Initial Child & Adolescent Intake

CLIENT INFO	PARENT INFO
Child's Full Name:____________________________ DOB: ________/________/_________ SSN:____ Address:_____________________________________ City:________________ State:______ Zip:_________ Current School:______________________________ Current Grade:_______________________________	Parent/Guardian Name:_____________________ Phone: ______________________________ Email:______________________________ Address:_____________________________________ City:________________ State:______ Zip:_________ Parent/Guardian Name:_____________________ Phone: ______________________________ Email:______________________________ Address:_____________________________________ City:________________ State:______ Zip:_________
EMERGENCY CONTACT INFO	
Emergency Contact:__________________________ Phone:_____________________________ Permission to contact this person in emergency: _______ (initial)	

HEALTH & MEDICAL
Primary Care Physician: ____________________________________Phone: ________________________ Address: ____ Date of last physical:______________________________ Please list any medical problems: ____ ____ ____ Please list any current medications: ____ ____ ____

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100 Cummings Center, Suite 325-A, Beverly, MA 01915
https://www.lauradichiapparilmft.com
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What is happening in your child's life that causes you to seek treatment now?

____
____
____
____

What do you hope your child to get out of treatment?

____
____
____
____

Please respond to each of the following with a checkmark (√) where applicable

History of:	My Child	My Family	Comments
Alcoholism			
Drug abuse/addiction			
Physical abuse			
Sexual abuse			
Trauma			
Violent behavior			
Suicide attempts/ideation			
Depression			
Anxiety			
Eating disorder			
Other psychiatric condition			

Additional information or comments that you feel may be of importance:

____
____
____
____

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Developmental & Medical History

Birth History

Delivery: Vaginal _____ Breech _____ Cesarean _____

Full-term _____ Premature _____ if premature, number of weeks _____

Birth Weight: __________

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc):____
____

Developmental History

If you can recall it, record the age at which your child reached the following developmental milestones:

Motor Development	**Early**	**At normal time**	**Late**
Good head control			
Rolled over			
Crawled			
Stood without support			
Walked without assistance			
Ran			
Showed hand preference			
Tied Shoelaces			
Language Development			
Babbled			
Pointed to request			
Said first words			
Self Care			
Bowel trained			
Bladder trained			

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Has your child received any services, such as physical, speech/language therapies or early intervention services? If so, please list:

____
____
____
____

Medical History

Indicate if you child has had the following by circling Yes or No.

Hearing problems……………….Y / N

Vision problems………………....Y / N

Allergies………………………….Y / N
To what?____

Headaches………………………Y / N

Serious head injury……………..Y / N

Surgery?..................................Y / N
Reason?____

Hospitalization…………………..Y / N
Reason?____

Any significant mental health, medical history or additional information:__________________
____
____
____
____

______________________ ____________
Parent/Guardian Signature Date

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Insurance Assignment, Release and Authorization

Insurance information: (*please give your insurance card to be copied*)

Primary insurance:___________________________________

Subscriber's Name:_______________________________ Subscriber's Date of Birth:_________

Address:______________________________________ City:______________ State:_________

Employer:____

POLICY Number:________________________________ GROUP Number:______________

Client's relationship to subscriber:___________________

Authorization/Referral Required: ___ Yes ___ No ___ Unknown

Co-pay Amount: _______

Insurance Assignment, Release and Authorization:

I hereby authorize the release of the Protected Health Information; including any/all medical records relating to my/my child's mental health treatment, to the insurance company indicated above. I further agree and acknowledge that my signature on this document authorizes Laura DiChiappari, LMFT to submit claims for payment of services rendered without obtaining my signature for every claim. I understand and agree I will be bound by this signature as though I had personally signed each claim. I hereby authorize the insurance indicated above the authorization to speak with and provide payment directly to Laura DiChiapppari, LMFT. I further acknowledge that any insurance benefits paid to Laura DiChiappari, LMFT will be credited to my account in accordance with the above assignment. I understand providing insurance information is not a guarantee of my coverage. I am responsible for payment, in full, of all session fees or other service fees incurred by myself or my minor child.

____ ____________________________

Client/Parent Signature Date Printed Name

Memorandum of Informed Consent

The purpose of informed consent is to make sure that clients are aware of important features of the law and of the therapist's office policies. Written informed consent ensures (1) that the client has been made aware of all such policies and (2) that he/she is made aware of them during the initial period of client evaluation (i.e., within the first two or three sessions).

Fees

The fee for each session is per clinical hour (45 – 50 minutes). I accept Blue Cross Blue Shield, Tufts, Cigna, United Behavioral Health, Harvard Pilgrim and Compsych Insurance Carriers. If you do not have insurance, a sliding scale may be used in some circumstances. Cash or check are acceptable forms of payment. Please make checks payable to "Laura DiChiappari."

If for any reason you need to cancel an appointment I ask that you call me 24 hours in advance so that I may fill your time slot. If I do not receive 24 hour notice you may be billed for the missed hour in the amount of $75.00.

Office Coverage

Office hours vary on a weekly basis. I check my voicemail daily, even when I am not in the office. However, it is strongly recommended that in an emergency the client call 911 or go directly to the nearest emergency room.

I may take vacations during the year. I will provide you with reasonable notice of any upcoming vacations and will make reasonable efforts to find coverage in the event that I am not available, in case of emergencies.

Snow is an expectation during winter months in New England. I will call you if I need to reschedule because of snow. Please do not hesitate to call or e-mail if you are not sure whether I will be in the office.

Confidentiality

Confidentiality is one of the most important elements of therapy and provides important rights to the client. Federal regulations known as HIPAA require that you be provided with a notice of how your Protected Health Information (PHI) will be handled. This is addressed in a separate document for your review and signature.

Please let me know if you have any questions about any of the above policies, and I will do my best to answer them.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that my identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable laws and ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with regards to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request, or by providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Without Your Authorization: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use of disclosure in a category will be listed. However, all the ways I am permitted to use and disclose information will fall within one of the following categories.

A. For Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services in my practice. For example, information obtained by a nurse, physician, or other member of your health care treatment team will be recorded in your record and used to determine the course of treatment for you. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant or health care provider only with your authorization.

B. For Payment: I may use and disclose PHI so that I can receive payment from you and your insurance company or a third party, for the services I have provided to you. For example, I may need to give your health care plan information about treatment you received from our clinic so your health plan will pay me or reimburse you for the treatment. I may also tell your health plan about a treatment you are going to receive in order to obtain prior approval for the service. The information disclosed will be limited to the nature of services provided, the dates of services, the amount due and other relevant financial information. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum about of PHI necessary for the purposes of collection.

C. For Health Care Operations: I may use or disclose your PHI for health care operations. This use and disclosures are necessary to run my practice and make sure that all of my clients receive quality care. For example, I may use medical information to review my treatment and services and to evaluate the performance of my staff in caring for you. For employee training or teaching purposes PHI will be disclosed only with your authorization.

D. Judicial and Administrative Proceedings: In any judicial proceeding, you have the right to refuse to authorize the disclosure of any communication between you and a therapist relating to your care and treatment. There are a few instances in which this privilege would not apply, and therefore, with which I could testify in the judicial or administrative proceeding. Specifically, I may disclose such communications during judicial or administrative proceedings, if (1) I determine that you need hospitalization or are a threat to yourself or to

others; (II) the communications were made in the course of a court-ordered psychiatric examination; (III) you are a party to a case and you have introduced your mental or emotional state as an element of a claim or defense; (IV) if the testimony is given in connection with a care and protection proceeding, or a petition to dispense with parental consent to adoption; (V) in connection with any malpractice action brought by you against me, where the disclosure is necessary for my defense; (VI) if the communications relate to your ability to provide care or custody in a child custody or adoption case; (VII) if the communication were made in connection with or during an investigation of allegations of child abuse, when I have made a reported that I have reasonable cause to believe that child abuse is occurring; or (VIII) if I believe a child, a disabled person, or an elderly person in your care is suffering abuse or neglect.

E. In an Emergency: I may disclose your PHI to a physician who requests such records in the treatment of a medical or psychiatric emergency. For example, if you are unconscious and the doctor treating you needs to know details regarding your medical history in order to decide on a course of treatment for you, I would disclose the PHI necessary for the doctor to treat you during this emergency. If it is not possible to obtain your consent to this disclosure, then notice of the disclosure will be provided to you as soon as possible.

F. As Required by Law: I may disclose your PHI as required by law, such as the mandatory reporting of child abuse or neglect, or mandatory government agency audits or investigations.

G. If Required by a Court Order: I may disclose your PHI in a judicial proceeding if required by court order.

H. If Necessary Because of Threat to Health or Safety: I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. I may use or disclose your PHI to the extent which is necessary to protect your safety or the safety of others, if (I) you present a clear and present danger to yourself or (II) you have communicated an explicit threat to kill or inflict serious bodily injury upon another person, and there is a basis for reasonable belief that the threat may be carried out. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization.

Revocation of Authorization: If you provide me with permission to disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your authorization, I will no longer use or disclose medical information about you for the purposes covered by the written authorization. However, I am unable to take back any disclosures that I have already made with your authorization.

Your Rights Regarding your PHI:
You, or your authorized representative, have the following rights regarding PHI that I maintain about you. To exercise any of these rights, please submit your request in writing to me at the above address.

- Right of Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would be reasonably likely to endanger the life or physical safety of you or another person. I may charge a reasonable, cost-based fee for copies. I will act on your request within thirty days of receiving your request.

- Right to Amend: If you feel that the PHI I have about you is incorrect of incomplete, you may ask me in writing to amend the information although I am not required to agree to the amendment.

- <u>Right to an Accounting of Disclosures:</u> You have the right to request an accounting of the disclosures that I make of your PHI. This is a list of certain disclosures I have made of your PHI. To make this request, you should submit it in writing.

- <u>Right to Request Restrictions:</u> You have the right to request a restriction or limitation on the medical information I use or disclose about your for treatment, payment, or health care operations. For example, you may request that particularly sensitive information (such as the existence of drug dependence) not be disclosed for any purpose. I am not required to agree with your request. To request restrictions you must submit your request in writing to me. In your request you must tell me (I) what information you want to limit; (II) whether you want to limit the use, disclosure, or both, and (III) to whom you want the limits to apply (for example, disclosures to your insurance carrier).

- <u>Right to Request Confidential Communication:</u> You have the right to request that I communicate with you about medical matters in a certain way or at a certain location (for example, you can ask that I only contact you at work or by mail).

- <u>Right to a copy of this Notice:</u> You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

IF YOU HAVE ANY OTHER QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT ME AT THE ABOVE TELEPHONE NUMBER/ADDRESS.

<u>Complaints:</u>

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Manager, myself, or with the

Office of Civil Rights
U.S. Department of Health and Human Services
Government Center
J.F. Kennedy Federal Building Room 1875
Boston, Massachusetts, 02203.
Voice phone (617) 565-1340.
Fax (617) 565-3809.
TDD (617) 565-1343.

I will not retaliate against you for filing a complaint.

The effective date of this notice is August 1, 2008.

I have received and reviewed the following documents and
I understand and agree with its terms and conditions:

_____ Memorandum of Informed Consent

_____ Notice of Privacy Practices

Client/Parent Signature ___________________________ Date______________

Print your name ______________________________

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