PEDIATRIC PSYCHOLOGY
ASSOCIATES

Aventura • Weston • Coral Gables
Miami-Dade (305) 936-1002
Broward (954) 753-1112
Fax (305) 936-1022

Dear Patient/Parent/Caregiver:

Welcome to our practice. Attached are several forms to fill out and sign to help us gather information regarding you and your family. Also enclosed are documents containing summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. The law requires that we provide you with a Notice of Privacy Policies (which is attached) and obtain your signature acknowledging that we have provided you with the information.

We encourage you to complete these forms prior to your first appointment and forward to info@mailppa.com or fax to (305) 936-1022. If you are unable to, please bring them to your first appointment.

Every member of our professional and support team has been chosen for their caring attitudes as well as their professional credentials. If you should have any questions, do not hesitate to contact us.

Warmest Regards,

Pediatric Psychology Associates

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FORENSIC FAMILY HISTORY FORM

Name of Parent/Caregiver Completing Form:_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

(If more than 4 children please write on back of paper-child's name, age, birthdate)

Do your children have a cellular phone? If so, please list child's name and number(s)_____

_____

What are the concerns or difficulties that cause you to seek professional help at this time?

_____

_____

_____

Parent 1 Name_____Age_____ Birthdate_____

Email:_____Occupation:_____ Education_____

Cellular_____Alternative Phone:_____

Home Address_____

City_____ State_____ Zip Code_____

Attorney's name (if applicable) _____

Parent 2 Name_____Age_____ Birthdate_____

Email:_____Occupation:_____ Education_____

Cellular_____Alternative Phone:_____

Home Address (if different than Parent 1 Address)_____

City_____ State_____ Zip Code_____

Attorney's name (if applicable) _____

Date of: Marriage _____ Separation_____ Divorce_____ Check if Never Married _____

Are there other persons in the home(s)? _____If yes, who?_____

_____

If applicable, relationship with parent's significant other or step-parent?_____

Is there a parenting plan in place at this time? Yes ____ No ____ (If yes, please provide a copy)

Has a Guardian ad Litem been appointed: Yes_____ No _____

If yes, Name _____ Contact information _____

Is/are child(ren) living with biological or adoptive parents (circle one)?

If parents are living apart (separated or divorced) is the other parent aware that you are seeking psychological services?* Yes ___ No ___ **A consent from must be signed by the other parent if parents are divorced or living apart AND if the children will be part of our psychological sessions.*

If child(ren) is/are not living with both biological/adoptive parents, describe living/time-sharing arrangements:_____

_____

_____

How often do you have contact with the children when they are not with you? _____

_____

Describe the contact (visits, supervised/unsupervised, phone, etc): _____

_____

_____

How would you describe your relationship with the other parent?

Excellent _____ Good _____ Fair _____ Poor _____ Could not be worse _____

What effect do you think this relationship has on the children?

A great deal _____ Some _____ A little _____ None at all _____ Not sure_____

How often do you have contact with the other parent? _____

How do you communicate (text, Talking Parents, Our Family Wizard, email)?_____

_____

Describe the problem(s) that have occurred between you and the other parent:

_____

_____

_____

Are you fearful of the other party for any reason? _____

_____

Has the other party ever threatened to hurt you in any way? _____

_____

Has the other party every hit you or used any other type of physical force towards you? _____

_____

Has the other party emotionally sexually or emotionally abused you?_____

_____

Have you ever called the police, requested a protection for abuse order, or sought help for yourself as a result of abuse by the other party? _____

_____

Has the other party ever threatened to deny you access to your child(ren)?_____

_____

Do you have any concerns about the children's emotional or physical safety with you or the other party?_____

_____

Have you or the other party abused alcohol or drugs?_____

_____

Present use of alcohol (including beer, wine, liquor)

Daily _____ Once or twice a week _____ Once or twice a month _____ None _____

Current or prior use or abuse of drugs? (Please check all that apply)

Current _____Past _____ Neither _____ If yes, please list type used:_____

Please list use of prescription and/or non-prescription drugs:_____

_____

Have you ever been arrested for an alcohol/drug related crime? _____ If yes, please explain:

_____

_____

Have you ever undergone treatment for substance or alcohol use/abuse? _____ If yes, please explain: _____

_____

Please rate the effectiveness of this treatment: Very effective ____ Helpful ____ Waste of time ____

Do you have concerns regarding the other parent's use of alcohol or other substances? If yes, please explain:_____

_____

Are you now or have you ever been on probation or parole? _____ If yes, please explain:

_____

_____

Have you ever had a restraining order filed against you? _____ If yes, please explain:

_____

_____

Is there a restraining order in effect right now that you are involved in? _____

Have you or the other parent participated in domestic violence classes, batterer's intervention or anger management? Yes _____ No _____If so, when? _____

If yes, please rate the effectiveness of these classes in eliminating abusive behavior:

Very effective _____ Helpful _____ Waste of time _____

Have there ever been charges filed against you for physical assault, battery, domestic violence, or stalking? _____ If yes, please explain: _____

_____

Do you have any concerns about your physical safety during joint meetings held with the other parent? _____ If yes, please describe:_____

_____

_____

Is there anything else that would be helpful for me to know about the other parent, your child, or your situation? _____

_____

_____

BRIEF FAMILY HISTORY

Are there any health/learning/emotional issues about your child(ren) I should be made aware of?

