KATZ COUNSELING & EDUCATIONAL PSYCHOLOGY, INC.

12641 World Plaza Lane, Building 56
Fort Myers, FL 33907
Tel: 239-247-1756 **Fax:** 239-690-2438 (fax)
www.katzpsychology.com

Informed Consent

I _____ voluntarily give my consent to Katz Counseling and Educational Psychology for the purposes of providing psychological and mental health services. (*If applicable:* This consent also includes psychological and mental health services for my child/children _____). These services may include but are not limited to: psychological assessment, counseling, consultation, parent training, and study skills enhancement. I understand that psychological and mental health services are confidential with the exception of the following scenarios: (A) knowledge or reasonable suspicion of harm to self or others, (B) knowledge or reasonable suspicion of child or elder abuse, and (C) court order of information regarding your case. I understand that if an individual accompanies me to my session(s), I am consenting to their participation in my services, including the sharing of my protected health information. I understand that if my child(ren), family members or other individuals participate in services with me, they may have rights to privacy and my access to their disclosures may be limited. Additionally, it is understood that minor children or dependents benefit therapeutically from privacy being respected by their parents or guardians. As such, the provider reserves the right to provide a treatment summary in lieu of extensive progress notes to assist with maintaining therapeutic rapport and alliance with the minor child or dependent adult client. If applicable, I agree to make a reasonable attempt to obtain consent for services from any and all medical decision making parent(s)/guardian(s) regarding the individual clients' services.

Psychological and mental health services are intended to be beneficial in the improvement of mental health or academic concerns; however, none of these benefits are guaranteed. You may disagree with the opinions offered to you and emotional distress may result from sensitive matters which are addressed during the course of psychological services. Alternative referrals to another health care provider will be given if desired.

Katz Counseling and Educational Psychology provides only outpatient mental health services and does not guarantee emergency intervention, particularly if it is necessary after business hours. If you should require emergency services after business hours, please call 911 or SalusCare (239) 275-3222.

By signing below, I confirm that I have read this form in its entirety or it was read to me, and I understood and agree with the information included in it. I have no additional questions and I have clarified any information with which I disagree. I concur that my consent is voluntary and can be revoked at any time.

_____
Name of client

_____ _____
Signature of adult client or parent/guardian of client Date

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Patient Consent for Use and Disclosure
of Protected Health Information (HIPAA Acknowledgement)

I hereby give my consent for Katz Counseling & Educational Psychology to use and disclose protected health information (PHI) about me to carry out psychological services (evaluation or treatment), payment and health care operations (TPO). (The Notice of Privacy Practices-Updated 9/23/13 provided by Katz Counseling & Educational Psychology describes such uses and disclosures more completely.) Any uses or disclosures of personal information not described in this Privacy Notice require a signed Authorization before PHI can be released. We are required to provide notification if there is a breach of insecure PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Katz Counseling & Educational Psychology reserves the right to revise its Notice of Privacy Practices at any time. An up-to-date Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Sheba Katz (239) 247-1756.

With this consent, Katz Counseling & Educational Psychology may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, Katz Counseling & Educational Psychology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, services availability and patient billing statements and medical records.

With this consent, Katz Counseling & Educational Psychology may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, , such as appointment reminder cards, services availability and patient billing statements and medical records. I have the right to request that Katz Counseling & Educational Psychology restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Katz Counseling & Educational Psychology to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Katz Counseling & Educational Psychology may decline to provide services to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian, if applicable

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Financial Responsibility and Guarantee of Payment for Services

We are glad that you have chosen Katz Counseling and Educational Psychology (KCEP) to work with you or your family. We hope that you find your experience with us helpful. The aim of this notice is to clarify the financial arrangements before services begin.

By signing below, you agree to be charged for direct and indirect services that we provide. Direct services are face-to-face services, such as psychotherapy, assessment, consultation, and observation. Indirect services, are services that are provided when the client is not physically present, which may include but are not limited to: review of records, school visits, collaboration between providers, advocacy, test scoring and interpretation, documentation, report writing, and phone calls. While some of these services are covered by insurance, others may not be deemed as medically necessary. Specifically, services designed to inform legal, educational or vocational needs may be outside the scope of medical insurance coverage. Additionally, insurance often has standard time allocations for services and may not cover extended professional time given to provide high-quality, comprehensive services. When insurance does not cover a service, you will be billed at the standard (45-55 minute) rate of $200/Hour. However, if eligible, a sliding scale rate based on income can also be calculated.

