

Healing Therapeutic Services, LLC HIPAA & PRIVACY DOCUMENTS

"Welcome to our practice. We continually work to provide you with appropriate, high quality services. We believe that a client who understands and participates in his/her care will achieve better results. We have the responsibility to respect your rights, provide you the best possible care and acknowledge your rights as a client. The following has been prepared to inform you of your rights and responsibilities."

NOTICE OF PRIVACY PRACTICES

During treatment at Healing Therapeutic Services, LLC (HTS, LLC) therapists gather information about your psychiatric, medical history and health. The information that identifies you and relates to your past, present, future physical or mental health is referred to as your PROTECTED HEALTH INFORMATION (PHI). This notice describes how your PHI may be used and disclosed and how you can gain access to this information. Please review this notice carefully.

Clients of HTS, LLC are both adults and children. When we refer to "you" or "your" in this notice, we refer to the client. When we refer to types of disclosures of information to "you", we mean disclosures of the client, the client's guardian, or the person legally authorized to receive information about the client.

Please note, after you have read this notice, you will be asked to sign a separate consent form. Signing this form will allow us to use and disclose your PHI in the following ways:

- **Treatment:** We will use your information to provide, coordinate and manage care and treatment. For example, a therapist may consult with another health care provider, including HTS, LLC clinicians regarding the case or a referral.
- **Payment:** We will use information to receive payment for the services we provide. For example: we will disclose information in order to submit claims to insurance companies, third party payers, Medicare or Medicaid.
- **Health Care Operations:** We will use the information for certain activities related to the functioning of HTS, LLC. For example, we may use or disclose information for quality assurance activities.
- **When Required by Law:** Applicable law and ethical standards permit us to disclose information about you without your authorization when required by law. HTS, LLC may disclose or use PHI when necessary to:
 - ✓ Report suspected abuse or neglect of a child or vulnerable adult
 - ✓ Comply with mandatory government agency (such as psychology board or health department) audits or investigation
 - ✓ Comply with court order
 - ✓ Report possible professional or sexual misconduct by a named health care professional
 - ✓ Prevent or lessen a serious and imminent threat to the health and safety of you or another person. If such information is disclosed, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. If it is to ensure your safety, information may be disclosed to others such as family members, other health care professionals, and/or law enforcement officials.

USES AND DISCLOSURES THAT REQUIRE SPECIFIC AUTHORIZATIONS

We will need your written permission to use your information for any purpose other than those listed above. If you do sign an authorization form that allows using or disclosing your PHI, you can revoke that permission, in writing at any time.

MINORS - PRIVACY AND CONFIDENTIALITY

Parents and legal guardians have a right by law to information in their children's files. Exceptions are minors who are married or have born a child and those who are living independently and managing their finances.

PRIVACY RIGHTS

- **Right to Inspect and Copy:** You have the right, which may be restricted only in exceptional circumstances, to inspect and obtain a copy of your PHI. You must make this request in writing. We will respond to your request within three business days. Your right to inspect and copy PHI will be restricted only in those situations in which there is compelling evidence that access would cause serious harm to you. If your request to inspect (or obtain) a copy of your record is denied, you have the right to have the denial reviewed by a health care professional. We will act upon your request within 30 days. We may charge you a reasonable, cost-based fee for copies.
- **Right to Amend:** If you feel that the information we have about you is incorrect or incomplete, you may ask us to amend the information. If your request is denied, you can write a statement of disagreement with the denial that we will keep with your medical information.
- **Right to Request Restrictions:** You may request that HTS, LLC not use medical information for treatment, payment or health care operations. You may also request that HTS, LLC not provide medical information to certain people. However, HTS, LLC has the right to refuse your request.
- **Right of Accounting Disclosures:** You may ask us to provide you with information about disclosures of your PHI we made in the past. Requests for accountings will not be made prior to September 5, 2006. Your request can go back six years after September 5, 2006.
- **Right to Request Confidential Communication:** You may request that HTS, LLC provide you with your medical information in a confidential manner. For example, you can request we send bills and other mailing to a different address or that we notify you of this kind of information in another way, such as by a telephone call. You must make this request in writing and specify another address or means of communication. We must agree to your written request. You may also ask you to give us information about how you will pay for your bills.
- **Right to File a Complaint:** If you feel your medical information privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services and/or your HTS, LLC privacy official, who is your therapist. Filing a complaint will not affect the quality of the services you receive from HTS, LLC and you will not be retaliated against for filing a complaint.

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The effective date of this notice is May 20, 2008. HTS, LLC is required by law to maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new notice of Privacy Practices will be effective for all PHI that we maintain at the time. We will provide you with a copy of the revised notice by sending a copy to you in the mail upon request or providing one to you at your next appointment.

