WILSON PSYCHOLOGICAL ASSOCIATES, PLLC
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Psychotherapy Information, Disclosure, and Contract – Minor Client

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you may have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

While the detail included in this document may seem tedious, I believe it is important that you understand from the beginning how situations will be handled in the typical work encountered in my practice. I believe you have the right to know the parameters of our relationship at the outset of our work together. *Sign the signature page* if you are in agreement with the terms presented.

PSYCHOLOGICAL SERVICES - PSYCHOTHERAPY

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist or therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be the most successful, you will have to work on issues we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have benefits for those who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to set up a meeting with another mental health professional for a second opinion.

My approach to therapy is called Cognitive Behavioral Therapy (CBT). This is a philosophy of psychotherapy characterized as structured, practical and effective in treating a number of psychological problems encountered in the course of living. This type of therapy is a strong tool

that works by identifying and addressing the behaviors and thinking patterns that maintain the problem or problems you are facing and focuses on your here-and-now thoughts and actions. We will look at how actions, or lack of actions, contribute to whether you feel bad or good. We will also look at the negative and unrealistic ways of thinking that may make you feel depressed, anxious, or uncomfortable. Cognitive behavioral therapy can equip you with the tools to think more realistically, to grow and to live and feel better. At times, there are problems we may work through together, examining both the potential rewards and consequences of particular courses of action you may take. While the therapy is typically focused on the here-and-now, it is sometimes helpful to revisit past experiences from which you may have learned lessons about living that may now out-live their usefulness. While traditional therapy focuses on insight and self-knowledge, CBT is more oriented to action and change. It is important to note that you will always guide the work through the goals and objectives you have for therapy.

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing or that I recommend you do, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and you can request that I refer you to someone else if you decide I am not the right therapist for you. You are free to leave therapy at any time, though my preference, if you decide to terminate therapy with me as your therapist, is for us to have one or two sessions to end our work together.

You normally will be the one who decides when therapy will end, with *four exceptions*. 1) If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. 2) If I am not, in my judgment, able to help you because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. 3) If you miss, without cancelling with appropriate notice, two scheduled sessions, I reserve the right to terminate therapy with you. 4) If you do violence to, threaten (verbally or physically), or harass me, the office staff, my family, or family members of the office staff, or damage or destroy property of any of the above mentioned persons, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but I cannot guarantee they will accept you for treatment.

I do not have social relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of the power that I have as a therapist. If you have questions about this policy, please bring them with you to your session so we may discuss them.

PSYCHOLOGICAL SERVICES – PSYCHOLOGICAL ASSESSMENT

At times, I may feel that psychological assessment is necessary to assist me in understanding your problem and to facilitate treatment; consequently, I may recommend another provider or I conduct this type of evaluation. Or, you may have been referred for psychological assessment by other professionals (e.g., physicians, teachers, counselors, or attorneys). Psychological assessment typically consists of a diagnostic interview and various objective and projective instruments measuring characteristics such as intelligence, memory, attention/concentration, personality, neuropsychological status, and/or psychological/emotional symptoms. If I recommend testing, you will be provided with a separate information form regarding the testing process.

MEETINGS

To schedule an initial appointment, I require you to provide me with a valid credit card to be kept on file in your HIPPA compliant and encrypted case file. If you do not provide sufficient notice of cancellation and break an appointment for reasons not beyond your control, payment for your broken appointment is your responsibility and will not be billed to your insurance company. Your credit card will automatically be charged for the broken appointment fee. Broken appointment fees are $100.00 (not your copay) and are not covered by your insurance. These fees are not contestable with your bank or credit card company.

With regard to psychotherapy, I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually recommend that you schedule one 53-minute session (one appointment hour of 53 minutes duration) per week as the schedule allows, although some sessions may be longer or more frequent. It is important to note that shorter sessions may be scheduled, but due to the nature of a typical therapy day, they are not routinely scheduled and must receive therapist approval before being scheduled.

As the schedule is done on a first-come, first-served basis, it is important that you make advance preparation with my office administrator, Courtney, for scheduling our meetings. I open my schedule for the third succeeding month on the fifteenth of each new month; any new appointments may be scheduled for the third succeeding month beginning that day (e.g., I will open the December schedule on September 15th and you may then schedule any appointments you desire for the month of December; January will be opened on October 15th, and so on). *It is best for you to schedule your time well in advance and cancel if you decide you no longer need to come or have conflicts that arise as the schedule tends to fill up one to two months in advance.* As only you know your schedule, I rely on you to make sure you are scheduled for the frequency of appointments that we agree upon.

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 53 minutes. If you are late, we will end on time and not run over into the next person's session.

Once an appointment hour is scheduled, to avoid a broken appointment fee, I ask you to provide advance notice of your desire to cancel *by 24 hours before your scheduled appointment,* (before Friday at noon for a Monday appointment or a holiday that falls on a Monday) *unless we both agree that you were unable to attend due to circumstances beyond your control*. If it is possible, I will try to find another time to reschedule your appointment. If you do not provide sufficient notice of cancellation, payment for your broken appointment is your responsibility and will not be billed to your insurance company; you will need to pay the broken appointment fee at or before your next session. This cancellation policy applies to meetings scheduled, and to each hour scheduled for psychological assessments. If you break an appointment for reasons that are not situations *beyond your control,* I will require that you have a valid credit card on file with my office for the duration of your future treatment. If you miss another appointment for reasons not beyond your control, your credit card will automatically be charged the broken appointment fee. If you develop a pattern of missing scheduled appointments, I reserve the right to terminate therapy with you and offer you a

list of referrals. This policy pertains to all clients except those covered by *SoonerCare* or Medicaid Insurance due to state limitations on charges to those covered by these programs.

