Ada Liberant, Psy.D.

CHILD AND ADOLESCENT INTAKE PACKET

Today's date: _____/_____/_____

Child's Name: _____

Date of Birth: _____/_____/_____Age: _____

Mother's Name: _____ Father's Name:_____

Step-Mother's Name:_____Step-Father's Name:_____

Legal Guardian's Name (if applicable):_____

Address:_____

City: _____ State: _____ Zip:_____

E-mail:_____

Child's Cell: (_____)_____Home: (_____)_____

Mother's Cell: (_____)_____Father's Cell: (_____)_____

Mother's Work: (_____)_____Father's Work: (_____)_____

School Name: _____Grade: _____

School Address: _____School Phone: (____)_____

If applicable to presenting concern:
School Psychologist/Guidance Counselor's Name:_____

Phone: (_____)_____E-Mail:_____

Teacher(s) Name(s): _____

Phone: (_____)_____E-Mail:_____

If your child is in Special Education, please specify_____

Primary Care Physician: _____Phone: (_____)_____

Referred by: _____

FAMILY INFORMATION

Please list all individuals who are currently living in child's primary residence:

Name	RelationshiptoChild	Age

If applicable, please list all individuals who are currently living in child's secondary residence:

Name	RelationshiptoChild	Age

Child's parents are: (Circle One) Single / Married / Separated / Divorced / Widowed / Cohabiting

Mother's Occupation:_____ **Father's Occupation:**_____

Step- Mother's Occupation:_____ **Step-Father's Occupation:**_____

Have there been any deaths of or separations from parents, family members, nannies, babysitters, or friends with whom patient was close or had frequent contact? (Circle one) ***Yes / No***
If yes, please explain and include dates of separation/loss and relationship to child:

Have any family members had emotional or psychiatric problems? (Circle one) ***Yes / No***
If yes, please indicate who? What was the nature of their difficulties? Was treatment sought?

DEVELOPMENTAL HISTORY

Pregnancy/Delivery/DevelopmentalHistory:
(If your child was adopted, please fill out the information as best you can and go to the next page.)

Please list any complications the child's mother had during pregnancy or delivery:

_____
_____
_____
_____

Child was born (Circle one):

PRE-TERM **ON-TIME** **POST-TERM**
By # _____days **By # _____days**

At what age did your child achieve these developmental milestones?

CRAWLING: _____ **WALKING:** _____ **TALKING (single words):** _____

TALKING (sentences): _____ **TOILET TRAINING:** _____ **READING:** _____

Did you have any concerns regarding your child's development from ages 0 to 5 years old?

EXCESSIVE CRYING: Y / N **HYPERACTIVITY: Y / N** **SPEECH: Y / N**

FEEDING PROBLEMS: Y / N **SLEEP: Y / N** **HEARING: Y / N**

MOVEMENT: Y / N **SOCIAL RELATEDNESS: Y / N** **VISION: Y / N**

If you answered yes to any of the items above, please describe:

_____
_____
_____
_____

Please provide any other important information about your child's development that you feel is important:

_____
_____
_____
_____
_____

ADOPTION HISTORY (Please skip page if not applicable.)

At what age was your child given up for adoption?_____ What country was your child born in?_____

Where did your child live before he/she came to live with you (e.g., orphanage, biological parents, biological family members, foster care)? What were the conditions like in the child's previous home(s)?

_____

_____

_____

What does your child know about his/her biological parents?

_____

_____

_____

What information about his/her biological parents or the circumstances of his/her adoption have you kept from your adopted child out of concern for its impact on his/her well-being?

_____

_____

_____

Does your child have other biological full or half-siblings? (Circle One) Y/N

If yes, do you or your child know their whereabouts?