NOTICE OF NON-DISCRIMINATION / CONFIDENTIALITY STATEMENT

HTS, LLC does not discriminate in access to treatment services due to race, color, national origin, sex, creed, handicap or sexual preferences.

POLICY REGARDING MINOR CLIENTS (AGES 17 AND UNDER)

In order to best meet the needs of minor clients and their families, it is our policy to require the presence of a parent or appropriate care provider at the initial appointment of a minor. If a minor resides in a foster home or a residential treatment facility, a written report of developmental history, pertinent information, and reason for referral must be forwarded by the referral resource (usually a county social worker) prior to the initial appointment. Additionally, the minor must be accompanied by a foster parent, social worker, or residential staff person who is knowledgeable about the child and available for consult during the session.

A parent or responsible adult must remain in the building during therapy sessions of any child age 15 and under. During the initial session, the therapist will discuss parental (foster parent or staff) participation in subsequent sessions. We strongly recommend that other siblings do not accompany the parent to the sessions since their presence in the interview may inhibit the sharing of pertinent information or distract from the needs of the minor client. Because we believe that these expectations are in the best interest of minor clients, we may not be able to provide services to minor s unless these guidelines are met.

Reminding parents and responsible caregivers of the following:

- Children age 15 and under or any child regardless of age who needs adult supervision should not be left unaccompanied in the reception space.
- A parent or responsible adult must remain on-site for any child 15 years or younger while the child is in session.

GRIEVANCE PROCEDURE NOTICE

Clients receiving outpatient mental health services have the right to complain if they feel their treatment has not been adequate and/or civil and legal rights have been infringed upon.

You have the right to obtain legal counsel if you feel your civil and legal rights have been denied you.

Complaints regarding the quality and type of treatment you have received should be brought to the attention of the therapist you are working with. If you are unable to resolve the conflict at this point, you have the right to present your complaint to the governing board

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who licensed the therapist assigned you.

If you continue to feel dissatisfied, you have the right to obtain legal counsel to aid in resolving the complaint.

Jennifer Zenz-Olson, MA, LICSW

Minnesota Board of Social Work
2829 University Ave SE, Suite 340
Mpls, MN 55414-3239
Ph) 612-617-2100

Brian Putz, MA, LP

Minnesota Board of Psychology
2829 University Ave SE, Suite 320
Mpls, MN 55414-3237
Ph) 612-617-2230

Alan Davis, MA, LMFT or Romy Sundem, MA, LMFT

Minnesota Board of Marriage and Family Therapy
2829 University Ave SE, Suite 330
Mpls, MN 55414-3222
Ph) 612-617-2220

CLIENT RIGHTS AND RESPONSIBILITIES

HTS, LLC and staff are committed to quality and professional mental health services; you have the responsibility and right:

- **To Be Honest:** You are responsible for being honest about everything that relates to you and your care. Please tell your therapist how you are feeling about what is happening in your life.
- **To Understand Your Treatment Plan:** Together with your therapist, the most appropriate treatment diagnosis and individual treatment plan will be developed for your care. You have the responsibility to understand your treatment goals to your own satisfaction. If you do not understand, please ask your therapist. Understanding your treatment plan is important for the success of your treatment. You are responsible for following your treatment plan and informing your therapist of whether or not you can and/or want to follow your plan.
- **To Keep Appointments:** Because your appointment time has been reserved for only you, we expect you will put a priority on keeping appointments. If is necessary to have at least 24 hour notice se we can offer the time to another client. If an emergency requires less than a 24 hour notice, please inform your therapist at the time of cancellation. Not showing for an appointment will result in the cancellation of future scheduled appointments.
=> If a pattern of TWO or more appointment are no shows or non- emergency late cancellations occur, it may result in services being discontinued and a referral made elsewhere for services.
- **Guidelines Regarding Children in Sessions:** We have an expectation that you will find appropriate care for minor children during your therapy appointment time. Having young children in your sessions may inhibit the sharing of pertinent information and distract you and/or your therapist. While we understand that children may need to accompany you occasionally, it may side tract or divert attention from you and your therapeutic goals.

