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: _____

Child's Name:_____Date of Birth:_____Age:_____

Child's School: _____ Grade:_____

Teacher:_____School Contact:_____

Referral Reason:_____

How did you hear about us?_____

Diagnosis (if applicable):_____

Client additional services/clinicians:_____

Parent (1):_____ Parent (2):_____

P1 Cell #:_____ P2 Cell #:_____

P1 Work #:_____ P2 Work #:_____

P1 Email:_____ P2 Email:_____

P1 Employer:_____ P2 Employer: _____

Home Phone:_____ Parent(s) marital status: Married__ Separated__

Address:_____ Divorced__ Single__ Remarried__ Widowed__

_____

_____ Billing Name:_____

Billing Address: _____

Family Members

Relationship					
Name					
Age					

Family members additional services/clinicians:_____

_____

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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 _____Gretchen Tucker
_____Christina Marrero _____Antonia Cianfrani

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.

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 Parent/Guardian signature

_____ _____
Date Parent/Guardian 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, _____, parent/guardian of _____ 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:_____

Parent/Guardian signature:_____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 or for my

child _____ in payment for services rendered.
(Name or child's 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 and your child/ren before an appointment and while your child is in therapy. 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.

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Child Therapy Agreement

Welcome to our therapy practice. We are glad that you are here and that we can help you and your child. Here are some things that we would like to share:

Sessions last for 50 minutes, the traditional "therapy hour". The 10 minutes in between clients is crucial time that supports our work with you and your child allowing for us to write our note, clean our office space, put away files and have a moment in between clients. Please respect this time and refrain from asking questions of the therapist. He/She will gladly email with any information that you need to know following a session, or simply follow up during the initial talk time with the parent at the next session.

It is critical for your child's sense of completion of the therapy hour that matters pertaining to therapy not be discussed in the waiting room. Additionally, no references or questions should be made to your child as to whether or not the session was "fun", " good", or "helpful". Therapy is a strange endeavor that works relationally and over time. It often feels odd or unusual to a child and should not have any judgments placed on it each week. Progress is noted over the course of time and is sometimes measured in ways that aren't always apparent or initially expected. To be sure, we do expect to see some positive change in behavior, emotional coping and understanding relatively quickly.

Parent sessions are crucial times to share information. They are scheduled as needed, approximately every 5-6 weeks. Please feel free to request one at any time.

Please keep cell phones or other electronic devices off when talking with your therapist. It is crucial that your child receive the message that this is important and that we will all give it our full attention. Emailing and texting are current forms of communication. While we welcome some of this as a way of sharing longer ideas out of session or scheduling an appointment, please be aware of the constraints on us to communicate in this way. We are not in front of computers or phones during much of our office time and cannot respond in a timely manner. Please call your therapist directly if you need to cancel or reschedule. If longer thoughts need to be shared, scheduling a parent session may be appropriate. The office phone has a voice mail system that will be checked regularly throughout the day and calls will be returned as soon as possible and in a timely manner. However, we handle all calls ourselves and do not have a full-time receptionist. Please know that we will do our best! Thanks for your patience in this. The phone does not take text messages.

Starting on time is important to the process of therapy. Pleases make every effort to arrive a few minutes before your child's session, have snacks or drinks or bathroom breaks complete before the time of your session. We understand that from time to time extenuating circumstances make this a challenge and we will respect the periodic late arrival. We do not have wiggle room in our schedules to go past the allotted 50-minute hour. Arriving more than 15 minutes late may require re-scheduling and the fee for the hour will be charged.

The process of therapy can be a bit elusive. We will talk about progress and moving toward therapeutic termination along the way. Please know that since this is a relational process, it is important that termination happen over a few sessions so that your child can have a chance to understand what they have worked on, reflect on the process and feelings, and have a thoughtful goodbye with their therapist and/or other group members if they are part of a group. We want them to leave with a memory of success and positive relationships!

Thanks so much! We look forward to supporting you and your child.

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Temperament Traits Questionnaire

The following questionnaire is designed to help the therapist understand the building blocks of your child's personality. Please consider your child's emotional and behavioral traits from infancy to the present.

1. **Activity/Energy level**-rate your child in terms of how busy, active or fidgety s/he generally is.

