Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 ◆ Overland Park, Kansas 66210
Telephone: (913) 451-8550 ◆ Fax: (913) 469-5266

Appointment Date/Time:

Client Registration Form — Adolescent

Today's Date:		**Name of Therapist/Clinician:**			
CLIENT INFORMATION					
Client's Last Name:	First Name:	MI:	Birth Date:	Age:	Sex:
Street Address:		City:		State:	Zip:
Home Phone:	Cell Phone:		Work Phone:		Social Security #:
School:		Grade:	Teacher/Counselor:		School District:
Referred by: ☐ Physician ☐ Relative ☐ School ☐ Friend ☐ Other Name:					
MOTHER'S INFORMATION					
Last Name:	First Name:	MI:	Birth Date:	Social Security #:	
Street Address:		City:		State:	Zip:
Home Phone:	Cell Phone:		Work Phone:		
Employer:		City:		State:	Zip:
FATHER'S INFORMATION					
Last Name:	First Name:	MI:	Birth Date:	Social Security #:	
Street Address:		City:		State:	Zip:
Home Phone:	Cell Phone:		Work Phone:		
Employer:		City:		State:	Zip:

DIVORCE POLICY

We recognize that many children live with two separate families. While you and your child's other parent may have an agreement about paying for health-related appointments, we are not able to be an intermediary in the process. **The parent who signs the paperwork at the initial visit will be considered the responsible party for all client balances.**

Unless you provide us with a court order indicating one parent has sole custody, any information in our possession concerning a minor child will be provided, upon request, to either or both parents.

I have read and understand the above stated policies.

_____	_____	_____
Printed Name	Signature	Date

Responsive Centers for Psychology and Learning

Name of Client: **Name of Therapist/Clinician:**

FINANCIAL POLICY

Copays for clients covered by insurance are due at the time services are rendered. For clients who are not using insurance, or are using an insurance plan with which their clinician is not contracted, payment in full is due at the time of service. Upon request, we will provide you with a Visit Summary to file with your insurance company for reimbursement.

If your insurance company requires prior authorization and you have not obtained it, the cost of that visit will be your responsibility. It is your responsibility to contact your insurance company to determine your outpatient mental health benefits. If your insurance changes during your treatment, it is your responsibility to provide that information to our office along with any authorizations required by your new plan.

I have read and understand the above stated policies.

_____ _____
Initials Date

AUTHORIZATION OF PAYMENT

Please choose **ONE** of the following:

1. **I am a private pay client. I will be responsible for payment in full at the time each service is rendered.**

_____ _____
Initials Date

2. **I authorize payment of insurance benefits to Responsive Centers for Psychology and Learning**, 7501 College Blvd, Ste 250, Overland Park, KS 66210 for services rendered. I further authorize the release to my insurance company of any medical or other information necessary to process my insurance claims. I understand that I am responsible for all balances not paid by my insurance company, including, but not limited to, deductibles, coinsurance, and copays.

_____ _____
Initials Date

EAP (EMPLOYEE ASSISTANCE PROGRAM) POLICY

I understand that if I am entitled to benefits through an Employee Assistance Program, I must present the billing information and the authorization number for that benefit **at my first appointment**. If, during the course of my treatment, I find out that I was entitled to an EAP benefit that I was unaware of, Responsive Centers will begin billing my EAP with the **next session**, provided I have obtained an authorization, and regardless of the beginning date of that authorization.

_____ _____
Initials Date

NO SHOW/LATE CANCELLATION POLICY

I understand that I will be charged for a missed appointment, or if I cancel an appointment less than 24 hours in advance. **Responsive Centers does not make reminder calls to clients prior to their scheduled appointments**. These fees must be paid at the time of the next appointment.

_____ _____
Initials Date

I have read and understand all of the above policies.

_____ _____ _____
Printed Name Signature Date

Responsive Centers for Psychology and Learning

Name of Client:	**Name of Therapist/Clinician:**
PRIMARY INSURANCE INFORMATION	
Primary Policyholder is: ☐ Father ☐ Mother ☐ Neither	
If NEITHER, please complete the following information about the primary policyholder:	
Primary Policyholder's Last Name: First Name: MI: Birth Date: Social Security #:	
Street Address: City: State: Zip:	
Home Phone: Cell Phone: Work Phone: Relationship to Client:	
Please complete the following <u>only</u> if you are unable to supply a copy of your card:	
Primary Insurance Company Name: ID#: Group #: Phone #:	
Street Address: City: State: Zip:	
SECONDARY INSURANCE INFORMATION (if applicable)	
Secondary Policyholder is: ☐ Father ☐ Mother ☐ Neither	
If NEITHER, please complete the following information about the secondary policyholder:	
Secondary Policyholder's Last Name: First Name: MI: Birth Date: Social Security #:	
Street Address: City: State: Zip:	
Home Phone: Cell Phone: Work Phone: Relationship to Client:	
Please complete the following <u>only</u> if you are unable to supply a copy of your card:	
Secondary Insurance Company Name: ID#: Group #: Phone #:	
Street Address: City: State: Zip:	

