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CONSENT FOR PSYCHOLOGICAL SERVICES – CHILD/ADOLESCENT

Thank you for seeking my services. This document covers important information about my professional practices and business policies. Please review it carefully and ask me any questions that you may have.

Please check which services you consent to receive:

_____ Initial Consultation (1-4 sessions)
_____ Psychotherapy
_____ Other – Describe: _____

The Nature of Psychological Services

- **Initial Consultation:** During our initial sessions, I will conduct an assessment of your child/family's needs and goals and then provide you with my initial impressions and recommendations for treatment. After the initial consultation, you are free to decide if you would like to begin treatment with me, or if we determine that I am not the best fit for your family, I will be happy to provide an appropriate referral.
- **Communication:** The therapist-client relationship is unique. I have a legal and ethical obligation to keep what you share with me private and confidential, to promote candid and complete communication between us. I am only able to provide you with truly beneficial services if I am aware of all information that might be relevant to your care. If you have questions or concerns about my services, please let me know.
- **Outcome:** Psychotherapy varies depending on the therapist, client, and particular circumstances. In general, the purpose is to provide a safe and supportive context to improve your life and relationships. While research shows that psychotherapy is effective in reducing distress and facilitating growth and change, risks include emotional distress, relationship challenges and issues previously unknown. Like any professional service, results cannot be guaranteed. Even so, many people find that therapy is worth the discomfort they might feel.
- **Termination:** Ideally, therapy concludes when the therapist and client agree that treatment goals are met. However, you are free to discontinue therapy at any time. I do strongly encourage you to speak with me first as this can be a helpful learning experience and I can also provide you with referrals to other services if needed.
- **Treatment of Minors:** In the case of a minor, you, the parent/legal guardian, have the right to know what transpires in the course of my work with your child, and your involvement in the treatment is vitally important. Simultaneously, in order to create a relationship in which the child feels comfortable talking with me, I will only provide you with general information about treatment progress and not the specific content your child shares without his/her permission. If an issue of safety or other serious concern arises, then I will talk with the child about how to share that with you. For more information, please see the attached Child/Adolescent Contract.
- **Divorced or Separated Parents:** It is my policy to seek consent for services from both parents and to invite both parents to participate in services. If you feel that there are important circumstances to consider with regard to this issue, please speak to me about it when services are initiated. I may ask that you provide me with a copy of your custody agreement so that I can keep this in your child's medical record. Also note that to provide consent for treatment for your child you must either have sole or shared legal custody.
- **Session Timing:** Session time includes transition to/from the office, payment and scheduling of future services. I will make every effort to stay on time. Please help me by having your payment and

scheduling information ready ahead of time. Thank you for your cooperation and courtesy toward other clients.

Contact

- **Emergencies:** If you are experiencing an emergency, please call 911, go to the nearest hospital emergency room, or call CMC's Behavioral Health Center (available 24/7) at 704-444-2400. Please also call me and let me know the nature of your situation as soon as you are able.
- **Telephone:** I am often not immediately available by telephone, but do have a confidential voicemail. I return calls as soon as I am able and make every effort to return your call within one business day. Please note, I do not communicate via text message.
- **Email:** The privacy and security of information sent by email cannot be guaranteed. You are welcome to contact me via email for routine matters, but sensitive information should be communicated via a confidential voicemail, phone consultation or office visit. Please do not communicate urgent or emergency information via email – please follow the above emergency procedures.

Confidentiality

The law and professional ethics require me to keep client information confidential. This means that, generally, I cannot share your child's health information without your written authorization and I will strive to protect your child's privacy.

Exceptions to Confidentiality:

- If I believe your child is threatening serious bodily harm to another, I am required to take protective action. This may include notifying the potential victim, contacting the police, or seeking hospitalization.
- If I believe your child is at risk of causing severe harm to him/herself, I may be obliged to seek hospitalization for them, or to contact family members or others who can help provide protection.
- If I have reasonable suspicion that any child, elderly person, or incompetent person is being abused or neglected, the law requires that I report this to the appropriate county agency.
- If a court of law orders me to release information, I am required to provide that to the court.
- If you are or become involved in any kind of lawsuit or administrative procedure where the issue of your child's mental health is involved, you may not be able to keep their records private in court.
- In order to provide your child with the best treatment, I may seek consultation from another licensed mental health professional. In these consultations, I make every effort to avoid revealing your child's identity. The consultant is also legally bound to keep the information confidential, although the exceptions to confidentiality apply to them as well. Similarly, when I am away or unavailable, my practice is covered by a licensed therapist. I may inform the on-call therapist about your situation to facilitate your getting appropriate support should your child need it in my absence.

Payment

- **Payment:** Payment is due at the time services are rendered, and the cost of services is your responsibility. I accept payment by cash, check or credit/debit card (Mastercard, Visa, Discover & American Express accepted), and I request that you keep a credit card securely on file to facilitate payment (see Credit Card Consent Form).
- **Fees:** The fee for the initial 60 minute session is $200. Subsequent 45 minute psychotherapy sessions are $150 and 60 minute sessions are $175 (allowing for notetaking, scheduling and billing time). Please also note that I may charge $150/hour for other professional services you may need, billed in 15-minute increments if the service provided is less than one hour. Such services include consultation with other professionals, report writing, telephone conversations lasting 15 minutes or longer, attendance at a meeting you have authorized, review of or preparation of records, travel time, and the time spent performing any other service provided in the interest of an established individual client.
- **Insurance:** I strive to keep my practice client-focused rather than driven by managed care so do not participate on insurance panels. If you wish to use your "out-of-network" benefits, I will be happy to provide you with a statement that you may submit to your insurance company for reimbursement. The

advantage of using health insurance benefits is that you may be reimbursed a portion of the fee. However, I will be required to provide a psychiatric diagnosis, you may need permission ("authorization") for treatment, a third party (the insurance company) may have access to your records, and reimbursement may be terminated before your treatment needs are met. If your employer offers a Health Care Flexible Spending Account, you may use this for payment. I encourage you to investigate your health insurance benefits prior to beginning treatment.

- **Payment Difficulties.** I aim to help you access important psychological services. If you are having difficulty paying your fee, please discuss this with me as soon as possible. I offer a sliding scale for eligible families and can assist you in accessing appropriate services either with me or another provider.
- **Legal Fees:** If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

Cancellations and Missed Appointments

Your child/family's appointment time is reserved exclusively for them. When you cannot keep your appointment, please call and give as much notice as possible. If an appointment is missed or cancelled with less than 24 hours' notice, you will be responsible for the full session fee. Monday appointments must be cancelled by noon the preceding Friday to avoid a charge.

ACKNOWLEDGMENT AND CONSENT

I voluntarily agree to receive psychological services from Emily C. Engel, Psy.D., PLLC. I understand and agree that I will participate in the planning of my care and that I may discontinue treatment at any time.

By signing this Consent for Psychological Services – Child/Adolescent form, I, the undersigned patient, acknowledge that I have both read and understood all terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Printed Name of Patient	Patient's Date of Birth
Signature of Patient's Representative	Date
Printed Name of Patient's Representative	Relationship to Patient
Witnessed by (Signature)	Date

Form Revised 8.31.16

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CHILD/ADOLESCENT CONTRACT

This document serves as an addendum to the CONSENT FOR SERVICES agreement and covers important information about my practices and responsibilities related to the treatment of minors. Please review it carefully and ask me any questions that you may have:

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child/adolescent's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the CONSENT FOR SERVICES agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

- One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain mine as well. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If you decide that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

- Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.
- It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you the specific content of what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. Periodically throughout treatment and at its conclusion, I will offer you a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.
- If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental attention and/or clinical intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

- Although my responsibility to your child may require my involvement in conflicts between family members, I need your agreement that my involvement will be strictly limited to that which will benefit your child. To that end, my role will remain exclusively to provide clinical treatment, and you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.). This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I

need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $200 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

ACKNOWLEDGMENT AND CONSENT

By signing this Child/Adolescent Contract, I, the undersigned, acknowledge that I have both read and understood all terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Printed Name of Patient	Patient's Date of Birth
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Form Revised 8.31.16

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NOTICE OF PRIVACY PRACTICES
Health Information Portability & Accountability Act (HIPAA) Law

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, ASK ME ANY QUESTIONS YOU HAVE, AND KEEP THIS FORM FOR YOUR RECORDS.

DISCLOSURE OF INFORMATION: This office is committed to and practices the following guidelines to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private, to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider all information about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for purposes of payment and business practices (as needed for billing, insurance claims, collections, and maintenance of your medical record). For treatment coordination and consultation, health care operations and other cases, I will ask for your authorization for use and/or disclosure of your PHI. I may not disclose your PHI without your informed and voluntary consent or authorization. Whenever your PHI is released or obtained, only the minimum information necessary will be communicated.

