McKINNEY NEUROPSYCHOLOGY
BEHAVIORAL HEALTH & WELLNESS

Consent for Treatment – Child or Adolescent

Date _____

Child's Name _____ Gender _____

Age _____ Date of Birth _____Ethnicity _____

Language(s) spoken other than English _____

Parents/Legal Guardian(s)' Name(s) _____

Home Address _____

City _____ State _____ Zip Code _____

Phone (Preferred):_____ (Secondary):_____

Email _____

==========

Does the child live in the home with both of his or her biological parents? _____

If not, which parent(s) have the right to consent to medical and/or mental health treatment?

_____

Please provide documentation of custody or guardianship arrangements, as applicable

Address | 7300 W Eldorado Parkway
Suite 265, McKinney, TX 75070
Telephone | (469) 714-0100
Fax | (469) 714-0205
Email | office@mckinneyneuropsych.com
Website | mckinneyneuropsych.com

Please read and initial each:

_____ I give my consent for my child or adolescent to receive psychological and/or neuropsychological services from clinicians of McKinney Neuropsychology.

_____ I understand that services are provided on a confidential basis and records are disclosed only when properly authorized or required by law.

_____ I acknowledge that I have had an opportunity to review the HIPAA Privacy Policy Form utilized by McKinney Neuropsychology.

This authorization shall remain in effect for one year from the date of signing or until_____.

_____
Child or Adolescent's Name

_____ _____
Signature of Parent or Legal Guardian Date

If signed by a guardian, please state legal basis for guardian status: _____

Any suspected violations of counselor ethics may be reported in writing to the following governing agencies:

TX State Board of Examiners of Professional Counselors OR **TX State Board of Examiners of Marriage & Family Therapists**

Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369
http://www.dshs.texas.gov/counselor/
http://www.dshs.texas.gov/mft/default.shtm

TX State Board of Examiners of Psychologists

Investigations and Enforcement Divisions
333 Guadalupe, Ste. 2-450 Austin, Texas 78701
https://www.tsbep.texas.gov

McKinney Neuropsychology

Behavioral Health & Wellness

Financial Agreement including
Credit Card Authorization and No Show Policy

At McKinney Neuropsychology, we require a credit or debit card on file as a convenient method of payment for the portion of services for which you are liable. Your credit card information is kept confidential and secure. Cash and check payments are always welcomed in lieu of a credit card transaction, though we still require a card on file.

Please read and initial each below, directing questions to the clinicians and/or office staff:

_____ I understand payment is due at the time of service and the appointment will be rescheduled if this obligation cannot be fulfilled.

_____ I understand insurance companies *do not* consider academic testing medically necessary and therefore do not cover the service. Should I decide to have academic testing, there will be an additional out-of-pocket fee of $500 that will not be billed through insurance.

_____ I understand if I no-show an appointment or cancel without at least *24 hour notice*, the credit card listed below will be charged $75 *per appointment hour missed*.

_____ I understand that if there is a balance on my account, McKinney Neuropsychology will charge the credit card on file after I have been notified. This may include balances due for services rendered the insurance company did not cover.

_____ I acknowledge I am encouraged by this office to review the Explanation of Benefits (EOB) provided to me by my insurance to ensure proper claim processing. Should my insurance overpay for services rendered, I am encouraged to contact McKinney Neuropsychology to request a refund.

_____ Lastly, I understand that if I provide a new or additional card that is not listed on this form, I am giving permission for it to be charged under the same aforementioned criteria.

☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Credit Card Number: _____

Expiration Date: _____/ _____ **CVV# (Security Code)** _____

Cardholder Name: _____

Billing Address: _____

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

Cardholder Signature: _____

Client Name: _____

Date: _____/_____/_____

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Email | office@mckinneyneuropsych.com

Website | mckinneyneuropsych.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year_____

ADDRESS _____

_____

CITY _____ **STATE**_____ **ZIP**_____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

McKINNEY NEUROPSYCHOLOGY

BEHAVIORAL HEALTH & WELLNESS

Child and Adolescent Intake Questionnaire

Please answer the following questions carefully and completely. The information provided within this questionnaire will be reviewed with the clinician so you will have an opportunity to further elaborate on your responses.

Date: _____

Child's Name: _____ Birth Date: _____

Race/Ethnicity: _____ Age: _____

Grade: _____ School: _____

Name of parent(s) or legal guardian(s):_____

Is there a biological or adoptive parent not present at today's clinical interview? _____

If so, is he or she aware of this evaluation? _____

How were you referred? _____

Problems and Concerns

Please list, in priority order, the problem(s) or concerns for which you are seeking help for your child, indicating when you first noted these difficulties:

Age when first noticed

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

Who is currently living in the child's home?

Name	Age	Education	Occupation	Relation to child

Other relevant family members not living in the child's home:

Name	Age	Occupation	Relation to Child

If birth parents are divorced or separated, what is the current custody arrangement?_____

_____

Please list any important changes or significant events that have occurred in your child's lifetime (for example: deaths, parent separations, divorces, remarriages, family moves, loss of important friendships, serious illnesses, financial problems, periods of parental conflict, family violence, etc.). Please provide your child's age at the time each event occurred.

Age of Child	Change or Event

Prenatal Development

Was the pregnancy: _____with prenatal care _____without prenatal care

Age of parents at time of child's birth: _____mother _____father

While the mother was pregnant, did she experience any of the following:

_____medical problems_____
_____accidents/injuries_____
_____surgeries_____
_____medications_____
_____alcohol intake_____
_____tobacco use_____
_____drug use_____
_____exposure to toxic chemicals or substances_____
_____stressful events for one or both parents_____

Were there any other serious illnesses or complications?

For mother: _____

For child:_____

Delivery

Was baby born at full term?_____If not, at how many weeks gestation?_____
Baby's weight at birth:_____Length of hospital stay for child: _____
Were any of the following present during or soon after delivery? (check all that apply)

_____baby was jaundiced (yellow)
_____baby was blue
_____baby needed oxygen
_____breech birth
_____baby needed blood
_____Rh factor present
_____baby was placed in an incubator. For how long? _____
_____other medical problems at birth_____
_____

_____C Section performed
_____emergency C section
_____baby aspirated meconium (breathed waste)
_____baby had trouble keeping milk/formula down
_____baby had trouble sucking
_____born with cord around neck

Developmental History

Did any of the following occur during infancy? (check all that apply and explain)

_____ baby had problems sleeping _____
_____ baby was frequently fussy or colicky _____
_____ baby had unusual crying _____
_____ baby had trouble breathing _____
_____ baby had problems eating or gaining weight _____
_____ baby experienced convulsions, seizures, or "spells" _____
_____ baby had excessive diarrhea or dehydration_____
_____ parent emotionally distressed (depression, anxiety, etc.) _____
_____ parent physically ill or injured _____
_____ significant family stressors _____

Who was primarily responsible for the baby's care? _____
Who assisted in the baby's care? _____

Do you believe your child formed an emotional attachment to you? ___ yes ___ no

How do you feel your child developed in the following areas?

Motor development	_____ faster than average	_____ average	_____ slower than average
Talking & language development	_____ faster than average	_____ average	_____ slower than average
Relationships & social development	_____ faster than average	_____ average	_____ slower than average

Estimate the age at which the following occurs (OK to leave blank if you cannot remember):

Age		Age	
_____	spoke first word	_____	took first steps
_____	spoke in full sentences	_____	walked alone
_____	toilet trained	_____	other

Temperament

What are the qualities you liked best about your child when he or she was a toddler?

_____

What were/are some troublesome qualities you noticed about your child as a toddler?

_____

Medical History

Does your child currently have any medical conditions? _____

_____

Has your child had any serious medical conditions, injuries, or surgeries in the past?

Type	Age

Has your child ever experienced any of the following? Mark by indicating the age(s).

_____ head injury	_____ diabetes	_____ menstrual problems
_____ seizure	_____ fractures	_____ odd weight gain/loss
_____ abnormally high fever	_____ allergies	_____ pneumonia
_____ problems with hearing	_____ asthma	_____ tonsillitis
_____ problems with vision	_____ frequent sore throat	_____ frequent earache
_____ sensory sensitivities	_____ cancer	_____ tubes in ears
_____ fainting	_____ regular stomachaches	_____ sleep difficulties
_____ motor or verbal tics	_____ nightmares	_____ problems with eating

_____ other conditions or concerns, explain: _____

Has your child ever received:?

brain imaging (i.e., CT/MRI)	____ yes ____ no	Date: _____ Results: _____
EEG	____ yes ____ no	Date: _____ Results: _____
Sleep Study	____ yes ____ no	Date: _____ Results: _____

My child's physician(s) are: _____

_____

My child's current medications are

Medication	Dosage/Frequency	Approx. Date Started

Previous medications and how child responded: _____

_____

_____

Has your child ever received the following professional services?

When	Services	Name of Provider/Results if Known
_____	Prior Psychological or Neuropsychological Testing	_____
_____	Educational Testing	_____
_____	Psychiatric (medication)	_____
_____	Neurological	_____
_____	Counseling	_____
_____	Speech Therapy	_____
_____	Occupational Therapy	_____
_____	Physical Therapy	_____

Has your child ever:

been subjected to abuse (physical, sexual, emotional)?	____ yes ____no
witnessed traumatic events?	____ yes ____no
expressed thoughts of self-harm?	____ yes ____no
attempted to harm self?	____ yes ____no
attempted to harm others?	____ yes ____no
seen or heard things other people do not see or hear?	____ yes ____no
used tobacco, alcohol, or recreational drugs?	____yes ____no

Please list anyone in the child's immediate or extended genetic/biological family who has been diagnosed with, or experienced difficulties with:

	Relationship to child
depression	_____
anxiety	_____
ADD/ADHD	_____
panic attacks	_____
anger management problems	_____
bipolar disorder	_____
schizophrenia, schizoaffective, or other psychotic disorders	_____
seizures	_____
autism spectrum disorder (including Asperger's syndrome)	_____
intellectual disability (i.e., mental retardation)	_____
dyslexia (reading disability)	_____
dyscalculia (math disability)	_____
dysgraphia (disorder of written language)	_____
language delay	_____
drinking problem/alcoholism	_____
drug problem	_____
criminal record	_____

Academic History

Did your child attend day care or preschool prior to starting kindergarten? ____ yes ____ no
If yes, how old was your child when he or she started?_____
and how did he or she respond? _____

List below the daycare centers, preschools, and schools your child has attended:

School	Location (City, State)	Grade

As best as you can recall, please provide a general description of your child's academic progress and/or concerns with the corresponding grade level:

Daycare/Preschool _____
Kindergarten _____
First _____
Second _____
Third _____
Fourth _____
Fifth _____
Sixth _____
Seventh _____
Eighth _____
Ninth _____
Tenth _____
Eleventh _____
Twelfth _____
College _____

Has your child ever repeated a grade? _____ Yes _____ No
If yes, what grade and what was the reason?_____

Is your child currently receiving specialized academic services from his or her school, such as:
_____ Special Education (IEP) _____ Section 504 _____other
If so, what specific services and when did they start? _____
_____
_____

If not currently, have they received services in the past? _____
_____

Please rate your child's ***current*** academic performance (if applicable):

Subject	below grade level	at grade level	above grade level
Reading or English	_____	_____	_____
Writing	_____	_____	_____
Math	_____	_____	_____
Spelling	_____	_____	_____
Other:_____	_____	_____	_____
Other:_____	_____	_____	_____

Social Functioning

How does your child get along with:

Younger children _____

Peers _____

Older children _____

Teachers _____

Parents _____

Siblings _____

Does your child have close friends? _____ Yes _____ No

What are their typical activities when together? _____

Please list any organizations, clubs, teams, or groups that your child belongs to: _____

_____

Please list any other special interests, hobbies, or activities: _____

_____

Please list any jobs of chores that your child has: _____

_____

Who is responsible for discipline (Check all that apply):

_____ Mother _____ Father _____Other: _____

Discipline most often used _____

Discipline most effective _____

Is there any additional, relevant information that you think we should know so that we can best be of service:?

_____

_____

_____

_____

_____

_____

_____

_____

_____