_____

_____

_____

Was your child the victim of suspected or confirmed neglect, physical or sexual abuse? (Circle One) Y/N

If yes, please describe:

_____

_____

_____

Please discuss the circumstances surrounding your (and your spouse/partner's) decision to adopt a child:

_____

_____

_____

Does your adopted child evidence any of the following behaviors? (Please circle):

RUNNING AWAY	EXCESSIVE CLINGING	SEXUALIZED BEHAVIORS	AGGRESSIVE BEHAVIORS
DIFFICULTY WITH SLEEP OR BEDTIME	DIFFICULTY RELATING TO PEERS	PHYSICAL DEVELOPMENTAL DELAYS	LYING OR STEALING

MEDICAL HISTORY

Please list your child's medical problems (from infancy to present time):

_____

_____

_____

_____

Hospitalizations / Surgeries:

Dates	ReasonforHospitalization/Surgery
_____	_____
_____	_____

Current Medications for Medical Issues:

Rx Name: _____ Dosage:_____mg Start Date: ____/____/____

Rx Name: _____ Dosage:_____mg Start Date: ____/____/____

PSYCHOSOCIAL TREATMENT HISTORY

Has your child ever had psychological / psychiatric treatment of any kind? (Circle One) Y/N If yes, please detail below:

Mode of Treatment	Dates	Reason for treatment
OUTPATIENT		
Individual		
Family		
Group		
Other		
INPATIENT		
Hospitalization		

Is your child currently taking medication for a psychiatric problem? (Circle one) Yes / No

If yes, please list the name, address, and telephone number of his/her prescribing psychiatrist:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:**_____

Office: (_____)_____Email:_____

If yes, please list the names, dosage, & dates of each of his/her medications:

Rx Name: _____ **Dosage:**_____**mg** Start Date: ____/____/____

Rx Name: _____ **Dosage:**_____**mg** Start Date: ____/____/____

REASON FOR REFERRAL

Please circle the issues or symptoms you are currently concerned about with respect to your child/adolescent:

SAD/DEPRESSED MOOD	SLEEP DISTURBANCES	HEARING VOICES
WORRIES/ANXIETY	NIGHTMARES	SEEING THINGS OTHERS DON'T SEE
WITHDRAWN	POOR ATTENTION/ CONCENTRATION	INNAPROPRIATE SEXUAL BEHAVIOR
IRRITABLE	HYPERACTIVITY	SHYNESS
PHYSICAL AGRESSION/ FIGHTING	ACADEMIC PERFORMANCE	SOCIAL SKILLS
DECREASED/INCREASED APPETITE	SCHOOL ATTENDANCE	VICTIM OF BULLYING
RESTRICTIVE EATING/ BINGING OR PURGING	OPPOSITIONAL/ DEFIANT TOWARDS ADULTS	CONFLICTS IN FAMILY RELATIONSHIPS
BEREAVEMENT	STEALING/LYING	ALCOHOL/DRUG USE
TRAUMA	SELF-INJURIOUS BEHAVIOR (e.g. Cutting)	WETTING/SOILING BED OR PANTS
PARENTAL DIVORCE/ SEPARATION	SUICIDAL THOUGHTS	REPETITIVE BEHAVIORS (e.g., Hand Washing)

Please elaborate on the reasons circled above and describe why you are seeking treatment for your child/adolescent:

_____
_____
_____
_____

When did these difficulties begin? Did any specific event occur prior to them beginning?

_____
_____

Does your child/adolescent agree with your understanding of the presenting issue(s)? (Circle One) Y/N

If no, please describe how your child/adolescent views your current concerns:

_____
_____
_____
_____

Please use the back of this page or attach additional pages to describe any other issues, questions, or concerns you have about your child or adolescent.

CANCELLATION AND FEE POLICIES

This policy statement has been prepared to prevent misunderstandings regarding your child's attendance and payment for sessions and consultations conducted by Dr. Liberant and to insure the continuity of your child's treatment.

APPOINTMENTS

I understand that once my child begins treatment with Dr. Liberant, he/she will have a specific time reserved to meet with her, typically once a week for 45 minutes. If my child or I appear late for a session it unfortunately means that we will lose time from that session.

FEE

I understand that Dr. Liberant and I will agree on a starting fee for treatment. I also understand that Dr. Liberant has the right to increase my child's session fee at any time by giving me verbal and/or written notice at least 4 weeks in advance of the fee increase.

