Jennifer White-Baughan Ph.D ., Psychologist
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Therapy Consent, Policies & Agreement

PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaborative identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 60-120 minutes depending upon the nature of the treatment modality. It is difficult to initially predict how many sessions will be needed but EMDR is most often 8-10 sessions. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur for the most efficient treatment outcome.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment within 24 of the scheduled appointment time or you will be charged full fee for the sessions.***

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If you cancel or rescheduled more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time.

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, an associate may contact you to cancel or reschedule an appointment.

FEES: The fee for each 60-minute therapy session is $300. Payment is due at the time of service. Acceptable forms of payment are: exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $ for any returned check), or credit/debit card. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the counseling relationship if more than 2 sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed directly to your account and must be paid at the next scheduled session.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, and you will be charged a fee of 500.00 per hour to include travel time, court time, preparing documents, etc.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $.35 per page and postage. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are from1-6, Monday, Thursday and Friday. If you need to contact the clinician for any reason please call 424-382-7259, leave a voicemail, and a return call will be made within 24-48 hours. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911, The San Francisco Crisis Line at 415-781-0500, or My Life textline 741741.

PART II: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse** - Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse** - Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written

correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.

- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of medical. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive.
- **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the therapeutic relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.**
    - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone.
    - **Do not use e-mail for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.
- **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk.

PART III: REASONS I DO NOT ACCEPT INSURANCE

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you must call the company and justify why you are seeking therapeutic services

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in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed.

- **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the therapist justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.
- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

  1. Denial of insurance when applying for disability or life insurance;
  2. Company (mis)control of information when claims are processed;
  3. Loss of confidentiality due to the increased number of persons handling claims;
  4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
  5. A psychiatric diagnosis can be brought into a court case (ie: divorce court, family law, criminal, etc.).

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couples therapy.

EMERGENCY CONTACT:

It is necessary that **Dr. White-Baughan Ph.D.** has someone to contact on your behalf. In case of an emergency who should we contact?

_____

Full Name Relationship Phone Number(s)

Please check here that you agree and sign below. Thank-you.

☐ I agree to allow **Dr. Jennifer White-Baughan** to contact my emergency contact on my behalf in the case of emergency

_____

Signature Date

PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Dr. White-Baughan**. My signature below indicates that I am voluntarily giving my informed consent to receive psychological services and agree to abide by the agreement and policies listed in this consent. I authorize **Dr. White-Baughan Ph.D.** to provide psychological services that are considered necessary and advisable.

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2. I authorize the **release of treatment and** I acknowledge that I am financially responsible for payment of all services rendered. I understand, in the event that fees are not paid at the time of service, Dr. **Jennifer White-Baughan Ph.D.** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Dr. White-Baughan to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain psychological services for my minor, I will provide the appropriate court documentation to **Dr. White-Baughan** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

*Witness –**DR. Jennifer White-Baughan*** *Date*

** Updated 2/15/18*

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CLIENT COPY

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Dr. White-Baughan**. My signature below indicates that I am voluntarily giving my informed consent to receive psychological services and agree to abide by the agreement and policies listed in this consent. I authorize **Dr. White-Baughan** to provide psychological services that are considered necessary and advisable.

2. I understand, in the event that fees for services are not paid that Dr. White-Baughan may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek psychological treatment for minor(s) in my custody and give permission to Dr. White-Baughan to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain psychological services for my minor, I will provide the appropriate court documentation to Dr. White-Baughan prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

_____

*Witness –**Dr. Jennifer White-Baughan Ph.D.***
Date

** Updated 2/15/18*

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Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

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5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the California Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the California Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

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- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes,

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however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, The California Board of Psychology, the State of California Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Jennifer White-Baughan, Ph.D. Date

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AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

I,_____ **DOB:**_____

hereby give my permission to **Dr. Jennifer White-Baughan Ph.D.**, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released/requested upon request to the following:

To/From: _____

First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * *from **Dr. Jennifer White-Baughan Ph.D.***	**To Be Requested** * *from third parties*
____Treatment Plans	____Treatment Plans
____Process Notes	____Process Notes
____Health/Medical Records (if applicable)	____Health/Medical/Academic Records
____Letter(s) of Progress	____Psychological/Psychiatric Evaluations/Assessments
____Bio Psychosocial Evaluation/Assessment (if applicable)	____Court Documents
__X Verbal Communication	__X Verbal Communication
____Other (Specify): _____	____Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **Dr. White-Baughan Ph.D.**.