THERAPIST RIGHTS AND RESPONSIBILITIES

1. A therapist shall limit practice to the areas of competence in which proficiency has been gained through education and training or experience.
2. A therapist shall accurately represent areas of competence, education, training, experience and professional affiliations of the therapist to HTS, LLC, the public and colleagues.
3. In cases in which a new service, technique or specialty is developing, a therapist shall engage in ongoing consultation with other therapists or similar professionals as skills are developed in the new area and shall seek continuing education which corresponds to the new area. A client whose treatment involves the use of a newly developing service, technique or specialty shall be informed of its innovative nature and of known risks associated with it.
4. A therapist shall recognize that there are other professional, technical and administrative resources available to clients and make referrals to those resources when it is in the best interest of clients to be provided with alternative or complementary services.
5. A therapist shall safeguard the private information obtained in the course of practice, teaching, or research. In any situation in which services of a therapist are requested by one part of another party, the therapist shall inform both the requester and the receiver of the services of the responsibility of the therapist regarding the privacy of any information gained in the course of rendering the services.
6. At the beginning of a professional relationship, a therapist shall inform a client who is a minor of the limit the law imposes on the right to privacy of a minor in respect to communications of a minor with the therapist.
7. A therapist shall limit access to client records and shall inform every person associated with the agency or facility of the therapist, such as a staff member, student, volunteer or community aide, that access of client records shall be limited only to the therapist with whom the client has a professional relationship, a person associated with the agency or facility whose duties requires access, and a person authorized to have access by the informed written consent of the client.
8. A therapist shall instruct the staff to inquire of clients and to comply with the wishes of clients regarding to whom and where statement of services to be sent.
9. Case report or other clinical materials used in teaching, professional meetings or publications shall be disguised so that no identification of the individual occurs.
10. Diagnostic interviews or therapeutic sessions with a client may be observed or electronically recorded only with the informed consent of the client.
11. A therapist shall continue to maintain as private information the records of a client after the professional relationship between the therapist and the client has ceased.
12. A therapist must not undertake or continue a professional relationship with a client in which the objectivity of the therapist is or would be impaired due to familial, social, emotional, economic, supervisory or political interpersonal relationship. A therapist whose objectivity becomes impaired because of the development of a listed interpersonal relationship during a professional relationship with a client shall notify the client orally and in writing that the therapist shall no longer see the

client professionally, begin termination of the relationship, and assist the client in obtaining services from another therapist.

13. A therapist must not undertake or continue a professional relationship with a client in which objectivity or effectiveness is or would be impaired due to the divorce, grief reaction, or would be impaired due to the divorce, grief reaction, severe health problem or chemical abuse or dependency of the therapist. A therapist whose objectivity or effectiveness becomes impaired during a professional relationship with a client because of such a personal problem shall notify the client orally and in writing that the therapist shall no longer see the client professionally, begin termination of the relationship and assist the client in obtaining services from another therapist.
14. A therapist has a right to expect fair and respectful treatment from the client. The therapist can refuse treatment to client who uses threats, verbal abuse or physical violence.

* EMERGENCY SERVICES *

You may contact your therapist during business hours for emergency purposes. If your therapist is not available or you are calling after hours, call one of the following 24 hour response centers:

- **CRISIS PLUS at 612-379-6363.**
- **RIVERWIND CRISIS RESPONSE SERVICES at 763-755-3801, if you are a resident of Anoka County.**
- **Call 911 if you are in a life threatening event.**

BILLING POLICIES AND FEE INFORMATION

INSURANCE COVERAGE

To assist you in obtaining insurance payments, you must provide us with accurate health insurance information:

- Name, address and phone number of your insurance company
- Group number, Personal identification number
- Name of policyholder and their date of birth
- Relationship of the policyholder
- Copy of your insurance card, front and back

We are in-network providers for most major insurance companies. As a courtesy to you, we work directly with your insurance and will make every effort possible to bill your insurance company.

- Once your appointment has been scheduled, we will verify your insurance benefit coverage and obtain any necessary authorization for you.
- Verification of benefit coverage is not a guarantee of claim payment. All benefits are subject to the terms and conditions (authorizations, network requirements) outlined in your member contract with your insurance company. We have no authority to make representations to you regarding coverage of items or services covered.
- It will be important for you to understand your benefit coverage. For benefit coverage questions, please call the customer/member service phone number on the back of your insurance card. **It is your responsibility to understand the provisions of your health plan before your initial visit to know your plan's limitations, deductibles and exclusions.**
- It remains your responsibility to pay any deductibles, co-payments, co-insurance or other amounts your insurance carrier or third party payer determines as payable by you – **this is to be collected by your therapist at each session.** Your insurance company informs you of the amount payable by sending you the explanation of benefits (EOB) at the same time that we are informed of this amount. If you are unable to pay at the time of service, please discuss the event with your therapist.
- **Insurance Changes:** It is your responsibility to provide us with updated information if your insurance carrier changes or your coverage terminates. Should your insurance carrier change, we will need the following information:
 - Name, address and phone number of your new plan
 - Policyholder information: Name, Date of Birth, relationship to the patient
 - A copy of your new insurance card, front and back
- If the insurance information you provide to us is later determined to be inaccurate resulting in denial of your claim, then you will be responsible for the amount denied by your carrier.
- You are responsible for charges not eligible and/or covered by your insurance plan.
- If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