The standard forensic hourly rate is $250 which may include, but is not limited to, court-involved or court-ordered psychological services, consultation with attorneys, producing reports or summaries for the courts, preparation for court, depositions and court testimony. If at any time your case becomes court-involved, or for use in legal proceedings, your fee will be switched to the forensic rate and cannot be billed to insurance by the practice.

Assessment services involve billing for actual hours spent testing and time spent scoring, interpreting, and writing up results. **A brief summary of the results of testing is included in evaluation fees; however, a comprehensive report can be prepared at the cost of the hourly rate. Comprehensive reports generally require between 3 to 6 hours and insurance companies may not cover this service.**

Appointments are specifically held for the client and it is important that you give a 24 hour notice if you intend to cancel or not attend. If we do not receive notification within that time frame, we will charge you a $100 per hour fee for the late cancellation or no show. Additionally, if two doctors' time has been reserved for the appointment a $200 per hour fee will be applied. This cannot be billed to insurance. For returned checks, you are expected to pay the bank fee and the full charge for those services in cash or cashier's check. Client will be responsible for all costs of collections.

By signing this form, you are also consenting to allow KCEP to contact your insurance company regarding payment for services. It is your responsibility to understand your insurance plan. Any precertification which is required by your insurance company must be done prior to your appointment. The precertification for services should be submitted to Katz Counseling and Educational Psychology before services are rendered. ***It is difficult to understand all of the caveats of each insurance***

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company and you will be responsible for payments which are <u>not</u> covered by your insurance company. Any issues with reimbursement are the responsibility of the client, not Katz Counseling and Educational Psychology.

Please provide the credit card information below. ***We do not accept American Express***:

VISA MASTERCARD DISCOVER

Full name on card _____

Credit Card #_____

Expiration Date_____ Security Code _____

If we are in-network with your insurance and your carrier does not pay within 30 days and you are notified by phone/email, you will be given an additional 10 days to settle the balance. If not, your card will be automatically charged for the unpaid balance.

If you are a self-paying client, your card will be automatically charged for any unpaid balance after services are rendered.

By signing below, you authorize Katz Counseling and Educational Psychology to charge your card for any unpaid balance after services have been rendered.

_____
Name of client

_____ _____
Signature of adult client or parent/guardian of client Date

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Child Client Information Form

Full Name:

Primary Address: (street/city/state/zip):

DOB: Age: Grade: SS#: Right or Left Handed

Relationship to Primary Insured:

Name of Pediatrician: Phone#:

Days/Times that you are available for an appointment:

How did you hear about us?

Reason for Referral:

Mother's Name	**Father's Name**
Address:	Address:
City/State/Zip:	City/State/Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Email address:	Email address:
Occupation:	Occupation:

Who does client live with (parent(s), grandparent(s), etc.)?

Name & Age of Siblings:

Insurance Information - Primary

Insurance Company: Insurance Phone Number:

Subscriber's Name: Subscriber's Birthdate:

Subscriber's Social Security # Subscriber's Employer:

Subscriber's Address:

Member ID# Group#

Insurance Information for Secondary Insurance (if applicable)

Insurance Company: Insurance Phone Number:

Subscriber's Name: Subscriber's Birthdate:

Subscriber's Social Security # Subscriber's Employer:

Subscriber's Address:

Member ID# Group#

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Child/Adolescent Background History

Name of Child	
Parent's Names	
Guardian's Names (if different)	
Who completed this form?	
Birthdate	
Age	
Date of Appointment	
School	
Grade	
Gender	
Ethnicity	
Languages spoken in Home	

What behaviors is your child struggling with most?

What are your child's strengths?

