

Child's Name: _____

DRISKILL & BATES PSYCHOLOGY, P.A.
5212 75th, Lubbock, TX 79424-2520
p: (806) 794-3393 f: 806-794-3733

Confidential Client Information-Child/Adolescent

Date: _____

Child's Name: _____ **Age:** ____ **Date of Birth:** _____

Name of School: _____ **Grade** _____

YOUR NAME: _____ **Relationship to the Child:** _____

Street Address: _____ **City:** _____ **State:** ____ **Zip** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Prefer to be called at: Home Cell Any **Can we leave a message?** Yes No

Currently living with: mother father stepmother stepfather foster parent other

Mother: _____ **Age:** ____ **Education:** _____ **Occupation** _____

Stepmother _____

Father: _____ **Age:** ____ **Education:** _____ **Occupation** _____

Stepfather _____

If child is in foster care, please complete the following:

Agency case manager: _____ **Email:** _____

CPS caseworker: _____ **Email:** _____

Parents are: Married Separated Divorced Never Married

If parents do not live together:

How old was the child when parents separated or divorced? _____

How often does the child see the non-custodial parents? _____

What is the overall relationship between the two parents? Neutral Cooperative Conflicted

Who has legal custody of the child? _____ **Relationship:** _____

Child's Name: _____

In case of emergency, who should be notified? _____ Phone: _____

List names, ages, and relationship to child of all people who live in your home:

Briefly describe the child's current difficulties and your reasons for seeking treatment at this time:

How long has this problem been of concern? _____

School information

Does your child experience difficulty at school? Please describe (grades, behavior, peer interactions)

Has your child repeated a grade? Yes No

Does your child receive special education services in school? Yes No

If yes, please describe:

Medical Information

I consider my child's current health to be: excellent good fair poor

List any significant medical problems or allergies: _____

List all current medications and give dose: _____

List any serious accidents, surgeries, or illnesses your child has had: _____

Does your child experience any of the following?

___Hearing difficulty ___Vision difficulty ___Speech/language difficulty

Is your child now or has he/she ever seen a psychiatrist, counselor, speech, OT, or PT ? Yes No

Child's Name: _____

If yes, Name of Clinician: _____

Date(s) of Treatment: _____

Reason for Treatment: _____

Has your child had a previous psychological or educational evaluation? Yes No

If yes, by whom? _____

How would you describe your pregnancy with this child? Easy Average Difficult

If difficult, what were the problems? _____

How would you describe your labor and delivery? Easy Average Difficult

If difficult, what were the problems? _____

During the pregnancy with this child, check any that apply?

- used prescription drugs used over-the-counter drugs used tobacco used alcohol
- had an extended illness had an accident had other physical problems
- Used illegal drugs

_____ None of the above

How would you rate your child's development when compared to other children his age?

- Advanced Average Slower (in what areas?) _____

How would you describe the child's overall temperament?

- Easy Average Difficult Unpredictable

Has your child or family experienced any major changes in the last 12 months? Yes No

If yes, please describe: _____

Has your child experienced any of the following: N/A

- Physical Abuse Sexual abuse as a child Emotional abuse/neglect
- Domestic Violence Alcohol or drugs in the family Other trauma

Please explain briefly: _____

Do you believe or know that your child has used drugs or alcohol?

If yes, what and when did it begin? _____

Has your child been in trouble with the police? _____

If yes, please describe: _____

Is your child a danger to himself or to others? Yes No

If yes, please describe: _____

Child's Name: _____

Below is a list of problems children can experience. Please check any of concern

<input type="checkbox"/> Argues with parents	<input type="checkbox"/> Refuses to do what is told	<input type="checkbox"/> Difficulty following directions
<input type="checkbox"/> Slow getting acquainted	<input type="checkbox"/> Being left out of things	<input type="checkbox"/> Too withdrawn or shy
<input type="checkbox"/> Says wishes I were dead or I had never been born	<input type="checkbox"/> Has mentioned suicide	<input type="checkbox"/> Has attempted suicide
<input type="checkbox"/> Has engaged in cutting or harming self in some way	<input type="checkbox"/> Has disturbing thoughts	<input type="checkbox"/> Odd or unusual behaviors
<input type="checkbox"/> Difficulty adapting to change	<input type="checkbox"/> Excessive focus on particular topics or activities	<input type="checkbox"/> Unusual or repetitive movements
<input type="checkbox"/> Needs things to be perfect or exact	<input type="checkbox"/> Has rituals or elaborate routines	<input type="checkbox"/> Poor eye contact
<input type="checkbox"/> Often feels worried/anxious	<input type="checkbox"/> Needs excessive reassurance	<input type="checkbox"/> Often demanding or clingy

Other problems or concerns: _____

What concerns you most about your child?

Please describe the best things about your child.

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FINANCIAL POLICY

We are committed to providing your child with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy. We must emphasize that as mental health providers, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy we extend to our families, **all charges are your responsibility from the date services are rendered.**

You are responsible for checking with your insurance company regarding their coverage prior to starting regular therapy. You will be held responsible for charges for treatments rendered that your insurance denies as detailed in your therapy services agreement, including initial assessments. Depending on your individual insurance coverage, a deposit may be required before your course of therapy begins.

