WEEDEN & ASSOCIATES, LLC

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weedenassociates.com

CHILD INTAKE FORM

□ Dennis C. Weeden, MSSW, LCSW, CSAT, CEAP
□ Jacqueline D. Weeden, MSW, LCSW, CSAT
□ Amanda Dahlman, MA, LPC-IT, NCC
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□ Paul Klotz, MSW, CAPSW
□ Andrew Theisz, MSW, CAPSW

Diagnostic Code (*Office Use*) _____ Date (*Office Use*) _____

Client's Last name _____ First _____ M.I. _____ D.O.B __/__/__

Social Security Number _____ Age _____ Sex: □ M / □ F Home Phone _____

Address _____ City _____ State _____ Zip _____

Mother's Name _____ Mother's SSN _____ Mother's D.O.B __/__/__

Mother's Cell Phone _____ Mother's Work Phone _____

Father's Name _____ Father's SSN _____ Father's D.O.B __/__/__

Father's Cell Phone _____ Father's Work Phone _____

Child Resides with (Please check one): □ Both Parents □ Mother □ Father □ Other: _____

Form of Payment (Please check one): □ Insurance □ Self Pay **Primary Insurance Company** _____

Insured Last Name _____ First _____ M.I. ____ Relationship to Client _____

Insured Employer _____ Work Phone _____ Social Security Number _____

Date of Birth __/__/__ Identification Number _____ Group Number _____

Secondary Insurance Company _____

Insured Last Name _____ First _____ M.I. ____ Relationship to Client _____

Insured Employer _____ Work Phone _____ Social Security Number _____

Date of Birth __/__/__ Identification Number _____ Group Number _____

I hereby authorize Weeden & Associates; L.L.C. to release such information as may be requested by my Insurance company for the purpose of billing or coverage clarification. I hereby authorize any insurance coverage providing benefits or payments for treatment received from Weeden & Associates, L.L.C. to be assigned to Weeden & Associates, L.L.C. I also permit a copy or other facsimile of this authorization to be used in place of the original assignment.

Parent/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

WEEDEN & ASSOCIATES TREATMENT ARGEEMENT

PLEASE READ AND DISCUSS WITH YOUR THERAPIST

Confidentiality- All contacts with our therapists and clinic are confidential, except in situations where you may be harmful to yourself or others. This includes physical or sexual abuse of a child. If your insurance has managed care, information will be shared for the purpose of coverage by your insurance. No information regarding you or your family members will be given to anyone outside of the clinic without your written consent. Within the agency, information regarding your case may be shared with the other clinic therapists for consultation purposes to enhance the services you receive.

Cancellation or Failed Appointments- Cancellations must be made 24 hours in advance or you will be billed for the professional fee; clients will also be billed for missed appointments.

Legal/Court Hearings- Due to the nature of issues involved in treatment, clinicians DO NOT attend nor participate in legal/court cases. As clinicians, we seriously doubt any involvement is an asset and might be an unwanted detriment to the client.

TREATMENT BILLING POLICY

Insurance Responsibility- It is your responsibility to know what coverage your insurance provides. All charges are the sole responsibility of the patient (or patient representative), regardless of insurance payments. If there is a problem with receiving payment from your insurance carrier or if the claim process extends over two months, you will be expected to make payments. We will then reimburse you when the insurance company makes payments. If the insurance check is paid directly to you, you are obligated to turn the check over to the clinic. Failure to do so will result in an 18% monthly interest fee which will be added to your account.

Information about Fees- The initial assessment fee is $175. The subsequent session fee is $160. If you are a member of a managed health care plan, your fee may be reduced from that stated above. A therapy session normally consists of **50 minutes therapy hour** of face to face contact. The fee for sessions lasting less or more than 50 minutes will be prorated accordingly.

Self Pay Clients- Our clinic expects that you and your therapist will make arrangements for the professional fee. Patients are expected to keep their balance current and pay at each session.

Collection Agency- Past due accounts will be given to our collection agency/attorney. All fees incurred by this action will be the responsibility of the patient.

I/We understand and agree to the above administration/billing policies in this agreement. My therapist has reviewed this billing with me and I/We agree to pay the deductible and any amount of my/our insurance does not cover. I/We are aware that an unpaid balance will be referred to an attorney/collection agency as well as necessary information.

Informed Consent HFS 94.03

The listed items have been reviewed with me: a) The benefits of the proposed treatment and services; b) The way the treatment is to be administered and the services are to be provided; c) The expected treatment side effects or risks of side effects which are a reasonable possibility; d) Alternative treatment modes and services; e) The probable consequences of not receiving the proposed treatment and service.

Parent/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

Revised on October 4th, 202

CHILD PERSONAL HISTORY

Name _____ Age _____ Date of Birth _____

Who referred you to Weeden and Associates? _____

Current Concern: What is the concern that prompted you to bring the child in for treatment?

□ Family □ Legal Explain the presenting concern:

□ Emotional □ Employer _____

□ Medical □ Court _____

□ School □ Other _____

What do you expect from treatment? _____

_____

_____

Where does the problem occur? □ Home □ School □ Community □ Other: _____

Age when problem began _____ Duration: □ Less than 6 months □ Greater than 6 months

How would you generally describe your child's overall mood? (Please check those that apply)

□ Positive (happy, laughing, upbeat, hopeful) □ Negative (depressed, cranky, angry, hostile)

□ Mixed, more positive than negative □ Mixed, more negative than positive

Child's Strengths: _____

Child's Limitations: _____

How would you describe your child's approach to new situations? □ Positive □ Withdrawn □ Cautious

SOCIAL HISTORY

Current school attending _____

City school is located _____ Grade _____ Teacher _____

Is your child currently receiving special services in this school? □ Yes □ No If yes, please specify: _____

_____

Has your child ever failed a class or been held back for academic reasons? □ Yes □ No If yes, please specify and state what grade this occurred: _____

Is your child expected to pass this school year? □ Yes □ No

Provide a few words describing your child's overall performance throughout his or her years in school: _____

Attitude towards present teacher and peers: _____

Attitude towards past teachers and peers: _____

STRUCTURED ACTIVITIES

Is your child involved in any clubs, religious organizations, or community groups? □ Yes □ No

If yes, what are they?_____

Activity level of your child: □ Inactive □ Average □ Overactive

FAMILY HISTORY

Parents currently married? □ Yes □ No How long (months/years)? _____

Parents currently divorced? □ Yes □ No How long (months/years)? _____

Parents deceased? □ Mother □ Father How long (months/years)? _____

Parents remarried? Mother to whom_____ How long? _____

Father to whom_____ How long? _____

Members of the Household:

	Name	Age	Occupation/Grade	Relationship to Child
1.				
2.				
3.				
4.				
5.				
6.				

Additional significant family members living in another household (step-parent, step-siblings, non-custodial parent, etc.):

	Name	Age	Occupation/Grade	Relationship to Child
1.				
2.				
3.				
4.				
5.				

Does child have contact with extended family members? □ Yes □No □ Grandparents □ Aunts/Uncles □ Cousins

MEDICAL HISTORY

Primary Care Physician: _____

Current Health Concern: Please check any area where you think there may be a problem.

□ Headaches □ Depression □ Breathing □ Anger or Temper □ Weight Loss/Gain □ Eating Disorders □ Digestion □ Guilt

□ Frequent Mood Changes □ Anxiety/Nervous □ Menstrual Cycle □ Bowel Function □ Self-Concept □ Memory □ Phobias

□ Problems w/Relatives □ Stomach Problems □ Urinary Function □ Sexuality □ Parenting Skills □ Eating/Appetite □ Smoking

□ Suicidal Ideas □ School Problems □ Sleep Disturbances □ Chronic Pain □ Indecision □ Tiredness/Fatigue □ Alcohol Use

□ Drug Use □ Work/Job Issues □ Concentration □ Interpersonal Relations □ Other _____

Has the child ever been physically abused? □Yes □No Sexually abused □Yes □No

Emotionally abused □Yes □No Verbally abused □Yes □No

Has the child or any family member made a suicide threat? □Yes □No A suicide attempt? □Yes □No

Has any family member completed suicide? □Yes □No If yes, who? _____

Please list all prior mental health services received by the child:

With Whom	Year	How Long	For What

Is your child currently under the care of a doctor for any physical or emotional conditions? If so, please list the doctor's name, reason for treatment, and date last seen: _____

_____

Current medications the child is taking (List all even non-prescriptive and occasional): Medication & Dosage: _____

_____ Prescribing Physician: _____

Please list any hospitalizations (dates & reasons): _____

_____

Is there a history of prolonged separations or traumatic events? If yes, please specify: _____

_____

DEVELOPMENTAL HISTORY

Did the birth mother experience any physical or emotional problems during pregnancy? If yes, please specify: _____

_____

Were medications taken during pregnancy? If yes, please list all: _____

_____

Did mother consume alcoholic beverages, cigarettes, or abuse any street drugs during pregnancy? If yes, please list: _____

_____

Was the delivery room normal? □ Yes □ No □ Unknown If no, please specify: _____

_____

What was the child's birth weight? _____lbs. _____oz. □ Unknown

Did the baby experience any problems immediately after birth? If yes, please specify: _____

_____

Did or does your child have any of the following:

Delayed sitting up □ Yes □ No Speech delay □ Yes □ No Coordination difficulties □ Yes □ No

Dalayed walking □ Yes □ No Bed wetting □ Yes □ No

What age did your child do the following? (Approximately)

Smiled (6 months) _____ Rolled Over (6 months)_____ Held Head Up (3 to 4 months) _____

Sat Alone (6 to 10 months) _____ Fed Self (2 years)_____ Talked in Sentences (30 to 36 months) _____

Crawled (6 to 10 months) _____ Pulled Up_____ Talked in Single Words (18 to 24 months)_____

Walked by Self (12 months) _____ Rode a bike (6 years)_____ Established Toilet Training (2.5 to 4 years)_____

Parent/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

WEEDEN & ASSOCIATES CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Patient Name: _____

Person or Organization Granted this Consent: Weeden & Associates, LLC

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for the other professional activities known as "health care operations" (for example, quality improvement activities).

With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that notice before signing this consent. We reserve the right to revise our Notice of Privacy at any time. If we do so, the revised notice will be posted in the waiting room. You may ask for a printed copy of our notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to revocation.

This consent is voluntary; you may refuse to sign this form. However, we are permitted to refuse to provide health care services if this consent is not granted or if the consent is revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

_____ _____

Signature of Patient or Personal Representative *Date*

Revised on October 4th, 202

Relationship of Personal Representative to the Patient: □ Self □ Spouse □ Parent □ Legal guardian

WEEDEN & ASSOCIATES CONFIDENTIAL COMMUNICATIONS- ALTERNATIVE CONTACT INFORMATION

Effective Date: _____

Patient Name: _____

For EAP USE ONLY: Start date of authorization: _____ **End date of Authorization:** _____

Number of Sessions Authorized: _____ **Authorization #:** _____

What Address Would You Like Your Billing Statements Sent To?

Name: _____

Address: _____

_____

Billing Arrangements/Instructions

_____

_____

_____

Phone Numbers:	Okay to Call?	Okay to Leave Message?
Home: _____	Y □ N □	Y □ N □
Work: _____	Y □ N □	Y □ N □
Cellular: _____	Y □ N □	Y □ N □
E-mail: _____		Y □ N □

Signature of Patient or Personal Representative: _____ Date: _____

Revised on October 4th, 202

Relationship of Personal Representative to the Patient: □ Self □ Spouse □ Parent □ Legal guardian

Electronic Communications Informed Consent

Weeden & Associates, LLC provides clients the opportunity to communicate with their physicians, other healthcare professionals, and administrative services by email/text/Skype/etc. Transmitting confidential client information by electronic communication, however, has a number of risks, both general and specific, that clients should consider before using electronic communication.

Conditions for the Use of Electronic Communication

- It is the policy of Weeden & Associates, LLC, that the clinician and administrative staff will make all electronic communication messages sent or received that concern the diagnosis or treatment of a client part of that client's medical/mental health record and will treat such electronic communication messages with the same degree of confidentiality as afforded other portions of the medical record. Weeden and Associates, LLC will use reasonable means to protect the security and confidentiality of electronic communication information. Because of the risks, Weeden & Associates, LLC cannot, however, guarantee the security and confidentiality of electronic communications.
- Thus, clients must consent to the use of electronic communication for confidential medical/mental health information after understanding the risks. Consent to the use of electronic communication includes agreement with the following conditions:
    - All electronic communication to or from the client concerning diagnosis and/or treatment will be made a part of the client's medical/mental health record. As a part of the medical/mental health record, other individuals, such as other physicians, nurses, physical therapists, patient accounts, personnel, and the like, and other entities, such as other healthcare providers and insurers, will have access to electronic communication messages contained in medical/mental health records.
    - Weeden & Associates, LLC may forward electronic communication messages within the facility as necessary for diagnosis, treatment, and reimbursement. Weeden & Associates, LLC will not, however, forward the electronic communication outside the facility without the consent of the client or as required by law.
    - If the client sends an electronic communication to Weeden & Associates, LLC, to a healthcare provider, or administrative department, Weeden & Associates, LLC will endeavor to read the electronic communication promptly and to respond promptly, if warranted. However, Weeden & Associates, LLC can provide no assurance that the recipient of a particular electronic communication will read the electronic message promptly. **Because Weeden & Associates cannot assure clients that recipients will read electronic communication messages promptly, clients must not use electronic communications in a medical emergency.**
    - If a client's electronic communication requires or invites a response, and the recipient does not respond within a reasonable time, the client is responsible for following up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
    - Because some medical/mental health information is so sensitive that unauthorized disclosure can be very damaging, **clients should not use electronic communications for communications concerning diagnosis treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases,**

such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug use.