Please describe any life changes that could be affecting your child:

Social History:

Birthplace (city, state, country): _____

Please list places your child has lived:

Location	Dates or Ages

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Please list your child's sisters and brothers (half, step, biological, foster, adoptive, etc.):

Name	Age/Grade	Learning problems?	Mental Health difficulties?	Relationship?
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good

Who currently lives in the family home?

Relationship with Father: N/A Poor Fair Good

Relationship with Mother: N/A Poor Fair Good

Biological Father's Job: Biological Mother's Job:

Are the child's parents married? Yes No Never Married

If No, are they divorced or separated? Yes No If yes, When?

Has the father remarried? Yes No If so, When?

Has the mother remarried? Yes No If so, When?

If divorced or separated please describe current parenting plan and relationship status of both parents.

Parent Time with Father: Frequency: Length of Visits:

Parent Time with Mother Frequency: Length of Visits:

Does the child have step-parents? Yes No Names:

Relationship with Step-Father: N/A Poor Fair Good

Relationship with Step-Mother: N/A Poor Fair Good

Step-Father's Job: Step-Mother's Job:

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Circle any of the following that have been present in your child's immediate/extended family members:

Heart Disease/Attack	Stroke	Cancer	Intellectual Impairment
Learning Problems	Anxiety	Depression	Social Difficulties
ADHD	Autism/Asperger's	Alcoholism	Drug Addiction/Abuse
Bipolar Disorder	Personality Disorders	Jail/Prison	Probation
Suicide	Extended Unemployment	Eating Disorder	Developmental Delays
Tic Disorders	OCD	Schizophrenia	PTSD
Sleep Disorders	Sexual Disorders		

Does your child attend a religious organization regularly? Yes No Where

Do you have friends or family that provide your family emotional support? Yes No

Is there enough food to eat in your home? Yes Sometimes No

Has your child ever been in trouble with the law/juvenile services? Yes No

If so, please list offenses and outcome

Who is in charge of discipline in the home?

Do all caregivers agree on discipline procedures in the home? Yes No

Describe discipline strategies that are used:

What are your child's chores and responsibilities?

History of Trauma (circle all that apply):

Serious Illness in Family	Serious Illness in Child	Poverty
Homeless	Multiple Caregivers	Foster Care/Adopted
Unsafe Neighborhood	Exposure to Domestic Violence	Child Abuse/Neglect
Emotional Abuse	Sexual Abuse	Attempted Sexual Assault
Victim of Violence	Attempted Physical Assault	Threatened with Violence
Threatened with a Weapon	Been afraid for your life	Victim of a Crime

Have the child's parents or guardians ever been on probation? Yes No

Have the parents or guardians ever served time in jail or prison? Yes No

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Has the Department of Children & Families (DCF) ever been involved with your family?

Yes No If yes, Explain:

Has the child ever lived outside of the home? Yes No

Explain:

What does your child do for fun?

Please circle any of the following mental health symptoms that your child <u>often</u> struggles with:

Irritable	Sad most of the day	Excessively nervous	Difficulty separating from parents
Poor attention to detail	Paying attention for long periods	Poor organization	Easily distracted
Does not listen when spoken to directly	Fails to finish work	Often loses things	Forgetful
Loss of interest in normally enjoyable activities	Refuses to attend school	Frequent mood changes	Purposefully injures self or cutting self
Mistrustful of others	Defiant	Low self-esteem	Sleeps with parents
Test anxiety	Impulsive	Social anxiety	Strong beliefs that are unsupported by reality
Sees or hears things that are not present	Talks about suicide	Unemotional	Obsessions
Lack of remorse	Suicide attempt	Phobia with _____	
Fidgets	Restless	Physical aggression	Verbal aggression
Argues with adults	Cruel to animals	Steals	Hyper
Sexually inappropriate	Trespassing	Interrupts others	Leaves house without parent permission
Runs away from home over night	Ritual/unusual routines	Difficulty remaining quiet	Hostile
Excess spending	Risky or illegal behavior	Talks excessively	Overly dramatic
Anger Management	Poor coping	Inflated self-esteem	Blames others for their mistakes
Lying	Anxious	Bizarre thinking	Procrastination
Panic Attacks	Hoarding	Lacks Motivation	Withdrawn
Breaks things when angry	Temper tantrums	Easily frustrated	Too negative

