



General & Specialized Psychological Services

### CHILD AND ADOLESCENT INTAKE FORM

Name of Child: \_\_\_\_\_

Child's Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Child's Race: \_\_\_\_\_

Your Name: \_\_\_\_\_ Your relationship to child: \_\_\_\_\_

Name and address of child's legal guardian: \_\_\_\_\_

Home Phone for guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_

Social Security Number for Child's Legal Guardian: \_\_\_\_\_

Who referred the child for this evaluation? \_\_\_\_\_

Why was the child referred? \_\_\_\_\_

**Family History:**

City and state where child was born: \_\_\_\_\_

Who did child live with after he/she was born? \_\_\_\_\_

Were the child's parents married? Yes / No (circle one) Did they divorce? Yes / No (circle one)

If they divorced, list date of divorce or child's age at time of divorce: \_\_\_\_\_

Did either parent remarry? Yes / No If so, list date or child's age when parent(s) remarried:

\_\_\_\_\_

Name of child's father: \_\_\_\_\_ Child's mother: \_\_\_\_\_

Stepmother(s): \_\_\_\_\_

Stepfather(s): \_\_\_\_\_

List all of the child's brothers and sisters, including step-siblings and half-siblings:

Name of sibling	Age	Sex (m/f)	Child's father	Child's mother

Father's job: \_\_\_\_\_ Mother's job: \_\_\_\_\_

Step-mother's job: \_\_\_\_\_ Step-father's job: \_\_\_\_\_

List all placements where child has lived (such as with parents, foster parents, group home, etc):

<i>Child's Age at the time</i>	<i>Placement / Name of caretakers</i>	<i>Reason for Leaving Placement</i>

List all of the people in the house or placement where the child currently lives. List names and ages for any children in the placement:

\_\_\_\_\_

\_\_\_\_\_

List anyone the child currently shares a bedroom with: \_\_\_\_\_

***Developmental History:***

Were there any problems during the mother's pregnancy and/or during the child's birth or delivery? Yes / No (circle one). If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Did the child show any delays in walking, talking, toilet training, or in achieving any other developmental milestones? Yes / No (circle one). If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

What grade does the child currently attend? \_\_\_\_\_

Has the child ever repeated a grade level? Yes / No (circle one). Grade(s) repeated: \_\_\_\_\_

Does the child have any history of learning problems? Yes / No (circle one).

Describe any learning problems: \_\_\_\_\_

Does the child have any reading difficulties? Yes / No (circle one).

What is the child's estimated reading level (by grade)? \_\_\_\_\_

Indicate the type of classes and/or school the child attends:

<input type="checkbox"/> Regular classes	<input type="checkbox"/> Psychoeducational program
<input type="checkbox"/> Alternative school	<input type="checkbox"/> Home school
<input type="checkbox"/> Special education classes	Specify type:
<input type="checkbox"/> Emotional/behavioral disorder classes (EBD)	<input type="checkbox"/> Other: _____

Check any of the problems that the child currently has in school:

<input type="checkbox"/> Problems paying attention	<input type="checkbox"/> Problems getting along with other students
<input type="checkbox"/> Problems understanding schoolwork	<input type="checkbox"/> Problems sitting still

<input type="checkbox"/> Problems following directions	<input type="checkbox"/> Being disrespectful to the teacher
<input type="checkbox"/> Other (describe): _____	

List any medical problems the child has had, including the dates or child's age:

\_\_\_\_\_

Does the child or the child's family have a history of: (check all that apply):

Child / Family	Child / Family	Child / Family
<input type="checkbox"/> <input type="checkbox"/> mental illness	<input type="checkbox"/> <input type="checkbox"/> sexual abuse	<input type="checkbox"/> <input type="checkbox"/> DFCS involved
<input type="checkbox"/> <input type="checkbox"/> physical abuse	<input type="checkbox"/> <input type="checkbox"/> homelessness	<input type="checkbox"/> <input type="checkbox"/> frequent moving
<input type="checkbox"/> <input type="checkbox"/> alcohol abuse	<input type="checkbox"/> <input type="checkbox"/> neglect	<input type="checkbox"/> <input type="checkbox"/> domestic violence
<input type="checkbox"/> <input type="checkbox"/> drug abuse	<input type="checkbox"/> <input type="checkbox"/> unstable lifestyle	<input type="checkbox"/> <input type="checkbox"/> Psychiatric hospitalization
<input type="checkbox"/> <input type="checkbox"/> criminal history	<input type="checkbox"/> <input type="checkbox"/> emotional abuse	