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **Dr. White-Baughan Ph.D.** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **Dr. White-Baughan Ph.D.** . **Dr. Jennifer White-Baughan** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **Dr. White-Baughan Ph.D.** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

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Release:

Signature Client/Next of Kin/Guardian **Date**

Clinician Signature/Credentials **Date**

Request:

Signature Client/Next of Kin/Guardian **Date**

Clinician Signature/Credentials **Date**

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424-382-7259

Child and Adolescent Intake Form

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Gender: _____

Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Name of parent(s)/guardian(s) who have legal custody of child (All legal parent(s)/guardian(s) MUST provide written consent for services):

_____

* *Address if parent/guardian lives in another residence:*
Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail?	*YES*	*NO*
Is it ok to send you something in the mail?	*YES*	*NO*

How were you introduced to us? _____
If you found us online what words did you search to find us?

_____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one? Put them in order of importance:

1. _____
2. _____
3. _____

**Updated 4/2018*

What do you think your child would say their biggest concern(s) is/are?

_____

_____

_____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____

_____

_____

Have you or your child(ren) had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results.

_____

_____

Change is Coming…

What are your expectations from therapy and the therapist?

_____

_____

If you had a crystal ball and were able to look into the future you will say therapy has been worth it because (list concrete changes you would like to see):

_____

_____

_____

What other things would you like to see change in your life and your family's life?

_____

_____

Do you foresee any obstacles to achieving your goals/changes?

_____

_____

How long will therapy need to last to achieve the changes/goals you want? Write down a target date:

_____

List 5 strengths about your child, give examples of each:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical Background

Jennifer White-Baughan Ph.D

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424-382-7259

Child and Adolescent Intake Form

Has your child ever received psychiatric services before? YES NO
If yes, how long ago, with whom, for what, and results:

_____
_____

Many parents have opinions on psychiatric medications, what are yours?

_____
_____

Does your child have any allergies (food, environmental, medicinal, animal, etc.)

_____

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

_____
_____

Is your child presently under a physician's care? If so, for what?

_____
_____

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:

_____
_____

Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

_____
_____

Tell us about your child's development milestones (delayed, on time, early)

_____

**Updated 4/2018*

Important Questions We Must Ask

Has your child ever had suicidal ideations? YES NO
If yes, please explain:

Has your child ever planned to hurt himself/herself? YES NO
If yes, please explain:

Has your child ever attempted to hurt himself/herself? YES NO
If yes, please explain:

Has your child ever felt like he/she wanted to seriously hurt or harm someone else?
If yes, please explain: YES NO

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

Is there any history past or present of abuse or violence? YES NO
If so, please explain:

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

Has your child ever witnessed or experienced a trauma? Does your child have reoccurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? If so, please explain:

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Are you concerned your child may see or hear things that don't appear to be real? If so, please explain:

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put him/her at risk? If so, please explain?

Do you have any concerns about your child's sexuality, gender or sexual development?

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or receive specialized academic services? If so, for what?

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc)?

What would your child say he/she likes and dislikes about school:
Likes: _____
Dislikes: _____

**Updated 4/2018*

What responsibilities does your child have at home?

_____

_____

If your child is age 15 yr. and above what other skills do you think your child needs to be independent? How is he/she learning them? What else does he/she need to gain independence?

_____

_____

What other responsibilities or skills would you like to see your child have/achieve?

_____

_____

Does your child have his/her own cell phone? YES NO

What are the rules around your child's cell phone use? Who enforces those rules?

_____

Understanding Your Family

* *Space left for therapist to draw family tree (genogram)*

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

If 1 or both parents are absent, if so for how long and reason for absences:

_____

_____

If parents are not together please describe the parents' relationship with one another:

_____

_____

Who lives in the house with the child?

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_____
_____

If parents are not together who lives in the other house with the child?
_____
_____

Does your family have any pets? If yes, names, types and relationship to each pet:
_____
_____

List 5 or more strengths of your family:
_____
_____

Is there anything that gets in the way of your family being the way you want it to be?
_____
_____

Describe your child's relationship with the following:
Mother: _____
Father: _____
Siblings: Age, Name and Sex:

a. Sibling 1 _____
b. Sibling 2 _____
c. Sibling 3 _____
d. Sibling 4 _____

Significant Other:
_____
Other(s): _____

Does your family belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?
_____

**Updated 4/2018*

Who else do you consider to be part of or supportive to your family (people or affiliations):

_____

Is there any thing else that you think is important for us to know about your child?

_____

_____