Circle any of the following harmful eating behaviors that your child struggles with:

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Refuses to eat in front of others	Induces vomiting after meals	Overly restrictive diet	Exercises right after meals
Uses diuretics/diet pills	Purposefully fasts	Binge eats	Overly picky eater

Circle any of the following social skills which are difficult for your child:

Eye contact when not in trouble	Does not initiate interactions with peers	Lack of desire to share enjoyment in activities	Does not understand give and take of social relationships
Lacks empathy	Does not take turns	Accepting criticism	Bossy
Inappropriate comments	Lack of age-appropriate pretend/make believe	Does not share	Bragging
Unable to hold conversations	Overly shy	Inflexible with routines/rules	Difficulty adjusting to change
Few close friends	Overly affectionate with strangers	Difficulty forming attachments with caregivers	Does not seek comfort when upset
Difficulties with social chit-chat	Bullies or taunts others	Misinterprets others' intentions	Unusual/immature interests for age

Circle any communication difficulties which affect your child:

Not using eye contact to interact with others	Problems reading facial expressions	Using nonverbal gestures to convey meaning	Difficulty expressing self effectively
Stutters	Facial expressions don't match their emotions	Speaks in an odd voice	Speaks too loud
Speaks too softly	Invades personal space	Difficulty with pronunciation	Verbal tics
Does not speak in everyday situations	Unusual rate of speech	Uses words that have no meaning	Curses excessively
Talks too much	Talks too little	Yelling	

Circle any sensory difficulties that your child struggles with:

Waves hands in front of face	Refuses to eat foods with certain textures	Rocks while seated	Twisting or ringing hands
Looks at things too closely	Often looks at things out of the corner of their eye	Overly sensitive to loud noises	Under-responsive to loud noises

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Motor tics	Refuses to wear certain fabrics	Only eats certain foods	Preoccupied with lights or parts of objects

Does your child make and maintain friendships easily? Yes No

If no, please explain:

Does your child often spend time with friends outside of school? Yes No

Quality of Relationships with Peers: Poor Fair Good

Developmental History:

Was your child's pregnancy normal? Yes No

Was your child's delivery normal? Yes No

If no, explain complication?

Premature	Low Birth Weight	Gestational Diabetes	Jaundice
C-Section	Mom drank alcohol	Mom smoked	Mom used illegal drugs

Number of days in hospital following birth?

When did your child reach the following developmental milestones (circle answer)?

Motor: On time Delayed Toilet training: On time Delayed

Speech/Language: On time Delayed

Describe any unusual development:

Was the pediatrician concerned with any of your child's development? Yes No

Please describe:

Infant Temperament (circle all that apply): Easy to Soothe Withdrawn

Under-responsive Fussy Difficult to Soothe Happy

Is your child's vision normal? Yes No

If no, what type of corrective lenses do they use?

Is your child's hearing normal? Yes No

If no, what type of corrective device do they use?

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Has your child ever had surgeries? Yes No
If so, please describe.

Has your child ever been hospitalized? Yes No
If so, what happened and when?

Did/Does your child qualify for services through FDLRS or Early Steps? Yes No

Place an "X" next to any medical diagnosis that your child has received:

Medical Disorder	Birth to age 12	As an adolescent
Failure to Thrive		
Broken Bones		
Head Injury		
Concussion		
Seizure/Epilepsy		
Lead Poisoning		
Digestion Issues		
Chronic Stomach Problems		
Chronic Ear Infections		
Genetic disorder		
Asthma		
Meningitis		
Diabetes		
Thyroid condition		
Cancer		
HIV/AIDS		
Other Illness_____		

History of Treatment Services:

Practitioner	*Name/Organization*	*Dates*	*Treatment/Duration*
Psychiatrist			
Pediatric Neurologist			
Occupational Therapist			
Speech Therapist			
Physical Therapist			
Psychologist/Mental Health Services	1. 2.		