Responsive Centers for Psychology and Learning

CONSENT FOR TREATMENT — ADOLESCENT

Welcome to our practice. Please read this document carefully and note any questions you might have so you and your clinician can discuss them. ***Once you sign this, it will constitute a binding agreement between us.***

NOTICE OF PRIVACY PRACTICES

By signing this agreement, you and your parent/guardian consent to the use of your personal health information for purposes of treatment, payment, or health care planning, according to the **Notice of Privacy Practices** posted on the Responsive Centers' website and provided at the Responsive Centers' office.

WHAT YOU CAN EXPECT

The purpose of meeting with a clinician is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life, including school. You may be here because you wanted to talk to a professional about these problems; or, you may be here because your parent/guardian, doctor, or teacher had concerns about you. When you meet with your clinician, you will discuss these problems. After listening to your concerns and asking questions, your clinician will suggest a plan for improving these problems. Sometimes these issues will include things you don't want your parent/guardian to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their clinician. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, the information you share with your clinician in your sessions is confidential, unless you have given your written permission to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information. In some situations, your clinician is required by law or by the guidelines of the profession to disclose information whether or not you give your permission. Some of these situations are listed below:

- You report you plan to cause serious harm or death to yourself, and your clinician believes you have the intent and ability to carry out this threat in the very near future. Steps will be taken to inform a parent/guardian of what you have told the clinician and how serious your clinician believes this threat is. Your clinician must make sure that you are protected from harming yourself.

- You tell your clinician you plan to cause serious harm or death to someone else who can be identified, and your clinician believes you have the intent and ability to carry out this threat in the very near future. In this situation, your parent/guardian must be informed as well as the person who you intend to harm.

- You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, your clinician needs to use professional judgment to decide whether a parent/guardian should be informed.

- You tell your clinician you are being abused physically, sexually, or emotionally, or that you have been abused in the past. In this situation, your clinician is required by law to report the abuse to the Kansas Department of Social and Rehabilitative Services.

- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, your clinician will not disclose information without your written agreement *unless* the court requires it. If your clinician is required to disclose information to the court, you will be informed that this is happening.

COMMUNICATING WITH YOUR PARENT/GUARDIAN

Except for situations such as those mentioned above, your clinician will not tell your parent/guardian specific things you share in therapy sessions. This includes activities and behavior that your parent/guardian would not approve of or would be upset by, but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then your clinician will need to use professional judgment to decide whether you are in serious and immediate danger of being harmed. If your clinician believes that you are in such danger, that information will be communicated to your parent/guardian.

Even if your clinician agreed to keep information confidential, it may be important for your parent/guardian to know what is going on in your life. In these situations, you will be encouraged to tell your parent/guardian and you will be helped to find the best way to tell them. Also, when meeting with your parent/guardian, your clinician may sometimes describe the problems you are discussing in general terms, without using specifics, in order to help them know how to be more helpful to you.

SCHOOL

Information will not be shared with your school unless both you and your parent/guardian provides permission. Sometimes your clinician may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for your clinician to give suggestions to your teacher or counselor at school. A very unlikely situation might come up in which your clinician may not have your permission, but both your clinician and your parent/guardian believe that it is very important to be able to share certain information with someone at your school. In this situation, your clinician will use professional judgment to decide whether to share any information.

DOCTORS

Sometimes your doctor and clinician may need to work together; for example, if you need to take medication in addition to seeing a clinician. Your clinician will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time information will be shared with your doctor, even without your permission, is if you are doing something that puts you at risk for serious and immediate physical harm.

REQUIRED SIGNATURES

We have read the above information and understand its contents. We give our full consent for treatment. By signing this document, we are also claiming we have the legal right to do so. We have had the opportunity to read and obtain a copy of the Notice of Privacy Practices either at the office or on the website.

Adolescent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Witness: _____ Date: _____

BIOGRAPHICAL INFORMATION

This information is to help your clinician/therapist prepare for your visit and to facilitate treatment planning.

Adolescent's Name: **Nickname:** **Date of Birth:** **Age:**

PRESENTING PROBLEMS

What concerns or problems, including symptoms, convinced you to seek help for your adolescent now?

On the scale below, please check the severity of the problem(s):

☐ Mildly upsetting ☐ Moderately severe ☐ Very severe ☐ Extremely severe ☐ Incapacitating

How long has this been a problem? Has your adolescent been treated for this problem before?

If yes, who treated your adolescent?