Please explain any items that were checked: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***Psychiatric History:***

Check any of the **emotional problems** the child has had. List the ages when the problem began and ended. Or, put a check if the client still has the problem.

Age problem began	Age problem ended	Child still has this problem	Problem
		<input type="checkbox"/>	Bedwetting
		<input type="checkbox"/>	Soiling or wetting pants during day
		<input type="checkbox"/>	Nightmares
		<input type="checkbox"/>	Difficulty falling asleep or staying asleep
		<input type="checkbox"/>	Frequent crying
		<input type="checkbox"/>	Sad much of the time

		<input type="checkbox"/>	Talks about killing self
		<input type="checkbox"/>	Withdraws from others
		<input type="checkbox"/>	Anxiety or nervousness
		<input type="checkbox"/>	Fear of separating from caretaker
		<input type="checkbox"/>	Clinging to adults
		<input type="checkbox"/>	Refusal to go to school
		<input type="checkbox"/>	Hyperactivity
		<input type="checkbox"/>	Low self-esteem
		<input type="checkbox"/>	Difficulty paying attention
		<input type="checkbox"/>	Difficulty getting along with peers
		<input type="checkbox"/>	Self-harming behaviors
		<input type="checkbox"/>	Complaints about health (such as headaches)
		<input type="checkbox"/>	Hoarding food or other things
		<input type="checkbox"/>	Hearing voices
		<input type="checkbox"/>	Seeing things that are not really there
		<input type="checkbox"/>	Overeating
		<input type="checkbox"/>	Obsession with weight
		<input type="checkbox"/>	Other: _____

Check any of the **behavioral problems** the child has had. List the ages when the problem began and ended. Or put a check if the child still has the problem.

Age problem began	Age problem ended	Child still has this problem	Problem
		<input type="checkbox"/>	Temper tantrums
		<input type="checkbox"/>	Refusing to obey rules or follow adults' requests
		<input type="checkbox"/>	Being disrespectful to parents
		<input type="checkbox"/>	Being disrespectful to teachers
		<input type="checkbox"/>	Destroying others' possessions
		<input type="checkbox"/>	Damaging property
		<input type="checkbox"/>	Setting fires

	<input type="checkbox"/>	Cruelty to animals
	<input type="checkbox"/>	Fighting with peers
	<input type="checkbox"/>	Physical aggression toward adults
	<input type="checkbox"/>	Lying
	<input type="checkbox"/>	Stealing
	<input type="checkbox"/>	Running away
	<input type="checkbox"/>	Using alcohol
	<input type="checkbox"/>	Using drugs
	<input type="checkbox"/>	Skipping school
	<input type="checkbox"/>	Bullying or threatening others
	<input type="checkbox"/>	Smearing feces
	<input type="checkbox"/>	Purposely urinating or pooping outside of toilet
	<input type="checkbox"/>	Other: _____

List any diagnoses the child has been given (such as ADHD) and list child's age when the diagnosis was given:

\_\_\_\_\_

List any medications the child has taken:

Medication	Reason for medication	Ages when taken	Check if still taking medication
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

List any counseling child has received:

Name of counselor      Reason for counseling      Ages when attended      Check if still attends counseling

Name of counselor	Reason for counseling	Ages when attended	Check if still attends counseling
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

List any psychiatric hospitalizations child has had:

Name of hospital      Age at hospitalization      Length of stay      Reason for hospitalization

Name of Hospital	Age at hospitalization	Length of stay	Reason for hospitalization

***Substance Use and Criminal History:***

Please complete the table for any substances your child has consumed:

	Age First Used	Age Last Used	Typical Amount Consumed	Frequency of Use
Caffeine				
Tobacco				
Alcohol				
Marijuana				
Narcotics				
Amphetamines				
Cocaine				
Hallucinogens				
Other:				

List any criminal charges the child has had:

Name of charge	Child's age at time of charge	What child was accused of doing	Sentence for charge

**Sexual History:**

Has the child ever been sexually abused? Yes\_\_\_\_ No\_\_\_\_ List sexual abuse below:

Child's age at the time	Perpetrator's Age	Child's Relationship to Perpetrator	Types of Sexual Acts	Period of Time of Abuse

Has the child ever been exposed to adult sexual activity? Yes / No (circle) At what age? \_\_\_\_\_

Describe how the child saw this: \_\_\_\_\_

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Describe any times the child has seen pornography: \_\_\_\_\_

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Describe any sexual behaviors that the child has been accused of: \_\_\_\_\_

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Check any of the **sexual behaviors** the child has shown or been accused of. List the ages when the behavior began and ended. Put a check if the child still shows this behavior.

Age problem began	Age problem ended	Child still has this problem	Age and sex (male or female) of other person involved	Sexual behavior
		<input type="checkbox"/>		Writing sexual notes to others
		<input type="checkbox"/>		Making sexual comments to others
		<input type="checkbox"/>		Making sexual gestures
		<input type="checkbox"/>		Sexual play with dolls or toys
		<input type="checkbox"/>		Showing private parts to adults

		<input type="checkbox"/>	Showing private parts to other children
		<input type="checkbox"/>	Touching child's private parts above clothes
		<input type="checkbox"/>	Touching child's private parts under clothes
		<input type="checkbox"/>	Having sexual intercourse (vaginal sex)
		<input type="checkbox"/>	Putting mouth on private parts (oral sex)
		<input type="checkbox"/>	Having someone perform oral sex on them
		<input type="checkbox"/>	Putting penis in someone's anus (anal sex)
		<input type="checkbox"/>	Having someone perform anal sex on them
		<input type="checkbox"/>	Showing pornography to another child
		<input type="checkbox"/>	Touching an adult's breasts
		<input type="checkbox"/>	Touching an adult's buttocks
		<input type="checkbox"/>	Touching an animal's genitals
		<input type="checkbox"/>	Peeping on others
		<input type="checkbox"/>	Showing pornography to others
		<input type="checkbox"/>	Dressing in women's clothing or make-up
		<input type="checkbox"/>	Stealing women's clothing
		<input type="checkbox"/>	Stealing fetish objects such as shoes
		<input type="checkbox"/>	Other: _____

Do you think that this child has a sexual problem? Yes / No (circle one) Why or why not?

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I declare that I am the custodial parent or legal guardian of this child and that I have the legal authority to bring him or her in for psychological evaluation or treatment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



**CLIENT CONTACT SHEET**

**Client's Full/Legal Name:** \_\_\_\_\_  
First Middle Initial Last Jr./Sr./III

**Client's Parent/Guardian Name:** \_\_\_\_\_  
 (If applicable) First Middle Initial Last Jr./Sr./III

**Relationship of Above to Client:** \_\_\_\_\_  
 (If applicable)

**Phone #'s:** \_\_\_\_\_ (h) \_\_\_\_\_ (w)  
 \_\_\_\_\_ (c) \_\_\_\_\_ (Fax)

**Client's Physical Address:** \_\_\_\_\_  
Street Address

City State Zip

**Client's Mailing Address (if different):** \_\_\_\_\_  
Street Address

City State Zip

**Client's Social Security #:** \_\_\_\_\_

**Client's Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Client's School/Employer:** \_\_\_\_\_

If client is child/dependent, complete the following:  
**Parent/Guardian's Social Security #:** \_\_\_\_\_

**Parent/Guardian's Date of Birth:** \_\_\_\_\_

**Parent/Guardian's Employer:** \_\_\_\_\_

\_\_\_\_\_  
 Signature of Adult Date  
*I certify that all the above information is true to the best of my knowledge and ability.*



## **INFORMED CONSENT FOR PSYCHOLOGICAL TESTING OF CHILDREN AND ADOLESCENTS**

### **Purpose of the Evaluation:**

Medlin Treatment Center will conduct an evaluation to examine the child's psychological functioning and treatment needs. Depending on the referral question, the evaluation will address the child's emotional adjustment, behavior, intellectual functioning, academic achievement, and/or attentional skills.