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	3.		
Behavioral Therapist (BCBA, ABA)			
Other Specialists			

Circle any of the following that your child often struggles with:

Headaches	Fainting	Seizures	Tension
Heart racing	Chest pains	Excessive sweating	Shallow breathing
Sore throat	Nausea	Eats too much	Eats too little
Stomachaches	Vomiting	Diarrhea	Constipation
Sleeps too little	Sleeps too much	Bed wetting	Bed soiling
Nightmares	Talks in Sleep	Walks in sleep	Night Tremors
Hair pulling	Nail biting/picks skin	Wets self	Soils self
Snoring	Poor sleep quality	Trouble falling asleep	Trouble staying asleep

Circle any motor difficulties that your child has/had:

Clumsiness	Awkward gait	Poor fine motor	Difficulty learning to ride a bike
Difficulty throwing or catching	Difficulty skipping	Not athletic	Difficulty coordinating movements
Poor Handwriting	Trouble learning to tie shoes	Poor balance	Poor muscle tone

For Females (as assigned at birth) Only:

At what age did your child's first period begin? _____

Does your child suffer from significant changes in mood before or around your period? Yes No

Has your child ever been diagnosed with Premenstrual Dysphoric Disorder (PMDD)? Yes No

Mental Health History

Has your child previously been psychologically evaluated? Yes No

Was this evaluation done through school or privately? School Private

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Circle any mental health disorder with which your child has been diagnosed:

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Impairment	Substance Abuse	Autism/Asperger's
Manic	Oppositional Defiant	Attachment issues	Tic Disorder
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Sleep Disorder	Speech/Language Issues	Developmental Delays	Eating Disorder
Gender Identity	Sexual Disorder	PTSD	
Other			

Has your child ever received inpatient mental health services? Yes No

Has your child ever threatened suicide? Yes No Has your child ever attempted suicide? Yes No

Has your child ever been baker acted? Yes No If yes, How many times?_____

If yes, Facility/Dates:

Please list any previous medications:

Please list any current medications:

Educational History:

Did your child attend Preschool? Yes No If so, where? _____

What is your child's current grade? _____

Please list the schools that your child attended since kindergarten:

School	City and State	Grade

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Circle how well your student typically does in each of the following subjects:

Math	D or F	C	B	A
Language Arts	D or F	C	B	A
Social Studies	D or F	C	B	A
Science	D or F	C	B	A
Art	D or F	C	B	A
Gym/PE	D or F	C	B	A

Circle any of the following which have been problematic for your child over the past year:

Failing grades	Detention	Suspension	Expulsion
Physical fights	Bullying others	Victim of bullying	Refuses to do homework
Drugs	Alcohol	Skipping school	Conflict w/teachers
Off-task behavior in class	Cigarettes	School refusal	School/Test Anxiety
Poor School Attendance	Several Changes of School times	Forgets Homework	Loses Planner

Has your child ever been retained in or repeated a grade? Yes No

If so, what grade(s)?

Has your child ever failed state-wide standardized testing (e.g., FCAT, FSA)? Yes No

Does your child have an individual education plan (IEP)? YesNo

Does your child have a 504 plan? Yes No

If so, circle all classifications/disabilities that apply:

Reading learning disability	Math learning disability	Writing learning disability	Speech/Language impaired
Hearing impaired	Visually impaired	Emotional disturbance	Intellectual Impairment
Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other Health Impairment
Physical Therapy Impairment	Occupational Therapy Impairment	Developmental Delay	Hospital/Homebound

What special services or accommodations do they receive at School? Mark all that apply.

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments

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Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

Has your child started the Response to Intervention (RTI) or Multi-Tiered Systems of Support (MTSS) process? Yes No

If so, which tier is he/she in? Tier I Tier II Tier III

What current intervention is being used?

What after school activities does your child participate in?

Future Educational/Career Goals:

<u>If Applicable, complete:</u>

Is your son/daughter dating? Yes No

Is your child sexually active? Yes No Don't Know

Do you have concerns about internet use or abuse? Yes No

Do you have any concerns about video game addiction? Yes No

To the best of your knowledge, does your child use any of the following?

Alcohol, PCP (angel dust), marijuana, amphetamines (speed), cocaine, crack cocaine, sleeping pills, hallucinogens (acid, mushrooms), ecstasy, methamphetamine (meth), opium, heroin, pain killers

Last used: