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 — Child

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

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 — CHILD

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 consent to the use of your child's 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.

PSYCHOTHERAPY

Psychotherapy is a very individual matter. It varies depending on the personality of both the clinician and the child and the particular issues that are being addressed. There are a number of different approaches that can be used. Outpatient psychotherapy is voluntary and requires an active effort on the part of your child and the cooperation of the parents. In order to be most successful, work will be required both during sessions and at home.

Psychotherapy has both benefits and risks. Psychotherapy often leads to significant reduction of feelings of distress, better relationships, and resolutions to specific problems. Risks sometimes include experiencing uncomfortable levels of feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. There are no guarantees about results.

By the end of the first few sessions, your clinician will be able to offer you an initial treatment plan for your child. You should evaluate this information, along with your own assessment about whether you feel comfortable continuing. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the clinician you select. As the parent of the client, you have the right to discontinue counseling at any time.

SESSIONS

If psychotherapy is initiated, 45-50 minute meetings will be scheduled at mutually agreed upon times, depending on your child's ability to participate. ***Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation (unless you and your clinician agree your child was unable to attend due to circumstances beyond your control).*** Missed appointments are not insurance reimbursable and must be paid for by the responsible party.

Your clinician will be happy to discuss session fees with you. You are expected to pay all copays at the time of each session. In addition to your appointments, we charge on a prorated basis for other professional services that are not insurance reimbursable, such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings, or consultations with other professionals that you have authorized or requested, preparation of records or treatment summaries, and/or the time required to perform any other services which you may request of your clinician.

CONFIDENTIALITY

Children represent a special circumstance with regard to confidentiality. Although parents have the right to full disclosure of the content of their child's therapy sessions, it is difficult to create and maintain a therapeutic relationship if the child believes what is said will be reported to the parents. For that reason, we ask that parents waive the right to parental disclosure. The specific information provided by the child will remain confidential, but the clinician will share clinical information that he/she deems appropriate at his/her discretion. As a mandated reporter, your child's clinician must report the following: 1) a serious threat to do harm to self or others, or 2) the report of physical, sexual, or emotional abuse. In some circumstances, such as child custody proceedings and proceedings in which your child's emotional condition is an important element, a judge may require testimony.

INDEPENDENT PRACTICE

Responsive Centers for Psychology and Learning is an association of independently practicing professionals who share certain expenses and administrative functions. While clinicians share a name and office space, they are completely independent in providing your child with clinical services and are fully responsible for those services. Any matters concerning your child's clinical care should be addressed with your child's clinician first. If the matter is not resolved to your satisfaction, you may contact our executive director.

Please note that your child's clinician is not authorized to practice medicine or prescribe medication, but will work closely with your physician to ascertain any medical or biological origins that may impact your child's symptoms.

REQUIRED SIGNATURES

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

Parent'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.

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

PRESENTING PROBLEMS

What concerns or problems, including symptoms, convinced you to seek help for your child 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 child been treated for this problem before?

If yes, who treated your child?

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?

Sibling names and ages:

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

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

Is your child 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 child 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 child ever attempted suicide? ☐ Yes ☐ No If yes, when:

Is your child currently having suicidal ideation? ☐ 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 child ever been arrested? ☐ Yes ☐ No If yes, for what reason and at what age?

SOCIAL HISTORY

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

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

Is your child frequently bullied or severely teased? ☐ 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 initial visit

EMERGENCY INFORMATION

Last Name:	First Name:	Relationship to Child:
Home Phone:	Cell Phone:	Work Phone:

Responsive Centers for Psychology and Learning

REPORT TO PRIMARY CARE PHYSICIAN

Please choose ONE of the following:

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

Please provide the following information so that we are able to contact your child'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 my child's primary care physician: _____
Parents'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: _____