For clients covered by *SoonerCare* or Medicaid through the Oklahoma Health Care Authority, in accordance with state regulations, if a visit is missed without notice, except in emergency situations, you will be asked to ensure that all future visits are cancelled with appropriate notice. If a second visit is missed without notice by the 24 Hour deadline the day preceding the appointment, I will assume therapy is no longer a priority and will terminate therapy with you after an appropriate termination session(s), if possible. If you still desire therapy services, a list of referrals will be provided, but I cannot guarantee another therapist will accept you for treatment.

Further, if you have multiple members of an immediate family unit in treatment at WPA (for example, you and your two children are each in therapy concurrently at WPA), for the purpose of calculating unpaid sessions, your family unit will be treated as one and the maximum number of unpaid sessions is three (3) in any combination. For example, if you have an unpaid session and your children subsequently each have an unpaid session, you will have met the maximum number of unpaid sessions for your family unit and we will assume that therapy is not a priority for you and will begin termination sessions with each of your family members. Whichever condition is met first will take precedent.

The following table summarizes these policies:

Number of Unpaid Sessions	***1***	***2***	***3***
Individual	Reminder of Policy	Begin Termination with Individual	N/A
2 Or More Clients in Immediate Family	Reminder of Policy	Reminder of Policy	Begin Termination with All Family Immediate Members

You have the right to refuse termination sessions; though, in accordance with the clinical research, I recommend that you participate in appropriate termination sessions to your treatment. The number of recommended termination sessions varies in accordance with how long you have been in treatment with me, and ranges from one session to many.

In order to assist you in remembering your scheduled appointments, my office staff makes reminder calls or sends texts two days before your appointment at the number you provide and prefer. However, it remains your responsibility to keep track of your appointments and to attend or appropriately cancel the time reserved for you. We do not overbook appointments; therefore, if you reserve an hour, it is yours unless you provide appropriate notification that you no longer desire the time.

Since I schedule my appointments up to three months in advance, there may be times when I must be out of the office unexpectedly, such as in the event of illness, family emergency, or my own healthcare provider appointments. If I must be out of the office at a time you have scheduled, I will let you know at the earliest point possible and will do my best to reschedule your appointment at a time that we both agree upon. Please know, I take my appointments with my clients seriously and do not cancel appointments arbitrarily.

PROFESSIONAL FEES

I have listed a schedule of fees for your information. My hourly fee for the first clinical intake session is $200 and the fee for each succeeding session is $165. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly charge if I work for periods of time less than one hour. Other services include telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Phone calls after office hours are considered crisis intervention and are billed at the rate of $300 per 60 minute hour.

With regard to psychological assessment, my 60 minute hourly fee is $190.00. Neuropsychological assessment (such as a dementia evaluation) is charged at the rate of $220.00 per hour. This fee structure includes review of records for assessment purposes, consultations with other persons, scoring, interpretation, and report writing time. I charge $25.00 for completing simple forms; for more complex forms, I charge a pro-rated rate of my hourly charge.

I do not accept patients who are involved in legal disputes who are seeking expert psychological testimony or psychologist participation without written prior agreement. 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 $775.00 per 60 minute hour for preparation, attendance, and participation, which includes time spent traveling and waiting; this includes any psychological evaluation/assessment or other report that may be required for legal proceedings. In addition to any in-office preparation time or research time, other time is calculated as "Door-to-door" time. There is a minimum 4 hour charge for any time I must be away from my office. Additionally, any and all travel expenses must be paid (including, but not limited to: airfare, lodging, mileage, meals, etc) in order for me to participate in these proceedings. *A forensic service deposit of $5000.00 must be paid prior to my participation in any legal work* and from this account your charges will be deducted as time is used; the balance of this account must be kept at or above $23750.00 during the legal proceedings and until the issue is settled. Any fee not used after the close of the proceeding will be refunded to you. This fee includes any testimony compelled by another party or by you in my role as a treating expert, fact witness, or expert witness and includes charges for both time for your attorney(s) and for your opposing attorney(s).

FEE SCHEDULE

Code	Service Description	Fee
90791	Diagnostic Interview	$200.00
90832	Individual Psychotherapy (1-20 min)	$70.00
90834	Individual Psychotherapy (38 min)	$120.00
90837	Individual Psychotherapy (53 min)	$165.00
90846	Family Psychotherapy (w/o patient present, 45 min)	$165.00
90847	Family Psychotherapy (with patient present, 45-50 min)	$165.00
90853	Group Psychotherapy	$75.00
90825	Psychological Evaluation/Review of Records (per hour)	$190.00
90822	Environmental Intervention (per hour)	$165.00
90900	Biofeedback (45-50 min)	$165.00
96101	Psychological Assessment (Psychologist)	$190.00
96102	Psychological Testing (Computer)	$190.00
96103	Psychological Testing (Technician)	$190.00
96105	Testing for Aphasia (per hour)	$220.00
96116	Chart Review, Scoring of Instruments (per hour)	$190.00
96118	Neuropsychological Testing (Psychologist)	$220.00
96119	Neuropsychological Testing (Technician)	$220.00
96120	Neuropsychological Testing (Computer)	$220.00
97770	Cognitive Rehabilitation (per hour)	$190.00
90889	Preparation of Report (per hour)	$190.00
99373	Telephone Consultation (per hour)	$190.00
99075	Legal Partic, Deposition, Testimony, Preparation, Att. (per hour)	$775.00
99049	Missed Visit, Not Cancelled with Notice (per scheduled hour)	$100.00
00000	Crisis Intervention/Critical Incident Stress Debriefing	$270.00
	Premarital Counseling (per hour)	$150.00
	Review of Records	$165.00
	Returned Check for Insufficient Funds	$30.00
	Contested Broken Fee Charge	$100.00

Document Fee for Record Copy: $2.00 first page; $1.00 for each additional page.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have become increasingly more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary for me to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or in some rare cases copies of the entire record. This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they will do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit to the insurance company, if you request it. Your signature on this document authorizes the above mentioned release.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless in rare cases this is prohibited by your insurance company policy and/or their contract with me as a provider. My Office Manager, Cindy, will assist you with the preauthorization and interpretation of your benefits.

BILLING AND PAYMENTS

You will be expected to pay for each session on the day of your appointment, unless we firmly agree otherwise in advance or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installation plan. However, I cannot barter for my services.

If you are the parent or guardian of a child and you share medical expenses with the child's other parent/guardian, you will be expected to pay the full fee when you bring the child and work out the portions of payment with your co-parent. At each appointment, the person bringing the child will be responsible for the payment of the fee due at each appointment. Our office does not bill portions (e.g., 60/40) to co-parents.

I am not willing to carry a balance on your account unless we have firmly agreed in advance on a structured payment plan, which is a rare occurrence. In these rare cases, if you do not fulfill your agreed upon payments as scheduled, I reserve the right to stop the payment plan and require full payment of fees at the time of the appointment. There will be a fee associated with a structured

payment plan and the plan must include a valid credit card to which the payments are posted each month.

Accounts that are not paid in full within 30 days will be subject to a $25.00 per month rebilling fee for each month the account remains unpaid. I reserve the right to use a collection agency or other legal means for balances that remain delinquent for more than 120 days. The cost of the collection will be included in the balance.

CONTACTING ME

I am often not immediately available by telephone. My office staff, Courtney or Cindy are available Monday through Thursday from 8:30 am to 4:30 pm and Friday from 8:30 am to 12:00 pm. The office is closed daily from 12:00 to 1:00 pm for lunch. If the office staff is not immediately available by phone, you may leave a message on the secure voicemail. The staff will make every effort to return your call within 24 hours of when you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform them of some times when you will be available. If you require a phone consultation with me lasting longer than 5 minutes, the staff will ask you to schedule time for us to speak by phone. If you are in the midst of a crisis and need to speak to me promptly, please inform the staff and they will relay that message to me. As email is neither private nor confidential, I will not communicate with you using this medium. I will do everything in my power to safeguard your privacy and information. I also have a secure voicemail on which you may leave any non-emergency messages.

I am away from the office several times per year for vacations. I will tell you well in advance of any lengthy absences and give you the name and phone number of the therapist who will be covering my practice during my absence. If you experience a crisis when I am out of town, or outside my regular office hours (after 5 pm on weekdays or over the weekend), please call my after-hours urgent-care number at **918-397-1930** to reach the on-call therapist. I cannot guarantee I will be the therapist on call if you need this service, but each therapist is trained and capable of helping you stabilize or helping you rally the resources needed to help you. The on-call therapist will not contact me until the next business day with a note indicating the nature of your call. While I know it will be your preference to speak to me if you have an urgent situation, I cannot be on call every day, all day, and therefore call is rotated among WPA therapists. (Note: These calls are billed as *Crisis Intervention* and may not be covered by your insurance.) As explained, the urgent care service is staffed by therapists associated with my practice, and on a rotating basis. If you utilize this service and you sign this document, you give authorization for the on-call provider to communicate the information to me when I return to the office to assist in your care.

IF, due to technical or other problems your call is not answered within a reasonable amount of time, please call the (1) Community Outreach Psychiatric Emergency Services – Tulsa (COPES) at **(918) 744-4800** to speak with a crisis counselor, or the (2) National Suicide Prevention Hotline at **1-800-273-8255**, or (3) **1-800-784-2433 (1-800-SUICIDE).** It is important for you to understand that, while I make every effort to be available to you in case of a crisis, there are unrelated circumstances (such as poor cell phone reception) that may prevent me from being available to you at the time you need assistance. Consequently, I believe it is important that you have these contingency plans in place if the on-call therapist is not immediately available by phone.

In a life-threatening emergency where you believe that you cannot keep yourself safe, please do not call the office or the answering service; rather, please go to the nearest emergency room and ask for the mental health worker on call, or call "911" and report to them that you have a life-threatening emergency and that you need transport to the nearest emergency room. Once your safety is assured, you may then have me contacted through the answering service.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the follow policy. This is because the use of various types of electronic communication is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for the matter, please discuss this with me during our time together so that we can deal with and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professional cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while you are in treatment together on any of these websites. This is because it has a signification potential to damage our ability to work together.

SOLE PRACTITIONER

While I share office space with other mental health practitioners, I am a sole psychological practitioner. This office is not to be understood as a 'group practice'; each practitioner is solely responsible for his/her professional conduct and practice.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. I keep brief records noting that you have been here, what topics we discussed, your diagnosis, and what interventions happened in each session. You are entitled to receive a copy of your records; however, because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore require that we review them in my presence so that we can discuss the contents. I will be glad to forward your records to any licensed mental health professional of your choice without review with you if you so desire. Clients will be charged the records review fee for any time spent in reviewing and/or preparing information requests. The full policy may be obtained from the office manager.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they consent to relinquish access to your records. You will find this agreement for minor psychotherapy clients immediately following this document in the packet of information. If they agree, I will provide them only with general information about our work together, unless I feel that there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a written summary of your treatment when it is complete. Before giving them any information, I will discuss this matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. Adolescent clients will be asked to review and sign an associated adolescent treatment agreement.