DISCLOSURES WITHOUT AUTHORIZATION: There are some situations in which the release of information without authorization is required and/or permitted by law and professional ethics. While I am required to take such action, I will do my best to communicate my disclosures with you in a timely manner. These include:

- Emergencies
- Reporting suspected abuse or neglect of a child, elderly person or incompetent person
- Disclosures required by court order
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public

YOUR RIGHTS REGARDING PRIVACY: By law, you have certain rights regarding the health information that I collect and maintain about you. These include the rights to:

- Request to inspect and obtain a copy of your medical record. Note, there may be a charge for printing/copying records. Additionally, due to the sensitive nature of professional clinical records, I may offer to have you review them in my presence so that I can answer any questions you might have.
- Request an amendment of any section of your medical record.
- Request restriction of disclosure of your PHI for the purposes of treatment, payment and healthcare operations.
- Request an accounting of the disclosures that your provider makes of your health care information.
- Receive a copy of this notice.
- Refuse to acknowledge receipt of this notice. However, if you chose not to accept these practices, I cannot treat you.

QUESTIONS AND/OR EXERCISING YOUR RIGHTS: If you have any further questions and/or concerns about this notice please contact me. In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also contact the Secretary of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC, 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot and will not make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint. I reserve the right to amend the terms of this notice.

Form Revised 4.19.16

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule, the federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice regarding the protection of their private health care information. The law further mandates that patients must sign an acknowledgement attesting that they have received the notice.

Your signature below indicates that you have been provided the Privacy Notice as required by the federal government's HIPAA legislation and your signature acknowledges this to be an agreement between you and your provider.

_____	_____
Signature of Patient or Patient's Representative	Date
_____	_____
Printed Name of Patient	Printed Name of Patient's Representative

Form Revised 4.19.16

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CREDIT CARD CONSENT FORM

Client Name: _____ Date of Birth: _____

With this Consent, Emily C. Engel, Psy.D. agrees to keep your credit card information securely on file and apply fees to it under the following conditions:

___ (Initial) I understand that by signing this agreement, I authorize Emily C. Engel, Psy.D. to apply fees for psychological services to my credit card.

___ (Initial) I authorize Emily C. Engel, Psy.D. to apply a full fee for missed appointments and/or appointments not cancelled according to Dr. Engel's 24-hour cancellation policy.

___ (Initial) I authorize Emily C. Engel, Psy.D. to apply any outstanding fees that are unpaid after 30 days.

___ (Initial) I understand that I may revoke this agreement at any time.

NAME _____

CARD TYPE _____ BILLING ZIP CODE_____

CARD NUMBER _____

EXPIRATION DATE _____

SECURITY NUMBER (on back of card) _____

NAME ON CARD _____

SIGNATURE _____

DATE AUTHORIZED _____

DAYTIME CONTACT NUMBER _____

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PATIENT INFORMATION FORM: CHILD/ADOLESCENT

Please complete the following information:

Patient Name: _____ Nickname: _____ DOB: _____ Age: _____

Race/Ethnicity: _____ Gender: _____ Religion: _____

Address: _____
Street City State Zip

Phone: Home: _____ Message OK? Y / N

Cell: _____ Message OK? Y / N

Work: _____ Message OK? Y / N

Email: _____Would you like to receive appt reminders via email? Y/N

Parent Name: _____ Date of Birth: _____ Age: _____

Parent Name: _____ Date of Birth: _____ Age: _____

Parents' Relationship Status: □ Married – years: ____ □ Partnered – years: ____ □ Single

□ Separated – date: _____ □ Divorced – date: _____ □ Widowed, date: _____

Parents: □ Biological □ Adoptive □ Foster □ Other: _____

Legal Custodian:_____

Parents' Occupation: _____ Employer: _____

Parents' Education Level: _____

Referred by: _____ May I contact him/her? Y / N

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Person responsible for the patient's payment: _____ Relationship: _____

Phone: _____ Billing address, if different than above:

_____
Street City State Zip

Reason for Current Inquiry

Please describe your current concerns: _____
_____
_____
_____
_____

Please list your child's strengths: _____
_____

Describe your goals in seeking services: _____
_____

Family Status

Please list the people residing in your child's home:

