INFORMATION AND CONSENT

Risks and Benefits: Psychotherapy can have both risks and benefits. The therapy process may include discussions of personal challenges and difficulties, which can elicit uncomfortable feelings such as sadness, guilt, anger, and frustration. While there is no assurance of specific treatment outcomes, therapy has been shown to have many benefits. Effective treatment requires your very active involvement in order to work towards growth and positive change.

Confidentiality: In keeping with ethical standards of the National Association of Social Workers and state and federal law, all services provides are kept confidential, except as noted below. At times we may consult as needed with supervisors or colleagues about the best way to provide the assistance that you might need. As required by social work practice guidelines and current standards of care, we keep records of your therapy. Neither the fact that you seek therapy nor any information disclosed in the therapy sessions will be disclosed except as requested by you and as noted in the exceptions below.

We have a legal responsibility to disclose patient information without prior consent when a patient is likely to harm himself/herself or others, unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself and when there is a valid court order for the disclosure of client files. Fortunately, these situations are infrequent. By signing this form you also give us permission to communicate with the emergency contact that you have designated if we believe that you are at risk. Please consult with us if you have any questions about confidentiality.

Cancellation policy: Consistency is essential for effective therapy and together we will agree upon the frequency of treatment. You are responsible for your regularly scheduled, standing appointment and will be charged for the time reserved. If you need to cancel we ask for **48 hours notice** to avoid charge. If you do not provide adequate notice or do not arrive for your session you are responsible for the full session fee.

Fees: We ask for payment at the time of session unless other arrangements are made. I accept cash, credit card and check. Please make checks payable to Mind Body and Beyond Center. The maintenance of a valid credit card on file is required to ensure a smooth billing process. If you do not make a timely payment your card will be charged the full-session fee(s) plus a late-fee of $25. Your card will never be charge without your being notified. All phone contact, other than scheduling, will be billed at the hourly rate after the first 15 minutes. In general, your fee will be assessed annually, though conditions may warrant more frequent assessment.

Please sign below to indicate that you understand and agree to participate in therapy in accord with the above policies.

Print Name:_____ Date:_____
Signature:_____

PATIENT INFORMATION

Name of child/adolescent:
_____

Age: _____ Date of Birth: _____

Name(s) of parent(s): _____

Local Address:_____

Billing Address :_____

Phone number: _____

Email: _____

Emergency Contact Name: _____

Emergency Contact's Phone number: _____

Relationship to Emergency Contact: _____

REFERRED BY: _____

COLLATERAL CONTACT

Does your child currently see a psychiatrist? Yes _____ No_____
Psychiatrist's Name: _____

Address:_____

Contact phone: _____
Do I have your consent to contact the psychiatrist? Yes _____ No_____
Your signature of consent to contact your child's psychiatrist:
Sign: _____ Date: _____

Does your child currently see a Nutritionist? Yes _____ No_____
Nutritionist's Name: _____

Address:_____

Contact phone: _____
Do I have your consent to contact the nutritionist? Yes _____ No_____
Your signature of consent to contact your child's nutritionist:
Sign: _____ Date: _____

Does your child currently see a Medical Doctor? Yes _____ No_____
MD's Name: _____

Address:_____

Contact phone: _____
Do I have your consent to contact the MD? Yes _____ No_____
Your signature of consent to contact your child's MD:
Sign: _____ Date: _____

Does your child currently see another psychotherapist? Yes _____ No_____
Psychotherapist's Name:

_____

Address:_____

Contact phone: _____
Do I have your consent to contact the psychotherapist?

Yes _____ No_____
Your signature of consent to contact your child's psychotherapist:
Sign: _____ Date: _____

MEDICAL and PSYCHIATRIC HISTORY

Height: _____
Weight: _____
Date of last pediatrician visit: _____

Highest lifetime weight at this height: _____

When was that? _____

Lowest lifetime weight at this height: _____

When was that? _____

Onset of menses: _____

Date of last known menstrual period: _____

List any major physical illness, hospitalizations, accidents that your child has had and at what age they occurred:

_____
_____
_____
_____
_____

Has your child had past psychiatric hospitalizations?

_____Yes _____No

If yes, please state where and reason for hospitalization

_____
_____
_____

_____
_____
_____
_____
_____

What prescribed medications does you child take regularly, if any?

_____
_____
_____

To your knowledge does your child use recreational substances?

_____

If so, how often do they use these substances (if not currently using, how often in past)?

_____
_____
_____

Does your child have any problems with their sleep habits? _____ Yes _____ No (If yes, please circle below)

Sleeping too little

Sleeping too much

Poor sleep

Disturbing dreams

Other

How many times a week does your child exercise? _____
For about how long each time? _____
What type of exercise do they do?

_____
_____
_____

Would you say you have concerns about your child's relationship to exercise? Y / N

What of the following behaviors have you noticed in your child:

Eating less

Vomiting

Eating more

Binging

Chewing and spitting

Restricting

Eating secretly

Food Rituals

Significant weight change

What activities does your child enjoy doing in their free time?

_____
_____
_____
_____

FAMILY BACKGROUND QUESTIONNAIRE

Where was your child born?

_____

Where does your child attend school? What grade are they in?

_____

Please list the members of your current family, including ages and occupations. Please be sure to state if family members are biological, adoptive, or other

_____
_____
_____
_____
_____

Please circle and describe any past or impending issues that apply to your family:

Alcohol abuse

Drug abuse

Emotional problems

Psychiatric Hospitalization

Anxiety

Depression

Other mental illness

Ulcers or colitis

Asthma

Serious physical illness

Weight/eating problems

Anorexia

Bulimia

Insomnia

Attempted/Completed Suicide

Epilepsy

Physical Abuse

Sexual Abuse

Disabilities

Childhood illness

Frequent relocations

Learning problems

Deaths

Divorce

Unemployment

Legal problems

Other

Please state in detail your child's present issues, how long they have persisted, and the reason for seeking treatment at this time (use as much space as you like. Feel free to write on back of this page).

GUARANTEE OF PAYMENT AND

CREDIT CARD AUTHORIZATION

I _____ understand that my credit card is securely being held on file for use in the event of a late payment. A payment is considered late 14 business days after the day of issued invoice. I understand that my credit card will only be charged if I do not make timely payments by cash or check. I agree to provide notification of any changes made to card information. I understand that these policies are in place to ensure smooth billing processes. My signature below indicates understanding and acceptance of aforementioned payment policies and hereby authorizes Mind Body and Beyond Center to charge the credit card below as needed.

If you would like your credit card used as your primary method of payment and charged after each session please initial the following:

I authorize Mind Body and Beyond Center to charge my credit card after each session [_____]

Individual responsible for payment: _____

Credit Card Number: _____

Expiration: _____

Address of Card Holder: _____

_____

Verification Code: _____

Email of Card Holder: _____

Phone number of Card Holder: _____

I (we) have read, understand, and agree with the provisions of the Financial Policy and procedures/policies of Mind Body and Beyond Center In the event, someone other than the Patient has agreed or will agree to pay the fees, charges and expenses on behalf of patient, such third party shall sign below and thereby agree to be bound by and adhere to the terms and policies set forth herein.

SIGNATURE: _____

DATE: _____