Also, due to the nature of the psychotherapy relationship and the need for the therapist's office to be a "safe zone," I require parents of minor children in therapy to sign an assignment of privilege to the minor child. This waiver is attached to this document and signifies your agreement to not access your child's record without his/her permission. Additional information regarding this waiver may be found on the waiver page attached.

PLEASE NOTE: ANY PARENT/GUARDIAN SEEKING SERVICES FOR A MINOR CHILD MUST HAVE:

1) FULL LEGAL CUSTODY (NOT ONLY FULL PHYSICAL CUSTODY; IF DIVORCED OR SEPARATED, COURT ORDERED DOCUMENTATION OF CUSTODY MUST BE PROVIDED PRIOR TO OR AT THE FIRST VISIT)

Or, 2) CO-SIGNATURE FROM ANY OTHER CUSTODIAL PARENT/GUARDIAN IF THERE IS A JOINT CUSTODY ARRANGEMENT.

If parents are divorced and documentation of FULL CUSTODY or JOINT SIGNATURES on all documents are not provided prior to or at the first appointment, the appointment will be cancelled and a broken appointment fee will be charged.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist or counselor is protected by law, and I can only release information about our work to others with your written authorizations. *But, there are a few exceptions*.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if s/he determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another person, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I strive to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

Finally, if you drive to my office in an altered state of consciousness, such as intoxication with recreational drugs or alcohol, or are observably over-medicated with prescription medication, I reserve the option of contacting a family member, friend, or the authorities to arrange transportation and to ensure your safety and the safety of those whom you may encounter. This situation has also rarely occurred in my practice.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

CONSULATION WITH PRIMARY CARE PHYSICIAN AND/OR PSYCHIATRIST

Many times during the course of psychotherapy, I deem it helpful to consult with my clients' primary care physician and/or psychiatrist in order to best serve their health care needs; with some insurers (e.g., Medicare), this communication is *required*. This information will be limited to the minimum amount necessary to accomplish your best health care. Typically, before I contact your physician, I will discuss my impressions with you and the reasons I think it would be helpful to speak with him/her. If you have questions about this, we should discuss them at our next meeting. ***Your signature on this document serves as your agreement to this disclosure of Protected Health Information for the purpose of healthcare coordination. If you <u>REFUSE THE RELEASE OF THIS INFORMATION UNDER HIPPA</u>, please initial here __________. (If you refuse, it may make it impossible for us to serve you due to insurance regulations.) Your signature on this document, minus any initial on the line above, authorizes us to release information to your healthcare providers for the purpose of healthcare coordination.***

AGREEMENT AND SIGNATURES

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You will be provided with a copy of this agreement if you so desire (please ask at your first appointment) and I will keep the original in your file at my office.

Your signature below indicates that:

1. You have had sufficient opportunity to read and understand this document.
2. You have asked the doctor to clarify anything you did not understand.
3. You agree to abide by the terms of this agreement in their entirety.
4. You understand that this form applies only to the policies and procedures for therapy services with the provider. A separate consent and agreement is needed for testing.
5. You are giving your consent to conduct counseling/treatment with you and/or your child.

______________________________________ __________________

Client/Guardian Signature Date

____

Relationship to Client (if client is a minor or unable to give legal consent)

____

Signature of Co-Parent or Co-Guardian if Joint Custody

____

Relationship to Client (if client is a minor or unable to give legal consent)

______________________________________ ______________________________

Client Printed Name Client Date of Birth

OFFICE USE ONLY

My signature below indicates that I have answered any questions raised by the client/parent/guardian. I have been told and believe that the person understands all of the issues discussed in this form, and I find no reason to believe that this person is not fully competent to give informed consent to services.

___ ______________________________ ____________
K. SPENCER WILSON, Ph.D., OK HSP PSYCHOLOGIST DATE

___ ______________________________ ____________
KRISTIN L. WILSON, M.A., LICENSED PROFESSIONAL COUNSELOR DATE

___ ______________________________ ____________
KEESHA L. KUNTZ, M.A., LICENSED PROFESSIONAL COUNSELOR DATE

___ ______________________________ ____________
JODY LANE, MA, LPC CANDIDATE DATE

___ ______________________________ ____________
JACKSON TEFERTILLER, M.A., LICENSED PROFESSIONAL COUNSELOR DATE

___ ______________________________ ____________
ADAM TURNER, M.A., UNDER SUPERVISION-LCSW DATE

INSURANCE/PAYMENT INFORMATION

Responsible Party
Last Name______________________ First Name ________________________ M.I.________
Address____
City_____________________ State______ Zip_______ Home Phone (____)______________
Date of Birth__________ SSN___________ Relationship to Patient _______________________
Employer____________________________ Address___________________________________
Occupation___________________________ Business Phone (____)______________________
Spouse Name_________________________ Spouse's SSN______________________________

Primary Insurance Co________________________________ Effective Date______________
Insured's Name________________________ DOB_____________ SSN___________________
Address (if different)____
Policy No.______________ Group No______________ Relationship to Patient ______________

Secondary Insurance Co______________________________ Effective Date______________
Insured's Name________________________ DOB_____________ SSN___________________
Address (if different)____
Policy No.______________ Group No____________ Relationship to Patient ________________

I (we) authorize payment of medical benefits to the provider herein for all medical/psychological services rendered. I (we) authorize the provider or Wilson Psychological Associates to release any information required to process my insurance claims. I (we) authorize my insurance benefits to be paid directly to Wilson Psychological Associates. I (we) understand that I (we) am (are) financially responsible for payment of any insurance deductible, copayments, and non-covered charges or services. A photocopy of this signature is valid as the original.