Name	Relation	Age	Highest grade completed	Occupation

Please list any other significant family members (i.e., child living out of home, noncustodial parent)

Name	Current age	Other information

Please list any significant stressors the family is experiencing: _____
_____
_____

Developmental History

Prenatal care began in the ___ month. Length of pregnancy: ___ weeks. Birth weight: _____

Please list any complications:

- Pregnancy (i.e., bedrest, unusual emotional strain, high blood pressure, gestational diabetes, medications, or use of alcohol/tobacco/drugs): _____
_____
- Delivery (i.e., induced, breech, forceps/vacuum used, injured during delivery, cord around neck, cesarean section, multiple births): _____
_____
- Neonatal (such as oxygen at birth, NICU, jaundice, infection, seizure, medications): _____
_____
_____

Please describe your child's temperament during infancy (0-12 mo.):

	√		√		√
Difficult to feed/colicky		Difficult to put on a schedule		Affectionate	
Difficult to get to sleep		Easy to comfort		Sociable	

Mark any of these skills that your child developed at an advanced (+) or delayed (–) age.

	+	–		+	–		+	–
Walked alone			Toilet trained			Spoke first word		
Skipped			Used scissors			Make-believe play		
Rode bicycle			Wrote name			Cooperative play		
Dressed him/herself			Tied shoes			Established friendships		

Educational History

Current School: _____ Grade: _____ Teacher: _____

Previous Schools Attended	City, State	Grades

Academic Difficulties	√		√
Poor handwriting, letter formation		Problems with classwork or homework completion	
Poor memory, short- or long-term		Procrastinates	
Late letter recognition		Forgets assignments/ materials	
Poor word recognition skills		Conflict with teacher	
Poor reading comprehension		Certified for special education (IEP or 504 Plan)	
Poor phonetic base in reading or spelling		Repeated grade	
Difficulty getting ideas on paper		Behavior gets him or her into trouble in school	
Problems in math		Attention difficulties	

If your child ever received any special services (i.e., IEP/504 Plan, Occupational Therapy, Physical Therapy, Gifted Program), explain: _____
_____

Medical History

Pediatrician: _____ Phone: _____ Date of last exam: _____

Please list any past or current medical conditions:

	√	Age		√	Age
Surgeries; hospitalizations; serious illnesses			Appetite problems (over- or under-eating)		
Seizures; head injuries			Enuresis/encopresis; constipation		
Allergies; asthma			Motor/vocal tics		
Chronic ear infections			Other:		
Hearing/vision difficulties					

List current medications:

Medication Name	Dosage/Frequency	Prescribing Provider

Psychological/Psychiatric History

Has your child ever been diagnosed with a psychological/psychiatric condition? If yes, describe:
_____
_____

Has s/he had any psychological testing or participated in treatment for the above? If yes, describe:
_____
_____

Please list any psychiatric medications prescribed:

Medication Name	Dosage/Frequency	Prescribing Provider

Please indicate if your child has experienced any of the following:

	√		√
Gets upset easily or has temper tantrums		Has excessive concern with weight	
Is overly active, fidgety, or high energy		Has self-injurious behavior	
Has excessive anxiety/unrealistic worry		Has unusual speech or motor movements	
Has difficulty with peers or siblings		Has decreased interest in pleasurable activities	
Is impulsive (interrupts, speaks before thinking)		Has thoughts of death or suicide	
Has difficulty with attention		Has difficulty with bedtime routine or sleeping	
Is sad or irritable; cries easily		Is socially inappropriate	
Lies or disregards rules		Has difficulty with independent self-care activities	
Is verbally or physically aggressive		Has unusual responses to sensations (loud noises, fabrics)	
Has a poor appetite or is a picky eater		Has difficulty with change in routine or with transitions	
Has excessive daytime sleepiness or chronic low energy		Has sexual difficulties or concerns	
Uses alcohol/drugs		Has difficulty performing chores at home	
Has poor frustration tolerance		Has rituals/compulsions	

Have any family members been diagnosed or suspected to have a psychological/psychiatric condition? If yes, describe: _____
_____

Have any family members had a substance abuse problem? If yes, describe: _____
_____

Thank you for completing this questionnaire. If your child participated in any psychological, educational, occupational, speech or physical therapy testing in the past, I would appreciate you bringing the report(s) to our initial visit.

_____ _____
Signature Date

Form Revised 4.19.16