If so, please list child's name and describe in detail:_____

_____

_____

_____

_____

What language(s) does your child(ren) speak and which is primary?_____

What language(s) are spoken in the home and which is primary?_____

Religious Affiliation:_____

Where does your child(ren) sleep in their home(s)? _____

By whom is your child(ren) usually disciplined?_____

What type of discipline is used?_____

Usually for what reason?_____

How does your child(ren) respond to discipline?_____

Do parents differ on discipline? No_____ Yes_____ If so, how?_____

_____

_____

Please mark any areas which constitute a problem for your child(ren)-check and list name of child:

Eating_____Sleeping_____ Nightmares_____Thumb sucking _____Nail biting_____

Bedwetting_____ Wetting in clothing _____Soiling in bed_____ Soiling in clothing_____

Getting along with friends_____Self-help skills (dressing, bathing, etc.)_____

List school and grade level of your child(ren):

_____

_____

Has your child(ren) ever had counseling/psychotherapy, psychoeducational or psychological testing, speech, occupational or physical therapy, or seen a psychiatrist or received medication for behavior, attention or emotional problems ? _____ If yes, list child(ren) name, date(s), name of practice/therapist(s) for each area:_____

_____

_____

Is there any family member (sibling, parent, grandparent, cousin, etc.) who presently or in the past have (or had) learning, attentional, or psychological/emotional issues or were in special classes? If yes, who and what kind/type?_____

In addition to the current family situation/conflict, has your child(ren) ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)?_____If yes, please list child's name and describe_____

_____

_____

Please put any other comments that will help me understand your child(ren) and current family situation better_____

_____

_____

What are your goals/expectations from treatment?_____

_____

_____

What do you think it would take to achieve your treatment goals? _____

_____

_____

_____

Please note <u>we do not confirm appointments</u>, although we typically provide courtesy appointment reminders through email and text message. Even in the event that you do not receive a courtesy reminder, you are still responsible for your appointment. Please list your email and best cellular contact number below if you would like a courtesy reminder.

Email address (please write clearly):_____

Cellular number:_____

How were you referred to our office?_____

Phone and/or email of referral source?_____

Is it okay to contact and thank the party responsible for the referral? ☐ Yes ☐ No

Signature _____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for treatment by Pediatric Psychology Associates for myself and/or my family members.

Signature_____ **Date**_____

Printed Name_____ **Relation to child**_____

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Forensic/Legal Services
Policies and Fees

Payment for Forensic/Legal services is $225 per 45-minute session. Additional services are billed in 15-minute increments. Prior to the beginning of this process, determination will be made as to how payment will be made and by whom. Treatment services include in office meetings with parent(s) and/or child(ren). Additional treatment services include consultations, video conferences, telephone contact and email contact with authorized parties (i.e., attorney, school, parents, parent coordinator, guardian-ad-litem, etc.). Time spent reviewing records and preparing reports/letters, preparing for depositions/court appearance, or any other services rendered by the treatment provider in this matter are also included.

If services involve court appearances or a deposition, the fees are $300 per hour with legal travel fees at $100 per hour (portal to portal). The parent requesting the treatment provider to appear in Court or a provide a deposition will be responsible for a minimum fee of 2 hours or the time frame requested for the provider to be available (plus travel costs if at a different location than the provider's office), payable 72 hours (3 business days) prior to the date of the required Court appearance or deposition. Cancellations less than 24 hours for court or any scheduled appointment will incur the full fee regardless of whether or not the provider testifies in court that day or provides the service.

Either a credit card on file or a retainer in the amount of $2,500 is required for services rendered. The credit card will be billed at the time of the service (with the exception of court/depositions which will be billed 72 business hours prior to the date). If a retainer is provided, once the balance falls below $300 (credit), an additional retainer of $2,500 will need to be provided to avoid a disruption in services. These services cannot, and will not, be billed to any health insurance provider for reimbursement.

If the retainer is not replenished or the credit card is not working, any amounts not paid within 30 days at the time of services, shall incur interest at the rate of eighteen percent (18%) per annum and computed monthly. A lien for the amount of the fee and expenses advanced shall exist in favor of the said provider, and said lien continues if said treatment provider is discharged. Failure to pay amount billed within thirty (30) days will be the basis for the treatment provider to withdraw from further services, and to do so without objection or complaint from the parent with a remaining balance. If you have any further questions, do not hesitate to discuss this directly with your treatment provider.

Patient(s) Name: _____ DOB: _____

Parent 1: Signature _____ Date: _____

Responsible for payment [ ] No [ ] Yes- If Yes, _____% responsible [ ] Retainer [ ] CC on file

Parent 2 Signature_____ Date: _____

Responsible for payment [ ] No [ ] Yes - If Yes, _____% responsible [ ] Retainer [ ] CC on file

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Credit Card Payment Consent Form

Patient Name:_____

Parent/Guardian:_____

Please charge my credit card (check one):

_____ One time only in the amount of $_____

_____ Recurrent charges after every service and for any outstanding balances.

Type of Card: □ Visa □ MasterCard □ AMEX

Cardholder's Name (as printed on card):_____

Credit Card Number _____ - _____ - _____ - _____

Expiration Date _____ CVV Number _____ 3-digit # **back** of the card (AMEX 4-digit # front of card)

Card Holder's Billing Address for Credit Card Statements:

Street Address:_____

City:_____ State:_____ Zip Code:_____

Best Contact Phone Number :_____

Best Contact Email address:_____

Signature _____ Date ____ /____ /____

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HIPAA Notice of Privacy and Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review this document carefully and keep it for your records.

Introduction

At Pediatric Psychology Associates, we are committed to treating and using health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice is effective June 1, 2005, and applies to all Protected Health Information as defined by Federal Regulations.

Understanding Your Health Record/Information

Each time you visit Pediatric Psychology Associates, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communicating among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer (i.e., insurance company) can verify that services billed were actually provided,
- Source of information for public health officials charged with improving the health of the State and the Nation, as required by law (i.e., reporting child abuse and neglect or reporting domestic violence),
- Basis for disclosing your child's health information to a law enforcement official, for purposes such as identifying or locating an individual, in complying with a court order or subpoena, and other law enforcement purposes,
- Source for public safety. We may disclose your child's health information to appropriate persons in order to prevent or lessen a serious threat to health or safety of a particular person, or the general public, and
- Tool in educating health professionals, source of data for medical research, and tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Pediatric Psychology Associates, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Health Information Practices upon request,
- Inspect and copy your health record, as provided for in 45 CFR 164.524,
- Amend your health record, as provided for in CFR 164.528,
- Obtain an accounting of disclosures of your health information, as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information, as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken.

Our Responsibilities

Pediatric Psychology Associates is required to:

- Maintain the privacy of your health information,
- Provide you with a copy of this Notice as to your legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this Notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice, provided those changes affect your health information, to you at the address you have supplied us, or if you agree, we will e-mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization, according to the procedures included in the Authorization.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact Pediatric Psychology Associates at (305) 936-1002. If you believe your privacy rights have been violated, complaints should also be directed to Pediatric Psychology Associates. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint with either, Pediatric Psychology Associates or the Office of Civil Rights.

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Acknowledgment of Receipt of HIPAA Privacy Notice and New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ (print name of adult patient, parent or guardian of minor), understand that as a part of my or my family's health care, Pediatric Psychology Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professions who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer (i.e., insurance) can verify that services billed were actually provided, and
- A tool for assessing quality and reviewing the competence of healthcare professionals.

I have been presented with a copy of Pediatric Psychology Associates' Notice of Privacy Policies detailing how my information may be used and disclosed under Federal and State law. I understand the contents of the Notice. Further, I permit a copy of this Acknowledgment to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply. I understand and have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this Consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this Consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this Consent or revoking this Consent, Pediatric Psychology Associates may refuse to treat me, as permitted by section 164.506 of the Code of Federal Regulations. I understand that Pediatric Psychology Associates reserves the right to change its notice and practices prior to implementation, in according with section 164.520 of the Code of Federal Regulations. Should Pediatric Psychology Associates change its practices, it will send a copy of any revised notice to the address I have provided by U.S. mail, or e-mail, if I agree.

I understand that as a part of Pediatric Psychology Associates' treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice.

Name of Patient (Printed): _____Date:_____

Patient, Parent or Guardian Signature: _____

If refused, reason for refusal: _____ Restrictions noted: _____

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Teletherapy Policies and Procedures

Pediatric Psychology Associates provides Teletherapy Services to individuals and families to supplement in-office sessions, as well as to individuals that may have transportation or scheduling conflicts to attend sessions in the office. In the event that you or your family decides to use our Teletherapy Services, this document has been provided to you to outline our procedures for those services. It contains instructions on how to connect with your therapist for your teletherapy sessions, along with important information about Pediatric Psychology Associates' Teletherapy Polices. ***Please read this document completely and save it for your records.***

1. Pediatric Psychology Associates uses Doxy.me (**www.doxy.me**) for its Teletherapy Sessions. The program is accessible through a web browser on your computer or a free app download on mobile devices. Doxy.me is HIPAA compliant and easy to use. When you schedule your teletherapy appointment, you will be given the "Waiting Room" web address for your therapist. This will be the address you will use every time you have a teletherapy session. You may access the waiting room at any time, and your therapist will be able to see that you have connected. At the time of your appointment, your therapist will initiate the teletherapy session. Please note that your computer or mobile device will require internet connection, a webcam, and a microphone.

2. In the case of a disconnection, you should attempt to reconnect to your therapist's doxy.me Waiting Room. If reconnection is not possible, please call the office at 305-936-1002 and your therapist will either resume your session via phone or may choose to reschedule the appointment.

3. The convenience of teletherapy sessions along with our tendencies to multitask while communicating via technology often leads patients to see teletherapy sessions differently than an in-office visit (e.g. try to get their session done "on the go" or while doing other things). Approaching a teletherapy session in this manner frequently leads to distractions, interruptions during the session, loss of privacy, and an overall reduction in efficacy of treatment. **It is very important that you treat your teletherapy session just the same as an in-office visit.** That means that you will need to be in a quiet, private place that is free of distractions and interruptions. If at the time of your session your therapist finds that you are not in a suitable location for the appointment, he or she may choose not to continue with the session, at which point you would be responsible for payment for the session as though it were a no-show.

4. Your therapist is not permitted to conduct teletherapy via any means other than Doxy.me (i.e. Skype, FaceTime, etc.) as these do not meet our required criteria for HIPAA compliance.

5. Because you are not physically in the office to remit payment, arrangements for payment for Teletherapy Sessions must be made in advance of the session.

If you have any questions regarding our Teletherapy Policies and Procedures, please do not hesitate to discuss them with your therapist or to give us a call at the office.

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Telehealth Services Agreement and Informed Consent

I _____(patient/guardian name/s) hereby consent to participating in Telehealth Services with *Pediatric Psychology Associates* (PPA).

Telehealth services are defined as communication between yourself and our practice via telephone, email, text message, video conferencing, or any other remote means that utilizes electronic transmitting technology. This includes what is defined as "teletherapy" (psychotherapeutic intervention done remotely via videoconferencing or telephone), as well as use of technology for administrative purposes (e.g. emails and phone calls regarding scheduling appointments). I understand that Telehealth allows my therapist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment. This Consent Form covers all forms of electronic communication (teletherapy and administrative). I have read and understand the following important information regarding Telehealth Services:

1. I have a right to confidentiality with telehealth services under the same laws that protect the confidentiality of my medical information for in-person psychotherapy, as noted in PPA's Informed Consent Form.
2. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective, and this includes Telehealth Services.
3. I understand that Telehealth Services risk technological failure that could cause distortion or complete disruption.
4. I understand that if my therapist believes Telehealth Treatment Services (e.g. psychotherapy via videoconferencing) are not an appropriate intervention, he/she will make an appropriate referral for services they judge to be more appropriate for my circumstances. This may include a referral for in-person treatment.
5. I have the right to withhold or withdraw this consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
6. I understand that PPA uses HIPAA compliant methods for Telehealth Services. However, no use of technology can be 100% protected. I also understand that the confidentiality of any text messages, emails, or voicemails I choose to keep is my responsibility and not the responsibility of PPA.

_____	_____	_____
Client/Guardian Printed Name	Client/Guardian Signature	Date

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PSYCHOLOGICAL RECORDS AND PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ **DOB:** _____

I, undersigned, voluntarily request and authorize the personnel at Pediatric Psychology Associates (PPA) to obtain from and/or release to the agency(ies)/individual(s) I have indicated below the information contained in my and/or my family's clinical and medical record. I authorize PPA to release and/or obtain this private information verbally, in writing and/or electronically. I understand the purpose of the release/sharing of information may include clinical information, treatment planning, consultation, protection of self or others, coordinating interventions, educational planning, billing and collections, etc.

Check all that apply: I hereby authorize PPA _____ to release to and _____ to receive information from:

Name/Agency	Contact Information (address, phone, email, fax, etc.)

I authorize PPA to (check one):

[ ] Release any or all medical records

[ ] Release specific information- please list here_____

_____

This authorization shall expire on (please check the box that applies):

[ ] Date ____/____ /_____ [ ] Treatment Termination [ ] No Expiration Date

By signing below, I agree to the exchange of the above information. I acknowledge that the nature of this information has been discussed with me in a manner that I understand, and that I have had an opportunity to have any questions regarding the above exchange of information explained to me. I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations. I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to one of PPA's offices.

Signature of Patient/Authorized Representative _____

Printed Name of Signer _____ Date _____