- Because employees do not have the right of privacy in their employer's electronic communication system, clients should not use their employer's electronic communication system to transmit or receive confidential medical/mental health information.
- Weeden & Associates, LLC cannot guarantee that electronic communications will be private. We will take reasonable measures to protect the confidentiality of the client's electronic communication, but Weeden & Associates, LLC is not liable for improper disclosure of confidential information not caused by Weeden & Associates, LLC's gross negligences or unprovoked misconduct.
- If the client consents to the use of electronic communications, the client is responsible for informing Weeden & Associates of any types of information that the client does not want to be sent by electronic communication other than those set out above.
- The client is responsible for protecting the client's password or other means of access to electronic communication sent or received from Weeden & Associates, LLC to protect confidentiality. We are not liable for breaches of confidentiality caused by a client.
- **Any further use of electronic communication by the client that discusses diagnosis or treatment by the client constitutes informed consent to the foregoing.** You may withdraw communications to Weeden & Associates, LLC at any time by electronic communication or written communications with your clinician.

I have read the above risk factors and conditions for the use of electronic communication, and I hereby consent to the use of electronic communication for communications to and from Weeden & Associates, LLC regarding my medical/mental health treatment.

Signature of the Client/Parent	Printed Name of the Client/Parent
Signature of Witness	Printed Name of Witness

Date

Revised on October 4th, 202

INFORMED CONSENT TO TELEMEDICINE

Telemedicine allows my therapist to diagnose, consult, treat, and educate using interactive audio, video, or data communication regarding my treatment, thereby increasing accessibility to psychological care. Telemedicine platforms utilized by Weeden & Associates, LLC clinicians are protected by end to end encryption. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telemedicine) with the clinician listed below:

Client Name: _____ Clinician: _____

I understand I have the following rights under this agreement:

- I have a right to confidentiality with Telemedicine under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.
    - There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatening danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telemedicine interaction to any other entities shall not occur without my written consent.
- I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telemedicine, results cannot be guaranteed or assured.
- I further understand that there are risks unique and specific to Telemedicine, including but not limited to, the possibility that our therapy sessions or other communications by my therapist to me regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.
- I understand that neither myself the client, nor my therapist the provider, will record any teletherapy sessions without prior written consent.
- In addition, I understand that Telemedicine treatment is different from in-person therapy and that if any therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, we will collaborate as to how we can provide such services.
- I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telemedicine communications by providing written notification to Weeden & Associates, LLC.

My signature below indicates that I have read this Agreement and agree to its terms.

Client Name (sign): _____

Guardian/Parent Name (print): _____ Date: _____

Guardian/Parent Name (sign): _____ Date: _____

PATIENT EASY PAY CONSENT FORM

I, _____(*print name*), hereby authorize Weeden and Associates, LLC. to confidentially retain and charge my credit card account for professional services as follows:

(Please ✓ all that apply)

_____ Full Fee for Service _____ **(Amount)**

_____ Co-pay Amount _____ **(Amount)**

_____ Fees Toward Deductable _____ **(Amount)**

_____ Late Cancellation Fees _____ **(Amount)**

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number: _____ Expiration Date: ____/____

Name on Card: _____ V- Code: _____

Cardholder/Patient Address: _____

City: _____ State: _____ Zip code: _____

Cardholder Signature: _____ Date: _____

When would you like your card to be processed: Every visit: □ Once a Month: □

If once a month please specify what time of month you would like this to be processed:

Beginning: □ Mid: □ End: □

Please note that this form is valid unless the patient cancels the authorization through written notice to the health care provider.

Please be aware that unless an agreement is negotiated with the provider all outstanding balances not paid within 30 days, after a bill is sent or insurance company has notified your or billing office of your balance, will be charged to your credit card.

Revised on October 4th, 202

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related care healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician/psychologist/psychotherapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing physician's/psychologist's/psychotherapist's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician/psychologist/psychotherapist to whom you have been referred to ensure that the physician/psychologist/psychotherapist has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's/psychologist's/psychotherapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and licensing. In addition, we may also call you by name in the waiting room when your physician/psychologist/psychotherapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected heath information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donations, research, criminal activity, military activity, national security, worker's compensation, inmates, required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that you're physician/psychologist/psychotherapist or the physician's/psychologists/psychotherapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

- **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use on a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any parts of your health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friend whom may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
  Your physician/psychologist/psychotherapist is not required to agree to a restriction that you may request. If physician/psychologist/psychotherapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
- **You may have the right to have your physician/psychologist/psychotherapist amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

  We reserve the right to change the terms of this notice and will inform you by mail, of any changes. You then have the right to object or withdraw as provided in this notice.

  Complaints

  You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

  This notice was published and becomes effective on /or before August 18, 2015.