Payment schedules and co-pays will be issued based on insurance coverage estimates. Our estimates are subject to final approval by your insurance company. Therefore, the amount due is subject to change. We cannot guarantee payment by your insurance company even after they give us the estimated payment. If they do not pay the full fee, you are responsible for any amount unpaid up to the full cost of the evaluation. Please confirm this full cost before completing the appointment.

I, the undersigned, do agree that if my insurance does not pay my claim for any reason within 45 days, I will be responsible to pay the balance in full to Driskill and Bates Psychology within 15 days. My failure to do so can result in my account being turned over to a collection agency. This collection address will affect my credit rating.

Unless prior arrangements have been made, all deductibles and co-payments are due at the time of service. We accept cash, checks, and credit cards for your convenience. A \$15 fee will be charged for all returned checks.

Please sign below if you have read and understand and agreed to this financial policy.

ASSIGNMENT OF BENEFITS

I authorize Driskill and Bates Psychology to bill my insurance for services they provide and accept assignment of those benefits. I further authorize Driskill and Bates to exchange any information pertaining to the patient necessary to ensure payment by my insurance carrier. I understand if my insurance declines payment for any reason, I am responsible for the full cost of the evaluation.

Signature **Printed name** **Relationship to Client** **Date**

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INSURANCE CLIENT ACKNOWLEDGEMENT STATEMENT

I understand that the service or items that I have requested to be provided to me or my child MAY NOT be considered by my insurance carrier or third party payer to be REASONABLE AND MEDICALLY NECESSARY for my care or my child's care.

I understand the services provided to me or my child by Driskill and Bates Psychology may be considered NON-COVERED SERVICES by my insurance carrier or third party payer.

I understand that I am responsible for payment of the services or items I request and receive at the time services are provided. If the services or items are

- Not paid by my insurance carrier or third party payer
- Considered not reasonable or medically necessary
- A non-covered service
- Other reason for non payment

I understand that I am responsible for payments or services provided by Driskill and Bates Psychology even if payment is initially received by a third party payer and then later recouped by payer from Driskill and Bates Psychology for any reason.

Signature

Printed name

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Date

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Informed consent for psychological testing

This form will provide information about our psychological assessment services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician or his/her Supervisor. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

We utilize both Licensed Psychologists and Psychology interns to complete the assessment process. Psychology interns are doctoral level clinicians under the supervision of Licensed Psychologists with expertise in psychological, educational, and cognitive assessment.

TESTING

Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you for this assessment. Throughout the assessment process, you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations.

The assessment process consists of three sections: intake, testing session, and a feedback session to review the results. Although it is sometimes possible to complete the testing in one sitting, at times clients will be asked to return for another session to finish the assessment battery.

Once testing is completed, the data will be analyzed and a comprehensive report will be written. You will then have the opportunity to meet with a Licensed Psychologist to discuss the results and receive a copy of the report. Typically, this feedback session will take place approximately 2-3 weeks from the time that all psychological testing is completed.

LATE/CANCELLATION POLICY

Due to the number of billable hours allotted/scheduled for your assessment, it is important that you keep your scheduled appointment. Please note that we require a 48 business hours (2 business days) notice for a cancellation. Otherwise, your appointment may not be rescheduled.

RELEASE OF RECORDS

Written records are released *only* after a consent form is signed by the client or their Parent/Legal Guardian.

INFORMED CONSENT

I understand that the information obtained in this evaluation is confidential and will not be released to any person or organization without my written permission. *(This release is available in our office or may be completed with any individual whom you wish to give such access, and then provided to us.*

The only exceptions to this policy are rare situations in which you are required, but law, to release

Child's Name: _____

information with or without my permission. These are 1) if there is evidence of physical and/or sexual abuse of children or abuse to the elderly; 2) if you judge that I am in danger of harming myself or another individual; and 3) if my records are subpoenaed by the court. In the rare event of any of these situations, you would attempt to discuss your intentions with me before an action is taken, and you would limit disclosure of confidential information to the minimum necessary to ensure safety. **Please initial** _____

I understand that I have the right to discontinue the evaluation process at any time. However, I understand that DB may be unable to provide feedback of the test results if testing is terminated, and that **I will still be responsible for payment of any testing, scoring, and evaluation time provided up until that point.** **Please initial** _____

By my signature below, I acknowledge that I consent to a psychological evaluation by Driskill Bates Psychology.

YOUR SIGNATURE BELOW INDICATES YOU ARE THE LEGAL PARENT OR GUARDIAN OF THE MINOR CHILD AND THAT YOU HAVE THE LEGAL RIGHT TO CONSENT TO PSYCHOLOGICAL SERVICES FOR THAT CHILD. If parents are not the legal guardians or if parents are separated or divorced, you may be asked to provide a copy of the legal document indicating your right to consent to treatment before the child can be seen. (Exception if the child has been placed in foster care or a foster care/ residential treatment facility.)

Your signature below indicates that you have read the information in the PATIENT AGREEMENT, have been given a copy, and agree to abide by its terms during our professional relationship. Your signature also serves as an acknowledgment that you have been provided the HIPAA NOTICE FORM.

Client Signature (over 18)

Print Name

Date

Parent or Guardian Signature
(If Client is a Minor)

Print Name

Date