Signature of Responsible Party_________________________________ Date______________
Signature of Spouse____ Date______________
(required if marital therapy)

Please provide us with your insurance card so that we may have a copy on file. Please notify us of any changes to your insurance. We reserve the right to require you to file your own insurance if we are not made aware of insurance changes within two visits of the policy change. Thank you for your consideration in this matter.

417 East Silas Street, Bartlesville, OK 74003 (918) 337-6050 fax: (918) 337-6061

Child's Name ______________________________Date of Birth (DOB) ______________ Age _______

Child's Social Security Number ______________________ Soonercare/Medicaid #________________

Address ______________________________City ____________________State ______Zip___________

School ____ Grade ________________

Child's Sex: __ Male __Female

PARENTS/GUARDIANS

____

Name of person completing this form | Relationship to Child

Mother's name DOB | Father's name DOB

Stepfather (Mother's spouse – if applicable) | Stepmother (Father's spouse – if applicable)

Mother's address (if different from child's) | Father's address (if different from child's)

Mother's Home/Cell Telephone # | Father's Home/Cell Telephone #

Mother's Employer Work # | Father's Employer Work #

Legal Guardian's Name (if different from above) | Emergency contact (other than parent or guardian)

Home/Cell # Work # | Home/Cell # Work #

____

Child's Pediatrician Address City, State, Zip

Office #

Others in the Home: name age rel to child

Immediate family living outside the home (such as biological parent, brothers, sisters, etc.)

REFERRAL HISTORY

1. Who referred to this clinic and what were the concerns that prompted the referral? Or, if you come seeking assistance without a physician referral, what prompted you?

2. Describe the problems that are affecting your child and family.

3. How long have the concerns been a problem for your child and/or family?

4. What seems to make the problems improve or lessen?

5. What seems to make the problems worse?

6. Have the problems persisted since they began or have they come and gone over time?

7. Have the problems worsened steadily over time or have they remained about the same since you noticed them? ____

____

____

8. What do you hope to gain from this visit and in what way do you hope we will be able to be helpful with these problems? ____

____

____

9. Has your child ever been seen by a psychologist, psychiatrist, or mental health counselor/therapist?
YES NO

If yes, please describe why and by whom:

____

____

10. Please list any mental health diagnoses your child has been given by a mental health or medical professional: ____

____

11. Alcohol or Drug Use:
Alcohol: ___Don't Know ___None ___Child/Adolescent Drinks Alcohol
___Child/Adolescent Used to Drink Alcohol
Drug Use: ___Don't Know ___None ___Child/Adolescent Uses Drugs
___Child/Adolescent Used to Use Drugs
Please list or describe any use of alcohol, illegal drugs, or abuse of prescription medications:

____

____

____

SOCIAL HISTORY

12. Does your child have friends in the neighborhood? YES NO At school? YES NO

13. Does your child have the opportunity to play with same age children? YES NO

14. Does your child participate in extracurricular, church, synagogue, parachurch, group, or club activities?
YES NO

If yes, please list:

____

____

15. Is your child involved in community support or self-help groups? (E.g., Big Brothers/Big Sisters, The Landing, etc.) YES NO

If yes, please list:

____

____

16. What toys or types of activities does your child seem to enjoy?

____

____

____

17. Do you have any concerns with your child's social skills or social life? YES NO
If yes, please describe:

____

____

PROBLEM AREAS (Please check any problems your child has experienced):

- ☐ Attention Problems/ Easily Bored or Distracted
- ☐ Developmental Delays
- ☐ Atypical or Odd Behaviors
- ☐ Depressed/Low Mood
- ☐ Sleeping too Much
- ☐ Anxious/Nervous/Worried
- ☐ Mood Swings
- ☐ Defiance of Authority/Disobedience
- ☐ Nightmares
- ☐ Perfectionism
- ☐ Impulsive Behavior
- ☐ Argumentative
- ☐ Hallucinations (Seeing, Hearing Things Not There)
- ☐ Having to Do Things Over and Over
- ☐ Specific Fears or Phobias
- ☐ Parents' Separation or Divorce
- ☐ Lack of Ambition or Energy
- ☐ Shyness
- ☐ Sexual Problems
- ☐ Addictive Behaviors (e.g., gambling)
- ☐ Other: ______________________________
- ☐ Excessive Energy, Like Driven By a Motor
- ☐ Social Awkwardness
- ☐ Poorly ControlledAnger/Temper
- ☐ Not Sleeping
- ☐ Inferiority Feelings
- ☐ Elevated/Overly Excited Moods
- ☐ Aggressive Acting Out
- ☐ Suicidal Thoughts
- ☐ Self Harm
- ☐ Compulsive Behaviors
- ☐ Poor Relationships with Family
- ☐ Delusions (odd, untrue thoughts)
- ☐ Need to be inControl
- ☐ Poor Self-control
- ☐ Violent Thoughts or Behaviors
- ☐ Relationship Problems
- ☐ Slow Cognitive Processing
- ☐ Problems with Appetite
- ☐ Significant Loss/UnresolvedGrief
- ☐ Learning Difficulties

Please explain any checked items from the list in detail:

____

____

____

____

ABUSE/TRAUMA HISTORY: Has your child ever been abused, experienced a traumatic event, or caused harm to another?