PAYMENT

I understand that payment is due in full at the end of each session. If I fail to pay for two or more consecutive sessions, Dr. Liberant has the right to stop treatment with my child and refer him/her to another appropriate treatment provider. I will pay by cash, check or credit card (Discover, MasterCard, or Visa).

If I choose to pay by cash or check, I agree to leave a debit or credit card on file in the event that I delay payment for my child's sessions by 10 or more days from the date of service. In the event that my check is returned for insufficient funds, I understand that a $20 fee will be incurred.

CANCELLATION POLICY

I understand that a **$50 fee will be charged for cancellation for any reason**, which includes, but is not exclusive to: illnesses, medical emergencies, child care conflicts, travel delays, and school demands. If my child has to miss a session, I or he/she will notify Dr. Liberant at least 24 hours in advance via e-mail at help@AdaLiberant.com in order to avoid incurring the charge of my session fee. *If I do not give 24 hours advanced notice, I understand that I will be charged $50.*

PHONE SESSIONS AND CONSULTATIONS

I understand that phone therapy sessions will be conducted only in emergency situations or under special circumstances that have been negotiated and agreed upon between Dr. Liberant and my child. In the event of a phone session, I will incur all long distance charges.

I understand that phone sessions conducted with my child, or phone or school consultations conducted at my expressed request with other professionals (e.g., my child's teacher or school psychologist), which I have provided Dr. Liberant a written release of information to contact, are prorated and billed on the basis of my child's full session rate. I understand billing for these consultation sessions begins only after the first 15 minutes of the phone conversation or consultation and will paid in full at my next treatment session.

☐ **I have read and reviewed Dr. Ada Liberant's cancellation and fee policies and agree to abide by them.**

Printed Name of Legal Guardian: _____ Name of Patient: _____

Signature of Legal Guardian: _____ Date: _____

Patient has received a copy for their records on: _____

(To be filled out by Dr. Liberant)

Ada Liberant, Psy.D.

CREDIT CARD AUTHORIZATION FORM

Please indicate how you would like to use your debit/credit card:

____I would like to put my card on file to pay regularly (e.g. weekly, bimonthly) for my child's sessions.

____I am planning to pay by check and would like to put my card on file to be used only in the event that Idelaypayment by 10 or more days from the date of service or for use on an emergency basis with my expressed verbal consent.

Client Name: _____

Card Holder's Name (If different from above):_____

Billing Address:_____

City: _____ State: _____ Zip:_____

Billing Phone: (_____)_____

Debit/Credit Card Type (Please check one):

____Discover ____MasterCard ____Visa

Debit/Credit Card Number: _____ _____ _____ _____ Exp. Date:_____/_____

Security Code: _____(This is a 3 to 4 digit number on the back of your debit/credit card).

I authorize Ada Liberant, Inc. to charge the debit or credit card listed above in accordance with the terms of the cancellation and fee policies agreement.

Card Holder's Signature: _____

HIPPA NEW YORK NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

HIPPA PROVIDES INDIVIDUALS WITH CERTAIN RIGHTS RELATED TO THEIR PROTECTED HEALTH INFORMATION (PHI), INCLUDING THE RIGHT TO REQUEST THEIR PHI BE KEPT CONFIDENTIAL. ALTHOUGH MINORS DO NOT GENERALLY HAVE THE AUTHORITY TO EXERCISE RIGHTS ON THEIR OWN BEHALF, STATE LAW AND HIPAA PROVIDE MINORS WITH THE AUTHORITY TO EXERCISE CONTROL OVER CERTAIN CATEGORIES OF THEIR OWN PHI, INCLUDING OUTPATIENT MENTAL HEALTH TREATMENT FOR CHILDREN OVERTHEAGEOF12.

THIS POLICY DESCRIBES WHEN, AND UNDER WHAT CIRCUMSTANCES, THE MINOR'S HEALTH CARE PROVIDER MUST MAINTAIN THE CONFIDENTIALITY OF A MINOR'S PHI WHEN IT IS REQUESTED BY THE MINOR'S PERSONAL REPRESENTATIVE. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your child's protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

"*Minor*" refers to an individual who is under 18 years of age, and who is neither married nor the parent of a child.