FAMILY INFORMATION

Mother's Name:

Father's Name:

Marital Status of Parents: ☐ Married to each other ☐ Remarried ☐ Divorced ☐ Separated ☐ Significant other

If parents are separated or divorced, which parent has legal authority for health care decisions?

Names and ages of siblings:

Others living in the home:

If parents are divorced or separated, please provide the current custody arrangements:

BIOGRAPHICAL INFORMATION (cont'd)

EDUCATIONAL HISTORY

Special education or special needs: ☐ Yes ☐ No If yes, please explain:

Has your adolescent ever had psychological and/or educational testing: ☐ Yes ☐ No If yes, please summarize the results:

Does your adolescent have an Individual Education Plan or 504 Plan in place? ☐ Yes ☐ No

Is your adolescent frequently absent from school? ☐ Yes ☐ No If yes, please explain:

How would you describe school behavior, grades, and progress?

MEDICAL HISTORY

Primary Care Physician: Date of last physical exam:

Medical problems your adolescent is being treated for currently:

Allergies:

Current Medications:

PSYCHIATRIC HISTORY

Previous mental health treatment: ☐ Yes ☐ No Level of care? ☐ Inpatient ☐ Partial hospital ☐ Outpatient

Reason for treatment:

Treating clinician(s)' name(s):

Has your adolescent ever attempted suicide? ☐ Yes ☐ No If yes, when:

Is your adolescent currently having suicidal ideation? ☐ Yes ☐ No ☐ Don't know

Does your adolescent have a plan? ☐ Yes ☐ No ☐ Don't know

Family history of psychiatric problems. Describe:

BIOGRAPHICAL INFORMATION (cont'd)

ALCOHOL/DRUG USE/ABUSE

Family member(s) abuse? ☐ Yes ☐ No If yes, who?

LEGAL HISTORY

Has your adolescent ever been arrested? ☐ Yes ☐ No If yes, for what reason and at what age?

SOCIAL HISTORY

Is your adolescent able to make friends? ☐ Yes ☐ No

Is your adolescent able to maintain friendships for over a year? ☐ Yes ☐ No

Is your adolescent frequently bullied or severely teased? ☐ Yes ☐ No ☐ Don't know

Is your adolescent sexually active? ☐ Yes ☐ No ☐ Don't know

If your adolescent is sexually active, is he/she using protection? ☐ Yes ☐ No ☐ Don't know

RELIGION

How strong are your family's religious beliefs or practices? ☐ Very strong ☐ Moderate ☐ Not strong ☐ Not Applicable

CLIENT'S RIGHTS AND RESPONSIBILITIES

Clients have the right to:

— Be treated with professionalism and respect
— Confidentiality (see Notice of Privacy Rights)
— Receive explanations about office procedures, or answers to any questions you may have
— Participate in decisions regarding your treatment plan
— Consent to or refuse any treatment

Clients have the responsibility to:

— Provide information needed by the professional staff to care for you
— Keep all scheduled appointments and be on time
— Cancel at least 24 hours in advance if you are unable to keep an appointment
— Pay your fees, deductibles, coinsurance and copays
— Provide insurance information if you wish to use your insurance benefits
— Obtain any authorizations required by your insurance company prior to your visit

EMERGENCY INFORMATION

Last Name: First Name: Relationship to Child:

Home Phone: Cell Phone: Work Phone:

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REPORT TO PRIMARY CARE PHYSICIAN

Please choose ONE of the following:

1. I **AUTHORIZE** Responsive Centers to exchange information with his/her primary care physician: _____
Parent's Signature

Please provide the following information so that we are able to contact your adolescent's physician. A phone book is available in the waiting room for your convenience.

Client's Name:	Client's Date of Birth:
Client's Social Security #:	Authorization # (if applicable):
Physician's Name:	Physician's Phone #:
Physician's Address:	Physician's Fax #:

2. **I DO NOT** authorize Responsive Centers to exchange information with his/her primary care physician: _____
Parent's Signature

FOR OFFICE USE ONLY

This is a(n): Initial Summary Interim Summary Termination Summary

Suggested Diagnoses:

Axis I: _____

Axis II: _____

Psychotropic Medications:

Current psychotropic medications: _____

Please evaluate this client for the appropriateness of medication for the treatment of: _____

Treatment Goals:

_____

_____

Treatment Modalities: ☐ Individual Therapy ☐ Family Therapy ☐ Group Therapy
☐ Psychotropic medication ☐ Referral to community resources: _____

Psychologist/Clinician Signature: _____ Date: _____

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Please complete and return if medication is prescribed or changed or if there are any medical conditions or medications that may be causing or contributing to the client's symptoms of mental disorder.

Medication prescribed: _____ Dose: _____

Medication prescribed: _____ Dose: _____

Physician's Signature: _____ Date: _____