- If you have medical coverage, you are expected to utilize it. If you choose not to do so, you or the responsible party will be expected to pay the full cost of services prior to each session.
- Account statements will be mailed monthly.
- **NSF Checks:** HTS, LLC will assess your account our bank fee associated with any checks written with insufficient funds.
- **Unpaid account balances:** I understand that if my account balance is more than 60 days and arrangements for payment have not been agreed upon, HTS, LLC will forward your account to our collections agency to secure payment. If legal action becomes necessary, its costs will be included in the claim and I understand that I will be responsible to pay said fees'. HTS, LLC reserves the right to withdraw care from clients if the client or responsible party does not fulfill their financial obligation.

Out of Network

In the event that we do not participate in your insurance plan's network, you may be eligible for out of network benefits. Please refer to your insurance provider's handbook or contact your insurance carrier if you are eligible for out of network benefits.

LATE CANCELLATION NOTICES OR FAILED APPOINTMENTS

YOU, NOT your insurance company, will be charged \$130 for any session you failed to attend or miss without providing a 24 hour notice **BEFORE** the scheduled appointment.

HTS, LLC CLINICAL FEES

- \$185/50 minute hour - Initial Diagnostic Assessment
- \$130/50 minute hour - Individual Psychotherapy
- \$130/ 50 minute hour - Family Psychotherapy
- \$130/50 minute hour - Couples/Marriage Psychotherapy
- \$150/full hour - Psychological Testing
- \$40-\$60/per session - Group
- \$300/full hour - Educational Group
- \$250/full hour - Court
- \$130-No Show or Late Cancellation Fee without 24 hour notice
- \$25/15 minute - Document Preparation/Consultation Fee
- NSF (Non-sufficient Funds) Bank fees will be assessed to client account

CELL PHONE POLICY

At HTS, LLC we value providing a safe, comforting, calming and confidential atmosphere for our clients. We ask you to refrain from cell phone use in our space and adhere to the following policy:

- Cell phones **MUST BE TURNED OFF OR SET TO VIBRATE**
- If necessary to accept a phone call, please step outside
- Please be aware of your conversation and surroundings even when outside
- HTS, LLC reserves the right to ask anyone to leave if he/she is being disruptive to others in our office space

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*Thank you for choosing to work with us. We are committed to providing quality care. Please feel free to talk with your therapist or client care advocate if you have any questions regarding the above information.*

Chart Number: \_\_\_\_\_

Client Name: \_\_\_\_\_

**HEALING THERAPEUTIC SERVICES, LLC  
HIPAA ACKNOWLEDGMENT & AUTHORIZATION**

“I hereby acknowledge that I have received a copy of the HIPAA & Privacy documents from HTS, LLC.”

**READ & PLACE A CHECK MARK IN ALL THE FOLLOWING STATEMENTS ACCEPTING RESPONSIBILITY**

- I grant authorization to Healing Therapeutic Services, LLC to release PHI to my third party payer and any prior authorization that is necessary for billing or to process any claims for services provided by HTS, LLC.
- I accept full responsibility for notifying HTS, LLC **IMMEDIATELY** of any changes in my insurance coverage or third party payer while receiving care. Failure to do so will result in my being responsible for any unpaid claims.
- I understand that **I AM** responsible for my bill.
- I authorize my therapist to act as my agent in assisting me in obtaining payment from my insurance company or third party payer.
- I authorize my insurance company or third party payer to send payment directly to Healing Therapeutic Services, LLC for all services provided.
- I will pay my co-payment and/or co-percentage **and** any outstanding balances owed to HTS, LLC **BEFORE** each visit.
- Deductible Plans **WE REQUEST** A credit card on File: *I hereby consent/authorize to charge my credit card/debit card for any outstanding balance at the end of each month such as deductibles, co-payments, co-insurance or other amounts my insurance or third party payer determines as payable by me.*

**CONSENT AND AUTHORIZATION GRANTED**

**PRINT YOUR NAME**

First \_\_\_\_\_ Last \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Minor \_\_\_\_\_

**INSURANCE / THIRD PARTY PAYER / SELF PAY**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- I request **NOT** to use my insurance benefits and understand I will **SELF-PAY** the cost of services provided by HTS, LLC.

**AUTHORIZATION GRANTED TO HTS, LLC TO DISCUSS BILLING RECORDS, ADMN QUESTIONS, GENERAL QUESTIONS WITH THESE PEOPLE**

- SPOUSE \_\_\_\_\_ PHONE # \_\_\_\_\_
- PARENT \_\_\_\_\_ PHONE # \_\_\_\_\_
- OTHER \_\_\_\_\_ PHONE # \_\_\_\_\_

## PRIMARY CARE PHYSICIAN CONTACT AUTHORIZATION

### Section 1

Client Name: \_\_\_\_\_ Client ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Section 2

Please indicate below whether you would like us to contact your primary care physician regarding your treatment at Healing Therapeutic Services, LLC.

- I authorize Healing Therapeutic Services, LLC to contact my physician as indicated below for the purposes of continuing care and case coordination. I also authorize my physician to disclose PHI to Healing Therapeutic Services, LLC for the same purposes.
- I do not have a primary care physician. I understand that I am encouraged to obtain one.
- I do not authorize Healing Therapeutic Services, LLC to contact my physician.

Name of Physician \_\_\_\_\_

Address \_\_\_\_\_  
Street, City, State, Zip Code

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Other Information \_\_\_\_\_

### Section 3

#### Description of Information to be Disclosed

- |                                                                               |                                                               |
|-------------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Diagnostic Assessment/Evaluation                     | <input type="checkbox"/> Treatment Plan or Summary            |
| <input type="checkbox"/> Progress Notes                                       | <input type="checkbox"/> Billing Records                      |
| <input type="checkbox"/> ARMHS Functional Assessment & Treatment Plan         | <input type="checkbox"/> Psychological/Psychiatric Assessment |
| <input type="checkbox"/> Chemical Dependency Evaluation Notes                 | <input type="checkbox"/> Other Facilities/Lab Reports         |
| <input type="checkbox"/> All Mental Health Information-Dates of Service _____ |                                                               |
| <input type="checkbox"/> Other-specify _____                                  |                                                               |

### Section 4

The Purpose of this Disclosure of information:

- Ongoing Care     Consultation     Case Coordination     Other – Specify \_\_\_\_\_

### Section 5

*I understand that information will be disclosed that is protected by Federal Laws and Minnesota Statutes. I understand that I have a right to revoke this authorization at any time, in writing, but that the revocation will not have any effect on the information released prior to notification of cancellation. If I refuse to sign this consent, treatment will not be withheld. A photocopy of this authorization will be treated in the same manner as the original. I understand that this consent expires **ONE YEAR** after signature date.*

*I release Healing Therapeutic Services, LLC from any and all liability resulting from disclosure. I do not authorize re-release of this information to anyone. I have read this consent prior to signing and I understand its contents.*

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Client or \*Legal Guardian/Responsible Party if under 18

\*Relationship to Client \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

#### Healing Therapeutic Services, LLC Office Use Only

Faxed     Mailed     Picked Up    Date: \_\_\_\_\_ Time of Day: \_\_\_\_\_ Initials: \_\_\_\_\_

# HEALING THERAPEUTIC SERVICES, LLC CHILD AND ADOLESCENT HEALTH AND DEVELOPMENTAL QUESTIONNAIRE

*“Please answer all the questions. Honest answers will allow the therapist to have a better understanding of your child and family. Feel free to ask questions if you need assistance.”*

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Child's Address: \_\_\_\_\_  
(Street Address) (City, State, Zip Code)

Child's Date of Birth: \_\_\_\_\_ Child's Current Age: \_\_\_\_\_

Child's Gender: Male  or Female  Child's Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes or  No

Work Phone: \_\_\_\_\_ May we leave a message?  Yes or  No

Cell Phone: \_\_\_\_\_ May we leave a message?  Yes or  No

Who referred you to Healing Therapeutic Services? \_\_\_\_\_

Race:  African/American  Asian  Hispanic  Native/American  Caucasian  Other

Are there ethnic/cultural/lifestyle/gender/religious considerations you would like us to be aware of during your care?  
 Yes or  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

What do you think your child needs help with at this time? \_\_\_\_\_  
\_\_\_\_\_

Are there any legal or custody issues, including who has legal custody, physical custody? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Section 1 – Developmental History

Were there any problems during pregnancy or delivery? (Such as medications, alcohol/drug or cigarette use, early labor, high blood pressure, diabetes, accidents, cord around neck, blue appearance, lack of oxygen, intensive care).

