



Parent to Child

THERAPY ASSOCIATES

1226 S. Broad Street
Philadelphia, PA 19146
P 215.644.9176 F 215.644.9177

parent2child.net

Client Information Form

Date of intake: _____ Therapist Name: _____

Client Name: _____ Date of Birth: _____

Referral Reason: _____

How did you hear about us? _____

Diagnosis (if applicable): _____

Client additional services/clinicians: _____

Cell #: _____ Work #: _____ Home #: _____

Email: _____ Employer: _____

Address: _____

Brief description of the current concern: _____

Other Comments: _____



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Consent to Psychotherapy

I voluntarily consent to therapy, knowing that I desire and/or require care and psychotherapy of a kind offered by Parent to Child.

I have been made aware and understand the nature, methods, and purpose of therapy. I have been informed and understand that treatment may consist of any one or combination of the following: individual therapy, art therapy, group therapy, and/or family meetings.

I am aware that all present and previous medical issues including, but not limited to, medications taken, illnesses or diseases, or alcohol/drug use, must be made known to my therapist; and I voluntarily release and hold harmless my therapist for conditions during the course of therapy.

I will be working with: ___Kathryn Snyder ___Kristen Rashid ___Antonia Cianfrani
 ___Jordyn Staar ___Sara Sculley

NOTICE

I have been made aware of the Health Information Portability and Accountability Act (HIPAA). I have been informed of and understand my right to privacy and confidentiality as protected under the federal and state confidentiality laws. I understand and have received a copy of the Administrative Policies form.

Date

Signature of client (14 years and older)

For clients under the age of 18 years

I am aware of the participation of my child/ward _____ in treatment with the above noted therapist at Parent to Child. I hereby give full permission to the noted therapist to provide appropriate services as deemed needed. If my child/ward is between the ages of 14 and 17 years, I am aware of the statement he or she has signed above and I agree to adhere to all of the conditions of the statement. I understand and will abide by the federal and state confidentiality laws regarding my child's/ward's right to privacy. I am also aware that I am an integral part of the therapy process and agree to participate fully as directed by the therapist.

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Signature



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HIPAA

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a clinician. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advanced consent. *Your signature on the Consent to Therapy form acknowledges this Agreement and provides consent for those activities*, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning professional services I provided to you, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written Authorization, or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I am treating a patient who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice:

- If I have reason to believe that a child who I am evaluating or treating is an abused child, the law requires that I file a report with the appropriate government agency, usually the Department of Youth and Family Services (DYFS). Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation, or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.
- If I believe that one of my patients presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may be required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.



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While this written summary of expectations 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 now or in the future. The governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, or the record makes reference to another person (unless such a person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting without charge]. In most circumstances, I am allowed to charge a copying fee per page (and for certain other expenses). If I refuse your request for access to your records, you have the right of review (except for information that has been supplied to me confidentially by others), which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several expanded rights with regard to your Clinical Record and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Consent to Therapy form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

For patients under 18 years of age who are not emancipated, their parents should be aware that the law might allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require a child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.



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Consent For Exchange Of Information

I, _____, give my permission for Parent to Child
clinician, _____ to exchange pertinent clinical information with:

I understand that this information remains confidential and the purpose of the exchange of information is to provide me with the best possible treatment.

Client signature (14 and older): _____ Date: _____

Therapist signature: _____ Date: _____



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Recurring Payment Authorization Form

You authorize regularly scheduled charges to your credit card after each office visit for you or for your child. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us in advance of the charge being processed.

Please complete the information below:

I _____ authorize **Parent to Child** to charge my credit card on file or as indicated below
(full name)

for \$ _____ for the intake appointment and/or for \$ _____ for each subsequent office visit for myself

_____ in payment for services rendered.
(Name)

Signature Date

Card Type: Visa _____ M/C _____ Other _____

Card # _____ CVV: _____ Expiration Date: _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Parent to Child** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next appointment date. If the above noted office visit dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.



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Administrative Policies Please Read

We hope that your visit to this office is as comfortable as possible. In order for us to best serve you, please review the following policies.

We hope that your visit to this office is as comfortable as possible. In order for us to best serve you, please review the following policies. The waiting room is available to you before an appointment. We prefer that you wait until your clinician comes to the waiting room to get you at the expected time rather than using the doorbell. Unfortunately, we are unable to let you back into the clinician's office hallway to use the bathroom or get water until we are between clients. We are more than happy to let people back at those times, we just cannot leave our offices while working with other clients.

Cell phone and other electronic device use is permitted, with some guidelines for use. All cell phones and electronic devices (such as hand held game systems) should be set to silent mode when in the building. Cell phones and electronic devices are not to be used in therapy offices during sessions or in the hallways, however they may be used quietly in the waiting room.

Therapists will provide you with the best phone number to reach them directly in case of an emergency or cancelled appointment. Please call your therapist directly if you need to cancel your appointment, and leave a voicemail if your therapist is unable to answer your call. The primary phone number for Parent to Child is a voice mail system and is not a method for contacting your therapist directly. As well, therapists do not always have access to email throughout the day, so in the case of an emergency or cancelled appointment, calling your therapist directly is the best way to reach them. In addition, therapists set their own policies regarding text messaging. If you are interested in using this form of communication with your therapist, please ask your therapist about their text messaging policy first.

Cancellation of a scheduled appointment is required 24 hours in advance of the session. Without this notice, your regular fee will be charged directly to your credit card on file. Exceptions will only be made for emergency situations.

We deal directly with each client individually and expect payment for services as they are rendered on a visit by visit basis. This means that payment by credit card (we use Square and can keep a card on file or send an invoice to be paid by you upon receipt) check or cash is expected at the end of every session. Checks should be made to: Parent to Child. A \$35.00 fee is charged for all returned checks. A statement (Superbill) that contains all of the necessary information needed for you to submit to your insurance company will be provided to you on a monthly basis. It is your responsibility to complete your claim form, attach our statement and forward it to your insurance company. Reimbursement from your insurance carrier for money you have already paid to us for your treatment should be sent directly to you. Please keep copies of our statements for your records. There is a \$25.00 charge if year-end statements are requested. If a duplicate copy of the current month or previous month(s) is requested, there is a \$5.00 charge per month. Our billing manager can be reached directly at: billing.parent2child@gmail.com.

Thanks for your understanding and cooperation. We appreciate working with you.