"*Minor's personal representative*" is the minor's parent, legal guardian, or another with documentation proving he/she has legal custody of the minor (e.g., a stepparent who presents valid custody papers).

"*PHI*" refers to protected health information, which is demographic and health information that could identify your child.

"*Treatment, Payment and Health Care Operations*"

- **Treatment is when I provide, coordinate or manage your child's health care and other services related to your child's health care. An example of treatment would be when I consult with another health care provider, such as your child's physician or another psychologist.**
- **Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your child's PHI to your health insurer to obtain reimbursement for your child's health care or to determine eligibility or coverage.**
- **Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.**

"*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies your child.

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"*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about your child to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization, or release of information, from you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

***Child Abuse*: If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment, or the local child protective services agency.**

Further, if I reasonably believe a minor has been or is subject to domestic violence, abuse, and/or neglect by the minor's personal representative and that keeping the minor's PHI related to the abuse confidential is in the best interests of the minor, I may refuse to release or provide access to the minor's abuse-related PHI to the minor's personal representative.

***Health Oversight*: If there is an inquiry or complaint about my professional conduct to the New York State Board for Psychology, I must furnish to the New York Commissioner of Education, your child's confidential mental health records relevant to this inquiry.**

***Judicial or Administrative Proceedings*: If your child is involved in a court proceeding and a request is made for information about the professional services that I have provided him/her and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when your child is being evaluated by a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.**

***Serious Threat to Health or Safety*: I may disclose your confidential information to protect your child or others from a serious threat of harm by your child.**

***Worker's Compensation*: If your child file a worker's compensation claim, and I am treating your child for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.**

IV. Patient's Rights and Psychologist's Duties

Patient'sRights:

***Minor's Right to Consent to Treatment*. A minor who is over the age of twelve (12) may seek and receive mental health outpatient services independently from his/her personal representative. (Parental consent is not required.) The minor's personal representative does not have the right to the minor's PHI if the minor alone consented to the treatment, unless the minor authorizes the release.**

***Right to Request Restrictions*: As your child's personal representative, you have the right to request restrictions on certain uses and disclosures of protected health information about your child. However, I am not required to agree to a restriction you request for your child.**

***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. (For example, you may not want a family member to know that your child is seeing me. Upon your request, I will send his/her bills to another address.)**

***Right to Inspect and Copy*: You have the right to inspect or obtain a copy (or both) of PHI in your child's mental health and billing records used to make decisions about your child for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.**

***Right to Amend*: You have the right to request an amendment of your child's PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.**

***Right to an Accounting*: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.**

***Right to a Paper Copy*: You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.**

Psychologist'sDuties:

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, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will provide you with an updated copy if your child is still in therapy with me. If we have ended therapy, you may request an updated copy to be sent to you by mail.

V. Questions and Complaints

If you are concerned that I have violated your child's privacy rights, or you disagree with a decision I made about access to your child's records, please contact Ada Liberant, Psy.D. at (201) 540-9170 or help@AdaLiberant.com about your concerns. If you do not feel comfortable doing this, you may call The New York State Psychology Licensing Board at 1-800-442-8106 or send an email to conduct@mail.nysed.gov with your questions or a complaint. You may also address your complaints to the Secretary of the U.S. Department of Health and Human Services by obtaining their contact information on their website at www.hhs.gov/ocr/hipaa.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 9, 2009.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by providing you with a paper copy at our next session from the date of revision. If your child is no longer in therapy, I will provide a revised notice only at your written request.

VII. Consent for Treatment

I have read and understood this policy statement. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to have my child participate in this intake evaluation and/or treatment. I understand that I may withdraw my child from treatment at any time.

Name of Patient: _____

Printed Name of Personal Representative: _____

Signature of Personal Representative: _____ **Date:** _____

Ada Liberant, Psy.D.'s Signature: _____ **Date:** _____

Patient's persona l representative has received a copy for their records on:

☐ _____

(To be filled out by Dr. Liberant)