3
15	Talks excessively	0	1	2	3
16	Blurts out answers before questions have been completed	0	1	2	3
17	Has difficulty awaiting turn.	0	1	2	3
18	Interrupts or intrudes on others	0	1	2	3
19	Loses temper	0	1	2	3
20	Argues with adults	0	1	2	3
21	Actively defies or refuses to comply with adults' requests/rules	0	1	2	3
22	Deliberately annoys people	0	1	2	3
23	Blames others for his/her mistakes or misbehavior	0	1	2	3
24	Is touchy or easily annoyed by others	0	1	2	3
25	Is angry and resentful	0	1	2	3
26	Is spiteful or vindictive	0	1	2	3

Please indicate whether your child has done any of these activities in the past *12 months*:

		NO	YES
1	Often bullied, threatened, or intimidated others	N	Y
2	Often initiated physical fights	N	Y
3	Used a weapon that can cause serious physical harm to others (e.g., a bat, broken bottle knife, gun)	N	Y
4	Has been physically cruel to people	N	Y
5	Has been physically cruel to animals	N	Y
6	Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)	N	Y
7	Has forced someone in to sexual activity	N	Y
8	Has deliberately engaged in fire setting with the intention of causing serious damage	N	Y
9	Has deliberately destroyed others' property (other than by fire setting)	N	Y
10	Has broken into someone else's house, building or car	N	Y
11	Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)	N	Y
12	Has stolen items of non-trivial value without confronting the victim (e.g., shoplifting, but without breaking and entering, forgery)	N	Y
13	Often stays out at night despite parental prohibitions. If "YES", at what age did this begin? _____	N	Y
14	Has run away from home overnight at least twice while living in parents' home, foster care, or group home. If "YES" how many times? _____	N	Y
15	Is often truant from school. If "YES", at what age did this begin? ____	N	Y
16	Use of drugs or alcohol	N	Y

HOME SITUATIONS QUESTIONNAIRE (Form6)

Does your child present any problems with compliance to instructions, commands, or rules for you in any of these situations?

	SITUATION	NO	YES	*Mild*								*Severe*
1	While playing alone	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
2	While playing with other children	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
3	At meal times	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
4	Getting dressed	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
5	Washing and bathing	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
6	While you are on the telephone	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
7	While watching TV	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
8	When visitors are in your home	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
9	When you are visiting someone's home	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
10	In public places (restaurants, stores, church, etc.)	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
11	When father is home	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
12	When mother is home											
13	When asked to do chores	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
14	When asked to do homework	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
15	At bedtime	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
16	While in the car	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
17	When with a babysitter	N	Y	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*

Does your child show any of the following anxiety symptoms? Please check all that apply.

___ Unrealistic worry about future events
___ Persistent refusal to go to school
___ Bothersome thoughts
___ Unrealistic concerns about competence
___ Repeated nightmares about separation from you
___ Excessive distress when separated from home or from you
___ Unrealistic and persistent worry that something will happen to you
___ Unusual fears
___ Avoidance of being alone
___ Physical aches and pains
___ Marked self-consciousness
___ Marked inability to relax
___ Ongoing refusal to sleep alone
___ Excessive need for reassurance
___ Panic attacks

Does your child show:

___ Diminished pleasure in activities
___ Depressed or irritable mood most of the day, almost every day
___ Poor appetite or overeating
___ Trouble sleeping or sleeping too much
___ Feelings of worthlessness or excessive inappropriate guilt
___ Poor concentration or difficulty making decisions
___ Suicidal thoughts or actions
___ Agitation or sluggishness
___ Low self esteem
___ Low energy or fatigue
___ Feelings of hopelessness
___ Self-injurious behavior

Does your child have any of the following:

___ Repeated unusual movements
___ Compulsive rituals (e.g., excessive washing)
___ Vocal tics (e.g., repetitive sniffing, throat clearing)
___ Motor tics (e.g., repetitive eye squinting, head jerking)
___ Excessive reaction to noise or failing to react to loud noise
___ Odd postures
___ Overreacts to touch

Has your child exhibited any symptoms of thought disturbance, including any of the following:

___ Can't get to the point, loses train of thought
___ Bizarre ideas (odd fascinations, strange ideas, hallucinations)
___ Disoriented, confused, staring or "spacey"
___ Incoherent speech (mumbles, uses words only the child understands)

Has your child exhibited symptoms of affective mood disturbance, including any of the following:

___ Explosive temper with little provocation
___ Excessively monotonous or bland affect
___ Situationally inappropriate emotions
___ Excessive reaction to changes in routine
___ Elated or Rage moods
___ Very high energy with very little sleep
___ Excessive mood swings

Comments regarding any of the above items which you checked: _____

_____

_____

_____

SCREEN TIME

How much time does your child spend on average:

- **playing any electronic games (gaming systems, phones, I-Pad, etc.)**
- **watching You Tube / TV / Netflix OR**
- **using a cell phone for texting, social media etc.**

___ My child does *not* play electronic games.

___ My child does *not* watch You Tube / TV.

___ My child does *not* use a cell phone

School days:

___ Number of school days per week with screen time, on average.

Comments/Description: _____

___ Less than one hour per school day

___ 1-2 hours per school day

___ More than two hours per school day

Weekends or other days they are not in school:

___ Number of *non-school* days per week with screen time, on average.

Comments/Description: _____

___ Less than one hour per non-school day

___ 1-2 hours per non-school day

___ More than two hours per non-school day

CULTERAL FACTORS

Please describe any information regarding any family, ethnic or other cultural factors you feel is important for me to consider in treatment and/or assessment e.g. values, traditions, religion.

: _____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. I know it is long and time consuming, but it really helps me to serve you and your child better. If you can return it to us prior to your visit, we will review what you have shared in order to better focus on your concerns. This information, as with all records, is strictly confidential. It will not be released to anyone without your written permission.

Rev. 8/1/19