YES If yes, check all below that apply. NO If no, SKIP THIS SECTION

☐ Victim of emotional abuse
☐ Victim of verbal abuse
☐ Victim of physical abuse
☐ Victim of physical neglect
☐ Victim of domestic violence/abuse
☐ Victim of sexual abuse/molestation
☐ Experienced a traumatic event (witnessed violence, etc.)

☐ Witnessed or community violence
☐ Physically harmed anotherperson
☐ Sexually abused or molested
☐ Harmed an elderly or disabled
☐ Purposely cut or burned
☐ Been cruel to animals
☐ Intentionally set fires to property

Please explain any checked (yes) answers:
____
____

DISCIPLINE: Please check the types of discipline used in your home for your child's behavior management:

☐ Time out ☐ Taking things away ☐ Grounding ☐ Extra chores ☐Ignoring

☐ Spanking ☐ Talking it out ☐ Praise/Reward for good behavior ☐ Yelling/Screaming

☐ Behavior chart ☐ Asking repeatedly ☐ Sending him/her outside or to a friends

☐ Other: ____

Consistency of your methods: ___ MOSTLY ___ SOME ___ NOT CONSISTENT

Please comment on the effectiveness of your discipline methods:
____
____

BIRTH, DEVELOPMENT AND PHYSICAL HEALTH HISTORY To be completed by birth mother if possible

Length of pregnancy (how many months, weeks?)
____

Child's birth weight ____________________ Number of hours in active labor ________________

Mother's age when child was born ______________Did mother receive regular prenatal care YES NO

Delivery was by: Vaginal birth Caesarian section (C-section) Was delivery difficult? YES NO

Please check any problems with delivery:

☐ Breech ☐ Emergency C-section ☐ Slow heart rate ☐ Fever ☐ Cord around neck

☐ Child required oxygen ☐ Other (please describe) ____

Apgar score at 1 minute ____________Apgar score at 5 minutes ________________ Don't know

MOTHER'S HEALTH *DURING PREGNANCY* Please check all that apply.

☐ **NO COMPLICATIONS**

☐ Had to take prescription medication(s) Names of medication(s):________________________________
☐ Bleeding ☐ Toxemia ☐ Pre-eclampsia/Eclampsia ☐ Serious illness or injury ☐ Diabetes
☐ Used Alcohol – Month _____ to Month ______ ☐ Used illegal drugs – Month ______ to Month
☐ Smoked cigarettes – Month _____ to Month ______☐ Had fever, rash, infection, or other illness
☐ Other____

INFANT'S HEALTH AT DELIVERY Please check all that apply

☐ **NO COMPLICATIONS**

☐ Trouble breathing☐ Hospitalized after birth for longer than 7 days ☐ Turned blue (cyanosis)
☐ Needed oxygen ☐ Birth defects ☐ Jittery ☐ Required **any** special care after delivery:
☐ Blood transfusions ☐ Incubator ☐ Medications
☐Other:____
____

INFANT'S HEALTH DURING 1ST MONTH Please check all that apply

NO COMPLICATIONS

Infections Feeding problems Gagged or vomited often
Difficulty latching on to breast or sucking Hospitalizations
Please explain any checked answers____
____

DEVELOPMENTAL HISTORY At what age did your child….

Sit up without help ______________________ Say single words meaningfully____________

Crawl ________________________________ Combine two or more words in phrase speech

Walk without help ______________________ Use sentences____________________________

Walk up and down stairs _________________ Show a hand preference_____________________

Which hand? RIGHT LEFT Is anyone in your family left handed or ambidextrous?
YES NO Whom? _____________

Was your child fussy as an infant? YES NO Difficult to rouse/overly sleepy? YES NO

Responsive to you when cuddled? YES NO Was your child sociable? YES NO

How insistent was he/she when he/she wanted something? VERY AVERAGE
LESS THANAVERAGE

How active was your child as a toddler? VERY AVERAGE LESS THAN AVERAGE

Has this child had difficulty separating? YES NO At what age? _______________________

Compared to other children her/his age, has your child been SLOWER in learning (check all that apply):

To talk To build with blocks, play with puzzles, draw pictures

To understand other people talk Gross motor skills (crawling, walking, riding bicycles)

To sit still for stories, TV, or video games? Fine motor skills(fastening buttons, zippers,drawing)

Is your child toilet trained? YES NO If yes, at what age? _______________________

Does your child wet her/himself during the day? YES NO How often? __________________

Does your child wet her/himself at night? YES NO How often? _______________________

Does your child soil him/herself during the day? YES NO How often? __________________

Does your child soil him/herself at night? YES NO How often? _________________

Does your child have sleeping difficulties? YES NO

Difficulty: Going to bed Falling asleep Staying asleep

Other problems with sleep?

____

Do you have concerns about your child's sexual development or sexual activity? YES NO If yes, please explain:____
____
____

CHILD'S HEALTH HISTORY After the first month of life, has your child had any of the following medical conditions?

☐ Eye or vision problems
☐ Chronic ear infections
☐ Became ill after an immunization/shot
☐ Appetite or feeding problems
☐ Speech/hearing problems
☐ Lead poisoning
☐ Food allergies
☐ Kidney problems
☐ Asthma
☐ Seasonal allergies
☐ Other allergies
☐ Pneumonia
☐ Frequent or severe headaches
☐ Frequent abdominal pain
☐ Heart problems or high blood pressure
☐ Seizures
☐ Broken bones
☐ Hospitalizations
☐ High fevers (> 103 degrees)
☐ Head injury (knocked out)
☐ Surgery/operation
☐ Developmental delay/Intellectual disability
☐ Impaired mobility
☐Other____

Please explain in detail any checked answers from the previous section (Child's health problems):
____
____

Are your child's immunizations up to date? YES NO
If no, please explain. ____

Has your child's vision been checked? YES NO
By whom? ____

Has your child's hearing been checked? YES NO
By whom? ____

Does your child receive regular dental care? YES NO
Dentist Name: ____

When was your child last seen by his/her physician/pediatrician?
____(date)

Females only:

Has your child started menstruation (had her first period)? YES NO If yes, at what age? ________

Has your child ever been pregnant? YES NO

MEDICATION HISTORY

Is your child taking **any** medications (prescription, over the counter, herbal, supplements) on a regular basis? YES NO

Has your child taken **any** medications (prescription, over the counter, herbal, supplements) in the past on a regular basis? YES NO

Please complete this section for any medications your child has taken in the past year:

Medication	Dose	How Often	Current	Prescribed by:
			Y/N	
			Y/N	
			Y/N	
			Y/N	
			Y/N	
			Y/N	
			Y/N	

Are you/your child compliant with the medication prescription direction for each of the medications listed as current? YES NO

If no, please explain:

____

____

Are there any significant negative side effects of any of the medications that you have listed as current? YES NO

If yes, please explain

____

____

FAMILY HISTORY AND INFORMATION

Mother's highest level of education: (circle one)

Grade School High School, didn't graduate High School, completed Technical Training after High School
Some college College Graduate Post Graduate Degree (Master's, Specialist, Doctorate)

Mother's occupation and place of employment (if applicable):
____

Work hours: ______________________________

<u>Father's highest level of education</u>: (circle one)

Grade School High School, didn't graduate High School, completed Technical Training after High School

Some college College Graduate Post Graduate Degree (Master's, Specialist, Doctorate)

Father's occupation and place of employment (if applicable):
____

Work hours: ______________________________

Marital Status of Parents: Married Separated Divorced Unmarried Widowed

Date: __________ __________ __________ __________ __________

If parents are divorced, who has legal custody of the child? MOTHER FATHER JOINT OTHER
If other, please specify:
____

If parents are separated or divorced, please describe physical custody and visitation arrangements:
____
____

Child is: Biological Step-child Adopted Foster child
Other______________________________

If the child is **adopted** or a **foster child**: How long has the child been in your home? ____________

Is the child aware that she/he is adopted or a foster child? YES NO

If the child is adopted or a foster child, please give as much information about the biological parents as you can:____
____
____
____
____

HUMAN SERVICES AGENCY INVOLVEMENT:

Has your child ever been involved with the following agencies? If yes, please explain below.

Child Protective Services YES NO Caseworker/phone #
____

Department of Human Services YES NO Caseworker/phone #
____

Court Appointed Special Advocate YES NO Advocate/phone #
____
or, Guardian Ad Litem

Law Enforcement YES NO

Probation/Juvenile Detention YES NO

Youth Shelter YES NO
Please explain any yes answers:
____
____
____
____

FAMILY HISTORY AND PROBLEMS:

During the past 12 months, has your family experienced any of the following situations? (List relationship to child for each checked answer)

☐ Death of a family member ________________________ ☐ Financial difficulties__________________

☐ Marital problems _________________________ ☐ Legal problems ______________________________

☐ Unemployment ___________________________ ☐ Moved in the past 3 years_____________________

☐ Serious medical illness/medical problems ________________________________ Which problems?
Headaches Chronic pain Stomach Nerves Asthma Diabetes Heart

☐ Serious mental/emotional problems ____________________________________ Which problems? Major Depression Anxiety Bipolar Disorder (Manic Depression) Thought Disorder (e.g., Schizophrenia)

How long has the child lived in the **current** home?
____

Has anyone in the **child's biological family** (other than the child) experienced any of the following? (Again, please list the relationship of the person to the child. E.g., "maternal uncle, paternal grandfather, 1st cousin," etc.)

☐ Speech or language problems ____________________ ☐ Alcohol abuse ____________________
☐ Trouble learning to read ____________________ ☐ Substance abuse ____________________
☐ Held back in school ____________________ ☐ Other addictive behaviors ____________
☐ Mental retardation ________________☐ Seen a counselor/therapist/psychologist ____________
☐ Anxiety________________________☐ Seen a psychiatrist______________________________
☐ Autism Spectrum ________________ ☐ Legal problems ______________________________
☐ Behavioral problems ________________☐ Victim of physical abuse ______________________
☐ Suicide or attempted suicide _______________☐ Victim of sexual abuse ___________________
☐ Depression ______________________☐ Sexually abused/molested another person___________
☐ Bipolar (Manic Depression) ______________☐ Physically harmed another person_____________
☐ Other:____

CULTURAL/SPIRITUAL HISTORY: Which of the following best describes …

Your child: ☐ White, not of Hispanic origin ☐ African American/Black , not of Hispanic origin
☐ Hispanic ☐ American Indian/Native American ☐ Asian/Pacific Islander
☐Other__________________

The child's mother:☐White, not of Hispanic origin ☐African American/Black,,not of Hispanic origin
☐ Hispanic ☐ American Indian/Native American ☐ Asian/Pacific Islander
☐ Other__________________

The child's father: ☐White, not of Hispanic origin ☐African American/Black,,not of Hispanic origin
☐ Hispanic ☐ American Indian/Native American ☐ Asian/Pacific Islander
☐ Other__________________

Does your child have any cultural or religious preferences or restrictions? YES NO If yes, please explain:____
____

Religious Affiliation: Protestant Christian Catholic Jewish 7th Day Adventist Jehovah's Witness None
Other:____

Cultural Background: Caucasian African American Hispanic American Indian Asian Pacific Islander Mixed
Other:____
Predominant language spoken at home: English Spanish
Other:____

Other languages spoken at home: English Spanish Sign Language/ASL Other: ______________

SCHOOL HISTORY:

Current school's name, address and school system (if a public school):
____

Did/does your child receive early intervention services? (e.g., Head Start) YES NO

Did your child attend preschool? YES NO If yes, name of school:______________________________
Age: ___________

Age at Kindergarten entrance _____________________Age at first grade entrance__________
Has your child ever repeated a grade? YES NO If yes, what grade(s)? ___________________________

Has your child had frequent changes of schools? YES NO If yes, how many schools? _______________

Has your child ever completed intelligence, achievement (other than standardized end of instruction tests), or other testing through the school? YES NO
If yes, when was your child tested? _________________________ Please either bring with you or request those records.

Does your child receive services through an **Individual Education Plan (IEP)** or educational **504 plan**?
YES NO If yes, at what age/grade was the plan started? ______________

Has your child ever been placed in a **special education program**? YES NO
If yes, please check the program type/classification:

☐ Cognitive disability ☐ Emotional Disability ☐ Specific Learning Disability
☐ Multiple Disability ☐ Other Health Impairment ☐ Traumatic Brain Injury
☐ Hearing Impairment ☐ Visual Impairment ☐ Orthopedic Impairment
☐ Other:____

Has your child received any of the following services? If so, please note at what age, and, if outside of school, where.

Speech and Language Therapy YES NO
____
Physical Therapy YES NO
____
Occupational Therapy YES NO
____
Learning Disability Tutoring YES NO
____
Counseling YES NO
____
Special Communication Devices YES NO
____
Other services (Please describe)
____

Is your child involved in any vocational education? YES NO NOT APPLICABLE
If yes, please describe:____

If you child is in school, please indicate how she/he is doing in each of the following areas of instruction:

	FAILING	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	EXPLAIN
Reading	☐	☐	☐	☐	____________
Spelling	☐	☐	☐	☐	____________
Language Arts	☐	☐	☐	☐	____________
Math	☐	☐	☐	☐	____________
Writing	☐	☐	☐	☐	____________
Science	☐	☐	☐	☐	____________
Social Studies	☐	☐	☐	☐	____________
Elective	☐	☐	☐	☐	____________

Does your child have difficulties in any of these areas? If so, please describe.

Problems with teachers? YES NO

____

Problems with classmates? YES NO

____

Behavioral problems? YES NO

____

Emotional problems? YES NO

____

Absenteeism or truancy? YES NO

____

Completing or turning
in work? YES NO

____

Suspensions/Expulsions? YES NO

____

Other areas? Please describe:

____

Does your child receive daycare, or before/after school services? YES NO

EMPLOYMENT HISTORY

Has your child ever had a job? YES NO If yes, please complete the following information.

Type of work:____

Name of employer: ___________________________________Job title: _____________________

Employment skills/interests:

____

Does your child receive SSDI? YES NO Does your child receive SSI? YES NO

BEST THINGS ABOUT YOUR CHILD

What are the things you like best about your child?

____

____

____

____

____

____

IMPORTANT INFORMATION NOT COVERED IN THIS QUESTIONNAIRE?

____

Referral Source:____

Address and phone number:____

Provider Signature: _________________________________ Date: ______________________

WILSON PSYCHOLOGICAL ASSOCIATES, PLLC
417 East Silas Street
Bartlesville, Oklahoma 74003
(918) 337-6050 Phone
(918) 337-6061 Fax

Confidentiality and Witness Waiver for Minor Psychotherapy Clients

For children (persons under the age of eighteen), therapy needs to be a place of safety and trust. If a child or adolescent is afraid that something he/she may say privately in therapy will be communicated back to his/her parents, then the value of therapy is diminished. Children have the same right to confidentiality as do their parents. However, you as parents also have the right to make responsible choices regarding your child's welfare and treatment. Consequently, by your signature below you agree to the following terms regarding your child's treatment:

1) I, as your child's therapist, will keep all information shared with me by or about your child confidential, unless your child agrees it may be shared. You will turn over the right of privilege to your child regarding his/her clinical information.
2) I will assist your child in sharing with you directly information that I or he/she think needs to be shared.
3) I will give you regular updates as to the progress of your child's therapy.
4) At the conclusion of therapy, I will provide you with a written summary of your child's progress in therapy.
5) If you child poses a serious risk to either him/herself or someone else, I will non-consensually break confidentiality in order to protect the person in danger. We will discuss and clarify the nature of 'serious risk' prior to beginning therapy.
6) When a family is confronted by parental separation or divorce, it is very hard on everyone. It is particularly hard on children. When the parental relationship is unsafe, it is even more important that therapy presents a safe environment. That safety is particularly endangered where a child has to worry that what he/she says in therapy will be revealed in court and used against one of his/her parents. In order to protect that safety, I want us all to agree that the therapist will not be called as a witness by either party. Everyone needs to understand that a judge may not honor this agreement and that I may be required to be a witness, although I will try to prevent that from happening.

My signature below indicates my understanding and agreement to abide by these terms.

______________________________	______________
Client Printed Name	**Date**
Signature of Parent*	**Date**
Signature of Parent*	**Date**
Staff Signature/Witness	**Date**

(*Both parents must sign if there is any type of shared custody of the child; if not, documentation of the sole custody order must be provided.)