Low activity level	1	2	3	4	5	High activity level

2. **Regularity**-rate your child in terms of his/her need or ability to stay on a meal/sleep schedule versus being inconsistent/unpredictable.

Predictable/Easy	1	2	3	4	5	Unpredictable

3. **Initial Reaction**

Eager & bold	1	2	3	4	5	Inhibited/Shy

4. **Adaptability**

Easy/flexible	1	2	3	4	5	Difficulty adjusting

5. **Intensity**

Mild/quiet	1	2	3	4	5	Strong/loud

6. **Mood**

Pleasant/optimistic	1	2	3	4	5	Negative/unfriendly/moody

7. **Persistence/ Attention Span**

Stays on-task/tries	1	2	3	4	5	Short attn span/gives up

8. **Distractibility**

Difficult to distract/engrossed	1	2	3	4	5	Easily distracted

9. **Sensitivity**

Unaware of feelings/environment	1	2	3	4	5	Highly sensitive

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Child Developmental Intake Questionnaire

Child's Name: _____

Brief description of the current concern: _____

Who does this child currently live with? _____

Describe a typical day in the child's life. _____

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Habits: Please rate the behaviors on the following scale: (No problem/Low/Moderate/Serious)

(N/L/M/S) Temper tantrums	(N/L/M/S) Easily frustrated
(N/L/M/S) Aggression	(N/L/M/S) Attention span
(N/L/M/S) Memory	(N/L/M/S) Fears
(N/L/M/S) Anxiety	(N/L/M/S) Interrupts adults
(N/L/M/S) Disobedience	(N/L/M/S) Clumsiness
(N/L/M/S) Stealing	(N/L/M/S) Awareness of danger/safety
(N/L/M/S) Fighting	(N/L/M/S) Self-esteem
(N/L/M/S) Eating	(N/L/M/S) Sleeping
(N/L/M/S) Fine motor control	(N/L/M/S) Gross motor control
(N/L/M/S) Quick mood changes	(N/L/M/S) Disturbs other children
(N/L/M/S) Accident Prone	(N/L/M/S) Restless/ Overactive
(N/L/M/S) Language (lisp, stuttering, articulation)	

Trauma: Has the child experienced any kind of trauma (death of relatives, friends, pets; medical interventions; abuse or neglect; divorce of parents; separation from parent(s); moves; etc.)?_____

Describe the child's friendships. At home? At school? Play dates?_____

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Describe the child's current school setting. How does the child do socially, emotionally, behaviorally, academically, cooperatively?

School History

Preschool - Name of school: _____

Describe your child in the school setting during this time: _____

Kindergarten - Name of school: _____

Describe your child in the school setting during this time: _____

Grades 1-4 - Name of school: _____

Describe your child in the school setting during this time: _____

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Grades 5-8 - Name of school: _____

Describe your child in the school setting during this time: _____

_____

_____

_____

_____

Grades 9-12 - Name of school: _____

Describe your child in the school setting during this time: _____

_____

_____

_____

_____

Medical History

Any Medical Concerns? (please check all that apply)

Illness____ Allergies____ Head Injury____ Ear Infections____

Eye Problems____ Frequent Colds____ Convulsions/Seizures____ Asthma____

Other_____

Comments: _____

_____

Medications & Dosages:

Medication	Dosage	Frequency

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Doctor's name:_____ Address:_____

Phone: _____ _____

_____

Early History

Is this a biological or adopted child?_____

If adopted, please describe the adoption process and age at which you were able to bring this child into your home: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Conception: Was it a conscious decision? Yes No

Pregnancy: Were there any problems during pregnancy? Please explain: _____

_____

_____

Delivery: Were there any complications with the delivery of the baby? Please explain:

_____

_____

Infancy (please comment on the following):

Baby at birth: _____

_____

First 3 months: _____

_____

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Feeding problems: _____

_____

Nursed? Age Weaned? Process of weaning? _____

_____

Excessive vomiting? _____

_____

Excessive crying? _____

_____

Other concerns or illnesses during the first year? _____

_____

Second year: _____

_____

Were there any physical problems with the parents in the first year? Second year? _____

_____

_____

Post-partum depression? _____

_____

_____

_____

Any physical issues with a sibling since the child's birth? _____

_____

_____

Age at which each parent went back to work: _____

_____

Who took care of the child?_____

_____

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Other Comments: