ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

Please print and complete this packet of paperwork, and bring it to your initial appointment. Please arrive 10 minutes prior to your appointment time to complete your registration.

Thank you!

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

Welcome to ABCD, Inc. This letter will briefly outline our procedures for beginning to work together. To facilitate the work, please provide some information prior to the first session. We understand that completing forms is tedious, but it is the quickest way to get the basic information we need to get started. Enclosed you will find several forms to complete prior to our meeting. Please bring them to your first visit; if you would like, we will make copies of them for you. If you have other records which you think are relevant to the problem, such as other evaluations or school reports, please bring copies of them as well. Be sure to read the financial agreement carefully so there is no confusion about insurance processing or your responsibility for payments. Although our primary desire is to provide the help you need, this can be done most effectively when the business side of our relationship is clear. If you have any questions or concerns about any of the forms, please don't hesitate to raise them when we meet. There is a map with directions to ABCD, Inc. available on our website, www.abcdseattle.com.

The focus of the first visit is to understand your specific concerns, the history of the problem and the broader situation, and generally get to know each other. When a child is the client, the first session is usually with the parents and the second session focuses on getting to know the child and helping her/him feel comfortable in the office. Depending on the child's age and comfort level, we may try to spend some time alone without the parents, but that depends on the child feeling comfortable separating from his/her parent. Depending on the nature of the problem and the purpose of the services, future sessions will focus either on more formal evaluations or talking about specific goals and options for psychotherapy.

If further sessions are recommended, we will discuss scheduling and the availability of appointment times. Our practice is quite busy and we know that it can be challenging to find a convenient time, but we will do what we can to make it work for you. *Please note that late afternoon hours are highly prized yet in limited supply.* If that is the only time you can make ongoing appointments, please call the office to see if or when that will be possible.

We hope this information is helpful to you in preparing for our first appointment, and look forward to meeting you.

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

PROFESSIONAL PRACTICES

Right to Refuse Treatment: You have the responsibility for selecting the provider and for approving the methods that the provider employs. You also have the right to refuse treatment at any time. In making decisions, we encourage you to inquire as to the rationale for any particular approach and to have that approach explained to you in detail. The State of Washington provides a complaint and discipline recourse procedure for clients of psychologists. The Department of Licensing phone number is (360) 753-3095 and their address is: Dept of Health, Examining Board of Psychology, 300 SE Quince Street, PO Box 47869, Olympia, WA 98504-7869. (All complaints must be registered in written form.)

Confidentiality: You are permitted to have privileged communication. This means that communication with your psychologist is confidential and this confidentiality is defined in law as the same as that between lawyer and client. Minors do not have a legal right to confidentiality; their parents or guardians own that right. Children ages 13 and above hold the right to privileged communication. Their signature will be required to release confidential information. Please see the *Notice of Privacy Practices* for further details.

Therapeutic Approach: A variety of theories and therapeutic approaches are used by the clinicians in this practice. Length of treatment varies according to the nature and complexity of the difficulties. Treatment sessions are generally 50 to 80 minutes in length and there may be additional phone conversations. Although we have a secretary to answer phone calls during weekday hours, you can leave messages on our voice mail system when our secretary is not available. We regularly check our recorded messages and try to respond within a 24-hour period.

Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 12.12.2013.

I have read the information provided above and I understand its content.

_____ _____

Print name of client Today's Date

_____

Signature of child if 13 years of age or older

_____ _____

Signature of Parent Signature of Parent

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

Client's Name: _____ Parent/Responsible Party: _____

Psychologist: _____

Insurance: It is your responsibility to consult with your insurance company regarding services covered. This includes, but not limited to, type of treatment, diagnosis, and number of sessions allowed. **If your provider is in our insurance network** this office agrees to submit claims to your insurance company and accept direct payment. A monthly statement will be provided to you showing services pending insurance payment and private balances. However, in the event that your claim is denied, this office does not accept responsibility for negotiating the claim with your insurance company. This is your responsibility. **If your provider is out of network**, this office does not submit claims to your insurance. Payment is due at the time of service. You may still be able to submit your own claims for reimbursement of fees. Please see the Private Pay option below.

INSURED CLIENTS (PLEASE INITIAL EACH SECTION)

I. ____ **Psychological/Psychiatric Diagnostic Evaluation/Initial Intake Sessions-Insurance:** I understand the initial evaluation sessions may not be covered by my insurance plan for reasons including, but not limited to, medical necessity, benefits, and/or diagnosis code submitted. In that case, I am responsible for paying the full fee of the session(s). Initial evaluations are generally completed in three sessions when formal psychological testing in not required. The first intake session is $300 and the second and third sessions are $180 per psychotherapy hour. Additional intake sessions may be required based upon complexity.

II. ____ **Psychotherapy Visits-Insurance:** I understand psychotherapy services may not be covered by my insurance plan for reasons including, but not limited to, benefits, diagnosis, type of psychotherapy, and/or pre-existing conditions. In that case, I agree to pay the full fee of $180 per psychotherapy hour.

III. ____ **Psychological Testing-Insurance.** I understand psychological testing may not be covered by my insurance plan for reasons including, but not limited to, medical necessity, benefit, and/or diagnosis code submitted at the conclusion of the evaluation. In that case, I am responsible for paying the full fee of $300 for the initial testing appointment and $180 per psychotherapy hour for subsequent sessions. I also understand additional fees may be applied to cover the cost of materials for a psychological evaluation that are not covered by my insurance plan. In that case, I am responsible for the cost of those materials. These vary depending on the specific issues of the case. Please discuss the details with your clinician.

IV.____ **Payment is due in 30 days.** I understand a finance charge will be applied to balances remaining on accounts over 60 days past due at a rate of 1% monthly, 12% annually. There is a $1.00 minimum fee applied. Delinquent accounts are subject to be turned over to a collection agency.

V.____ **Release of Information.** I give my permission for information to be released to my insurance company for the purpose of filing claims.

PRIVATE PAY CLIENTS (PLEASE INITIAL)

I. ____ **Private Pay Option:** I do not have insurance, within network benefits, or do not want my insurance billed for services, therefore, I voluntarily choose to pay out of pocket the full fee of $300 for the intake session and $180 per psychotherapy hour for these services. Payment is expected at the time of service. If you have out of network benefits, a monthly statement will be provided for you to submit to your insurance company for reimbursement.

FOR ALL CLIENTS (PLEASE INITIAL)

I: _____ (initial only if applicable): **Divorced or Separated Parents:** I understand that I am responsible for the payment of services in full and that ABCD does not split portions of the fees between parents. I understand that if there is a parenting plan in effect which holds only one or both parents responsible for payment, this will need to be settled between parents. ABCD will not be responsible for enforcing this.

II: _____ **Additional Services:** Telephone and professional consultations, parent and patient phone consultations, record review, school visits, travel, report writing, letter writing, and most other clinical services are billed at a prorated rate of $180 per hour. Insurance cannot be billed for many of these services. A separate fee agreement is required for school visits, conferences for IEP or 504 meetings, and classroom observations. These services will not be billed to insurance since they are routinely not covered by insurance.

III: _____ **Missed or late Appointments:** I understand that my appointment time is held exclusively for me and that the clinic requires **two business days (48 hours notice) for cancellation**. For example, a Monday 1 PM appointment must be cancelled by 1 PM on the previous Thursday. Therefore, I will be charged 50% of the appointment fee for the first late cancellation or missed appointment, and 100% of the full fee for each additional late cancellation or missed appointment. I understand that reminder calls and emails may be done to help remind me of my appointment time but that it is ultimately my responsibility to know my appointment time. **Insurance cannot be billed for late cancellations or missed appointments**.

Client/Responsible Party: _____ Date: _____

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

Dear Clients,

If you would like to receive a reminder phone call or email, please let us know the best way to contact you. Please note, reminder calls and emails are to help remind you of your appointment time but it is ultimately your responsibility to know your appointment time. We have a 48 hour cancellation policy and you will be charged for missed appointments or late cancellations.

Client's Name and date of birth: _____
Parent's Name (if indicated): _____
Please select the method:

I would like to receive a reminder call at this phone number: _____
I would like to receive a reminder text at this phone number: _____
or
I would like to receive a reminder email at this address: _____

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

Family Information Form

The purpose of this questionnaire is to provide historical information about your child, and to shorten the time necessary for the initial evaluation. All answers will be treated as confidential information.

Child's Name_____ Gender_____
Birthdate _____ Age _____
Address_____ Todays Date_____
_____ Home Phone_____
Name of person completing form_____
Relation to child_____ Does this child live with you?_____
Is this child your biological child?____ Adopted?____ Foster Child?_____ Your stepchild?_____
Ethnic/Cultural Background_____
Who referred you to ABCD, or how did you learn of our services?
_____
Who is your child's physician? _____Phone Number_____

FAMILY

Parent #1 name_____ Birth date_____
Parent #2 name_____ Birth date_____

Occupation:	Parent #1_____	Parent #2_____
Education:	Parent #1_____	Parent #2_____
Marital Status:	Parent #1_____	Parent#2_____
Previous Marriages:	Parent #1 Yes____ No_____	Parent #2 Yes_____ No_____
Length of current marriage:	Parent #1_____	Parent #2_____
Number of children from Previous marriages:	Parent #1_____	Parent #2_____

Please list siblings and other individuals living in the home:

Name	Age	Sex	Grade in School	Relationship to child
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

For families where a Parenting Plan has been approved by the courts:
Date of separation(_____) and/or divorce(_____) from other parent
Legal Custodian:_____
Decision-Making, as specified in the Parenting Plan:
Education:_____ Non-Emergency Health Care:_____ Religious Upbringing:_____
Residential Schedule:_____

YOUR CONCERNS AND GOALS FOR SEEKING HELP

Please briefly describe the concerns or problems that led you to seek help from us.

How do you hope ABCD can help you with your concerns?

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

Please evaluate the following areas in which you think your child has a problem. Write a "1" next to the area which you think is most important, "2" by the next most important, etc. Include only as many as you think are appropriate.

___Disobedience
___Hits, steals, is destructive
___Temper tantrums, moody
___Anxiety, worry, fears
___Unhappy or depressed often
___Poor relationships with other children
___Lacks self-confidence
___Easily distracted
___Very active, always on the go
___Coordination and/or motor skills
___Poor school achievement or learning (relative to potential)
___Poor speech or language skills
___Vision or hearing difficulties
___Weight problems
___Sleep problems
___General physical health
___Diet and/or feeding
___Enuretic (urinating)
___Encopretic (soiling self)
___Other (please specify):_____

PREGNANCY

Was this child a planned pregnancy? No Yes
Was the mother under a doctor's care? No Yes
Number of previous Pregnancies/Miscarriages _____
Check any of the following complications that occurred during the pregnancy.
___Toxemia ___Abnormal Weight Gain ___Anemia
___Excessive Vomiting ___Excessive Swelling ___Emotional Problems
___Vaginal Bleeding ___High Blood Pressure
___Other (Rh Incompatibility, etc.)_____
___Hospitalization During Pregnancy: _____
___Medications Used During Pregnancy: What kind?_____
___Alcohol Used During Pregnancy: Frequency_____
___Cigarettes Used during Pregnancy: Frequency_____

BIRTH

Was this child born in a hospital? Yes No If no, where?_____
Length of Pregnancy:_____weeks Birth weight_____lbs_____ oz
Length of Labor:_____hours Apgar Scores(if known)_____
Child's Condition at Birth_____
Mother's condition at Birth_____
Check any of the following complications that occurred during birth.
___Forceps Used ___Breech Birth ___Labor Induced ___Caesarean Delivery
___Other Delivery Complications: Describe_____
___Incubator:
___Jaundiced: Bilirubin lights? No Yes
___Breathing Problems Right After Birth?
___Supplemental oxygen
Was anesthesia used during delivery? No Yes
Length of Stay in Hospital: Mother:_____days Child:_____days

DEVELOPMENT

Please check any milestones that were late:
_____Turn over _____Babble or coo _____Stand Alone
_____Sit Alone _____Gesture (point, wave, grasp) _____Walk Alone
_____Crawl _____Speak one word _____Speak two word phrases
Was this child breast-fed? No Yes When weaned?_____
Was this child bottle-fed? No Yes When weaned?_____
When was this child toilet trained? Days:_____ Night:_____
Did bed-wetting occur after toilet training? No Yes If yes, until what age?_____
Did your child wet or soil during the day? No Yes If yes, until what age?_____

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

Has this child experienced any of the following problems?

___Unclear speech
___Difficulty understanding spoken language
___Difficulty making eye contact
___Difficulty accepting affection
___Playing with toys in unusual ways
___ Disinterest in playing with others
___Difficulty making friends
___Swallowing, feeding, or eating problems
___Weight problem (underweight or overweight)

Which hand does this child use to hold a pencil? L/R Throw a ball? L/R

MEDICAL HISTORY

Childhood Illnesses/Injuries

___Measles ___Mumps ___Meningitis ___Chicken Pox
___Encephalitis ___Anemia ___Broken Bones
___Head Injury: Describe_____
___Coma or Any Loss of Consciousness: Describe_____
___Sustained High Fever: Describe_____

Please describe other serious illnesses or operations:

Illness/Operation	Age
_____	_____
_____	_____

Please indicate whether this child currently has any of the following problems.

Allergies	No	Yes	Asthma	No	Yes
Hay Fever	No	Yes	Seizures/Convulsions	No	Yes
Frequent Diarrhea	No	Yes	Sucks Thumb	No	Yes
Constipation	No	Yes	Grinds Teeth	No	Yes
Stomach Pain	No	Yes	Has Tics/Twitches	No	Yes
Urination in Pants/Bed	No	Yes	Bangs Head	No	Yes
Bites Nails	No	Yes	Rocks Back and Forth	No	Yes
Speech Problems	No	Yes	Sensory Sensitivities	No	Yes
Speech Defects	No	Yes	Hearing Problems	No	Yes
Ear Infections	No	Yes	Ear Tubes	No	Yes

Date of Most Recent Hearing Exam_____
Vision Problems No Yes
Wears Glasses or Contacts No Yes
Date of Most Recent Vision Exam_____

MEDICAL CARE

Child's Physician_____ Telephone_____
How often does this child see a doctor?_____ Date of Last Visit_____
Is this child currently on medication? No Yes
If yes, indicate the medication, dosage, and reason _____
_____
Are there any medication allergies? No Yes
If yes, indicate the allergy _____

Has this child ever had psychological counseling or therapy? No Yes
If yes, counselor's name_____
Telephone_____ Dates of Service_____
Reason or Type of counseling_____

Has this child ever had a psychological or psychiatric evaluation? No Yes
If yes, doctor's name_____
City_____ Date of Exam_____
Reason for Exam_____

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

FAMILY HEALTH

Please check all that apply regarding the child's biological parents and their families (natural siblings of biological parents and grandparents).

	Mother	Mother's side of family	Father	Father's side of family	Natural siblings of child
Birth defects	_____	_____	_____	_____	_____
Intellectual Disability	_____	_____	_____	_____	_____
School or learning problems	_____	_____	_____	_____	_____
Mental or emotional disorders	_____	_____	_____	_____	_____

	Mother	Mother's Side of family	Father	Father's side of family	Natural siblings of child
Behavior/conduct problems	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Bipolar Disorder	_____	_____	_____	_____	_____
Eating Disorder	_____	_____	_____	_____	_____
Neurological disorders	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Drug/alcohol abuse	_____	_____	_____	_____	_____

FRIENDSHIPS

Please indicate how this child relates to other children.

Has Problems Relating to or Playing with Other Children	No	Yes
Fights Frequently with Playmates	No	Yes
Prefers Playing with Younger Children	No	Yes
Has Difficulty Making Friends	No	Yes
Prefers to Play Alone	No	Yes
Are there children in the neighborhood with whom this child could play?	No	Yes

FAMILY RELATIONS

Languages Spoken in the Home_____

What do you enjoy most about this child? _____

RECREATION/INTERESTS

What activities does this child enjoy?

Sports:_____

Hobbies:_____

Other:_____

BEHAVIOR/TEMPERAMENT

Please indicate wither this child exhibits any of the following behaviors.

Is Easily Overstimulated in Play	No	Yes	Seems Overly Energetic in Play	No	Yes
Has a Short Attention Span	No	Yes	Seems Impulsive	No	Yes
Lacks Self Control	No	Yes	Seems Unhappy most of the time	No	Yes
Withholds Affection	No	Yes	Requires a Lot of Parental Attention	No	Yes
Hides Feelings	No	Yes	Cannot Calm Down	No	Yes
Overreacts to Problems	No	Yes			
Uncomfortable Meeting New People	No	Yes			
Has Fears	No	Yes	If yes, describe._____		

ABCD, INC / ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

EDUCATIONAL HISTORY

Current school_____ Private or public?_____
Grade in School_____
Teacher's name_____
Principal/Director_____ Telephone#_____
School District_____

Schools attended – please begin with child's earliest school experience (preschool or kindergarten)

Name of School	**Regular or special Ed?**	**Grades attended**	**Age at entry**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has this child ever had tutoring, speech therapy, physical therapy or anything similar? Please specify.

Please describe any specialized testing that has been done by school staff (for example, educational evaluation, speech evaluation.) Attach photocopies, if possible.

READING HISTORY

Please check if your child/adolescent has had any of the following problems with reading and spelling.

Past	Present	
_____	_____	1. Spelling difficulty
_____	_____	2. Poor penmanship
_____	_____	3. Problems learning letter names
_____	_____	4. Difficulty learning phonics (sounding out words)
_____	_____	5. Difficulty comprehending what he/she reads
_____	_____	6. Reversal of letters or words (such as confusing "b" & "d"; or "was" and "saw")
_____	_____	7. Slow reading rate
_____	_____	8. Keeping his/her place on a page
_____	_____	9. Word substitution in oral reading (such as "boy" for "board" or "a" for "the")
_____	_____	10. Omission or addition of words or phrases
_____	_____	11. Reading below grade or expectancy level
_____	_____	12. Problems learning days of the week or months of the year
_____	_____	13. Problems remembering names, lists, or complex instructions
_____	_____	14. Recalling things read as opposed to things heard (i.e. lecture)
_____	_____	15 Received extra help or retained in a grade because of problems with reading and spelling