- As a baby, were there any: \_\_\_\_\_ Feeding problems, colic, food allergies  
\_\_\_\_\_ Problems forming a close relationship between mother and child  
\_\_\_\_\_ Baby sleeping too much or too little

- As a toddler or small child, were there any: \_\_\_\_\_ Problems with activity level  
\_\_\_\_\_ Absence or odd speech  
\_\_\_\_\_ Problems relating to others  
\_\_\_\_\_ Unusual repetitive behaviors

Please describe any issues marked above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Section 2 – Developmental Milestones

Please check the most appropriate box regarding your child's developmental activity.

| Activity                 | Normal Range | Early | On Time | Late | Don't Know |
|--------------------------|--------------|-------|---------|------|------------|
| Crawling                 | 3-6 Months   |       |         |      |            |
| Walk Alone               | 11-15 Months |       |         |      |            |
| First Words & Sentences  | 8-18 Months  |       |         |      |            |
| Toilet Trained (Bladder) | 2-3 Years    |       |         |      |            |
| Toilet Trained (Bowel)   | 2-3 Years    |       |         |      |            |

Were/are there any problems with bed wetting or soiling? \_\_\_\_\_

## Section 3 – Chemical / Alcohol History

Are there any chemical use issues for your adolescent? [ ] Yes or [ ] No If yes, check all that apply below.

- |                                              |                                         |                                          |
|----------------------------------------------|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> Tobacco Use         | <input type="checkbox"/> Alcohol        | <input type="checkbox"/> Cocaine/Crack   |
| <input type="checkbox"/> Heroin              | <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Diet Pills      |
| <input type="checkbox"/> LSD/Acid/Angel Dust | <input type="checkbox"/> Marijuana      | <input type="checkbox"/> Methamphetamine |
| <input type="checkbox"/> Other               |                                         |                                          |

Do you think anyone else in your family has a chemical / alcohol use / addiction problem? Please explain: \_\_\_\_\_

## Section 4 – Current / Previous Mental Health Services

Name of current Psychiatrist or Clinic: \_\_\_\_\_

Name of County Social Worker: \_\_\_\_\_

- Name of Prior Psychiatrist: \_\_\_\_\_ Years Treated: \_\_\_\_\_

Medications: \_\_\_\_\_

- Name of Prior Therapist: \_\_\_\_\_ Years Treated: \_\_\_\_\_

Issues: \_\_\_\_\_

- Most recent psychiatric hospitalization: \_\_\_\_\_ Hospital Name: \_\_\_\_\_

Approximate number of psychiatric hospitalizations: \_\_\_\_\_

If members of your family have been treated for a mental illness, please indicate relationship to child and diagnosis: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Section 5 – Medical History

Child's Primary Care Physician and / or clinic name: \_\_\_\_\_

Address of Physician and / or clinic name: \_\_\_\_\_

Please list all prescription and over the counter medications your child takes on a regular basis: \_\_\_\_\_

Has your child ever had a problem with any of the following?

- |                                                       |                                                    |                                                               |
|-------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Allergies to Medications     | <input type="checkbox"/> Other Allergies           | <input type="checkbox"/> Asthma                               |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Vision Problems           | <input type="checkbox"/> Heart Murmur or Heart Problems       |
| <input type="checkbox"/> Hearing Loss                 | <input type="checkbox"/> Seizures (staring spells) | <input type="checkbox"/> Head Injury, Concussion, Knocked Out |
| <input type="checkbox"/> Surgery (What Kind)          | <input type="checkbox"/> Anorexia                  | <input type="checkbox"/> Bulimia                              |
| <input type="checkbox"/> Suicide Thoughts or Attempts | <input type="checkbox"/> Self Injury               | <input type="checkbox"/> Other                                |

Please explain: \_\_\_\_\_

Are there any **blood relatives** of your child who have any other following problems?

- |                                          |                                                |                                                       |
|------------------------------------------|------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Suicide Thoughts or Attempts |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Bipolar               | <input type="checkbox"/> Heart Disease                |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Seizures Disorder     | <input type="checkbox"/> Schizophrenia                |
| <input type="checkbox"/> ADHD            | <input type="checkbox"/> Anxiety Disorder      | <input type="checkbox"/> Other                        |

### Section 6 – Preschool / Daycare History

Did or does your child attend preschool or daycare? [  ] Yes or [  ] No

Were or are there any problems with his or her behavior? [  ] Yes or [  ] No

Please describe any of those problems or behaviors: \_\_\_\_\_

Did your child have problems separating from parent(s) for more than the first few days? [  ] Yes or [  ] No

Please describe any of those problems or behaviors: \_\_\_\_\_

**Section 7 – School History**

Name of Child’s School: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Are there any behavior or academic concerns for your child? [ ] Yes or [ ] No

Please explain those behavior or academic concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When were these problems **first** noticed by parent(s) or school? \_\_\_\_\_

Check problems that apply to your child:

- Fighting       Stealing       Arguing with Teachers       Refusing to Do School Work
- In School Suspension, Suspended or Expelled       Police or Court Involvement because of Behavior Problems
- Truancy, Unexcused Absences, Skipping – If Yes, How much school has your child missed? \_\_\_\_\_

Is your child receiving special educations services? [ ] Yes or [ ] No    Accelerated/Gifted Services? [ ] Yes or [ ] No

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 9 – Peer Relationships**

Please answer the following regarding your child:

- Is shy or timid       Is bossy or controlling       Gets upset if she or he doesn’t get her or his own way
- Has many friends       Has few friends       Has no friends

Any other relationship issues you are concerned about with your child? \_\_\_\_\_  
\_\_\_\_\_

Is your child old enough to be employed? [ ] Yes or [ ] No

If yes, what is his or her experience: \_\_\_\_\_  
\_\_\_\_\_

**Section 10 - Stressors**

Has your child experienced any of the following and at what age was your child?

- |                                                                  |                              |                                                                    |                              |
|------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------|------------------------------|
| <input type="checkbox"/> Death of Parent                         | <input type="checkbox"/> Age | <input type="checkbox"/> Death of a Close Friend or Relative       | <input type="checkbox"/> Age |
| <input type="checkbox"/> Death of a Pet                          | <input type="checkbox"/> Age | <input type="checkbox"/> Parental Separation or Divorce            | <input type="checkbox"/> Age |
| <input type="checkbox"/> Accident or Serious Injury              | <input type="checkbox"/> Age | <input type="checkbox"/> Prolonged Separation from Parent(s)       | <input type="checkbox"/> Age |
| <input type="checkbox"/> New Person in Household                 | <input type="checkbox"/> Age | <input type="checkbox"/> Recent Move or Change in School           | <input type="checkbox"/> Age |
| <input type="checkbox"/> Physical Abuse                          | <input type="checkbox"/> Age | <input type="checkbox"/> Sexual Abuse                              | <input type="checkbox"/> Age |
| <input type="checkbox"/> Emotional Abuse                         | <input type="checkbox"/> Age | <input type="checkbox"/> Witnessed Violence towards Family Members | <input type="checkbox"/> Age |
| <input type="checkbox"/> Other Stressful or Traumatic Experience | <input type="checkbox"/> Age |                                                                    |                              |

# CHILD BEHAVIOR CHECKLIST

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Completed By: \_\_\_\_\_

Please circle **Y** = yes for behaviors that are a concern for your child, **S** = sometimes for behaviors that are sometimes a concern for your child and **N** = no for behaviors that are not a concern for your child.

## ATTENTION

When symptoms began (date) \_\_\_\_\_

|                                      |   |   |   |
|--------------------------------------|---|---|---|
| Careless mistakes                    | Y | S | N |
| Poor attention span                  | Y | S | N |
| Doesn't listen                       | Y | S | N |
| Doesn't finish tasks                 | Y | S | N |
| Problems organizing                  | Y | S | N |
| Avoids tasks requiring concentration | Y | S | N |
| Loses needed items                   | Y | S | N |
| Easily distracted                    | Y | S | N |
| Trouble remembering/forgetful        | Y | S | N |
| Fidgets, squirms                     | Y | S | N |
| Leaves seat when required to sit     | Y | S | N |
| On the go, seems driven              | Y | S | N |
| Runs, climbs excessively/restless    | Y | S | N |
| Talks all the time                   | Y | S | N |
| Problems waiting turn                | Y | S | N |
| Interrupts                           | Y | S | N |

## MOOD

When symptoms began (date) \_\_\_\_\_

|                                                       |   |   |   |
|-------------------------------------------------------|---|---|---|
| Weight changes/appetite changes                       | Y | S | N |
| Energy level changes                                  | Y | S | N |
| Sleep disturbances                                    | Y | S | N |
| Difficulty concentrating                              | Y | S | N |
| Crying spells                                         | Y | S | N |
| Loss of interest/pleasure                             | Y | S | N |
| Hopeless feelings                                     | Y | S | N |
| Guilty feelings                                       | Y | S | N |
| Isolates self                                         | Y | S | N |
| Low self-esteem/self-hate                             | Y | S | N |
| Gives things away                                     | Y | S | N |
| Wishes to be dead                                     | Y | S | N |
| Injures self                                          | Y | S | N |
| Thinks about death/violence often                     | Y | S | N |
| Rage outbursts                                        | Y | S | N |
| Bizarre behaviors, hallucinations                     | Y | S | N |
| Rapid, hard to follow speech/thoughts                 | Y | S | N |
| Thinks s/he is the smartest, best person in the world | Y | S | N |

## OPPOSITIONAL BEHAVIORS

When symptoms began (date) \_\_\_\_\_

|                                |   |   |   |
|--------------------------------|---|---|---|
| Touchy, easily annoyed         | Y | S | N |
| Argues                         | Y | S | N |
| Defiant                        | Y | S | N |
| Angry                          | Y | S | N |
| Tantrums                       | Y | S | N |
| Bothers others deliberately    | Y | S | N |
| Spiteful/mean                  | Y | S | N |
| Blames others for own mistakes | Y | S | N |

## ANXIETY/WORRY

When symptoms began (date) \_\_\_\_\_

|                                                                                   |   |   |   |
|-----------------------------------------------------------------------------------|---|---|---|
| Worries something terrible will happen to self or important adults                | Y | S | N |
| Frequently refuses or is reluctant to go somewhere fear of separation             | Y | S | N |
| Avoids being alone                                                                | Y | S | N |
| Nightmares about separation                                                       | Y | S | N |
| Physical complaints about the time of separation transition                       | Y | S | N |
| Worries about parent(s) leaving                                                   | Y | S | N |
| Fearfulness of new situations, people or objects                                  | Y | S | N |
| Engages in repeated behaviors (counting, cleaning organizing, hand washing, etc.) | Y | S | N |
| Excessive worry about everyday things                                             | Y | S | N |
| Fear/excessive worry about social situations                                      | Y | S | N |

## CONDUCT

When symptoms began (date) \_\_\_\_\_

|                                         |   |   |   |
|-----------------------------------------|---|---|---|
| Bullies/threatens others                | Y | S | N |
| Starts fights                           | Y | S | N |
| Used a weapon                           | Y | S | N |
| Physically cruel to people/animals      | Y | S | N |
| Forcibly stolen from victim             | Y | S | N |
| Stolen without confronting victim       | Y | S | N |
| Forces sexual activity                  | Y | S | N |
| Deliberately sets fires to cause damage | Y | S | N |

Further comments about any of the above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CHILD'S STRENGTHS:

In school setting: \_\_\_\_\_

In social setting: \_\_\_\_\_

In home setting: \_\_\_\_\_

Special Interests/Hobbies: \_\_\_\_\_

## CONSENT TO PROVIDE SERVICE TO A MINOR

(A minor is any client age 17 years old and under)

|                                       |
|---------------------------------------|
| Client _____                          |
| Client ID # _____ Date of Birth _____ |

"I, \_\_\_\_\_, \_\_\_\_\_  
Print Name of Responsible Party Relationship to Minor

Hereby authorize HEALING THERAPEUTIC SERVICES, LLC to provide treatment to the above name client – minor.

As a parent, I understand that I have the right to information concerning my minor child in therapy, except where otherwise stated. I also understand that this therapist believes in providing a minor child with private environment in which to disclose him/her to facilitate therapy. I therefore give permission to this therapist to use his/her discretion, in accordance with the professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**HEALING THERAPEUTIC SERVICES, LLC  
PARENTAL CONSENT and MEDICAL LIABILITY RELEASE**

**CLIENT INFORMATION**

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
City, State, Zip Code

Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Medical Insurance: YES \_\_\_\_\_ NO \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

Allergies or Medical Conditions & Medication(s): \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION**

Name of Parent / Legal Guardian: \_\_\_\_\_

Address of Parent / Legal Guardian: \_\_\_\_\_  
City, State, Zip Code

Phone: Day \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

In case of a medical emergency should the parent or legal guardian cannot be reached.

Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_  
City, State, Zip Code

Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

**CONSENT and MEDICAL LIABILITY RELEASE**

*I give permission for my child / client named above to participating in activities, events that may take place outside the office of Healing Therapeutic Services, LLC during any scheduled therapy session. This will include transportation driven by our clinical staff member(s). My child / client named above and I understand that SEAT BELTS SHALL BE WORN AT ALL TIMES during transportation. This authorization and consent will expire one year from this signed consent and release document.*

*I hereby release, indemnify and hold harmless Healing Therapeutic Services, LLC its staff members and agents from any and all liability, damage, claim of any nature whatsoever arising out of or in any way related to participating in outside events or activities during any scheduled therapy session, including transportation to and from the office of Healing Therapeutic Services, LLC.*

*I authorize and consent to the giving of all treatments, medications, and or emergency care should the need arise. We further authorize the use of disclosure of my personal health information should medical or emergency treatment become necessary.*

\_\_\_\_\_  
Name of Parent / Legal Guardian (Printed)

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

Office Use Only: Copy of Signed Consent and Release given to Parent / Legal Guardian. Date: \_\_\_\_\_ Staff Initials: \_\_\_\_\_