### **Tests Used:**

The child will be administered a battery of psychological tests as part of the evaluation process. Those tests will include some or all of the following, depending upon the child's age and nature of the referral question:

**Diagnostic Interview:** The child will be interviewed regarding his or her background history, family history, and issues related to the referral question. Additional information will be gathered from the child's parents and other sources as needed. It should be noted that the examiner is legally required to report to Child Protective Services any allegations of physical or sexual abuse of a child.

**Children's Apperception Test (CAT):** In this test, the child is asked to tell stories about pictures that depict general family themes. This test provides insight into the child's emotional state and psychological issues.

**Children's Depression Inventory (CDI):** This is a self-report measure that assesses a child's level of depression. This test contains scales that assess negative mood, interpersonal problems, loss of pleasure, negative self-esteem, and feelings of ineffectiveness.

**Kaufman Brief Intelligence Test (KBIT):** This test assesses verbal skills and abstract reasoning. This test takes approximately 20 minutes and provides a quick measure of general intellectual functioning.

**Piers-Harris Children's Self-Concept Scale:** This is a self-report measure that was designed to assess how children and adolescents feel about themselves.

**Projective Drawings:** The child is asked to draw pictures. These drawings can reveal insights about the child's emotional state and psychological issues.

**Revised Children's Manifest Anxiety Scale (RCMAS):** This self-report questionnaire measures a child's level of anxiety, and nature of anxiety.

**Minnesota Multiphasic Personality Inventory - Adolescent Form (MMPI-A):** This is a widely used test to assess emotional adjustment and attitude toward test-taking.

**Multiaxial Diagnostic Inventory – Revised (MDI-R):** This questionnaire assesses symptoms associated with various psychiatric disorders.

**Personal Problems Checklist:** This questionnaire asks about general problems that many adolescents have.

**Test of Variables of Attention (T.O.V.A.):** This is a computerized test that was developed to assess attention and impulse control. The child is presented with visual or auditory stimuli on the computer and is asked to respond according to certain rules.

**Trauma Symptom Checklist for Children (TSCC):** This questionnaire is a self-report measure of posttraumatic distress and related psychological symptoms. The TSCC is intended for use in the evaluation of children who have experienced traumatic events, including childhood physical and sexual abuse. The TSCC measures anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns.

**Wechsler Intelligence Scale for Children (WISC) – 4<sup>th</sup> Edition:** This test assesses intellectual functioning. It contains subtests that assess the child's verbal skills and nonverbal reasoning.

**Woodcock-Johnson Tests of Achievement III (WJ III):** This test assesses academic achievement in the areas of reading, spelling, mathematics, and written language.

**Wide Range Achievement Test (WRAT) – Fourth Edition:** This test assesses academic achievement in the areas of reading, spelling, and arithmetic.

**Substance Abuse Subtle Screening Inventory (SASSI):** This questionnaire assesses for substance abuse issues in adolescents.

**ADDES 2<sup>nd</sup> Edition – Home & School Versions:** This is a parent or teacher questionnaire that the child's parent or caretaker (home version) or teacher (school version) completes. This questionnaire provides information about the parent's or teacher's observations of the child's behaviors.

**Achenbach Child Behavior Checklist (CBCL):** This questionnaire is also completed by the parent or caretaker. This questionnaire provides information about the child's emotional or behavioral problems.

Other tests may be used as needed to further assess the referral question.

**Uses of the testing:**

The overall purpose of the testing is to assess the child's psychological functioning and to address the referral question. The test data may be used in the following ways:

- 1) To help develop an understanding of the child's emotional and behavioral adjustment;
- 2) To help develop ideas about any problems the child may be experiencing such as depression, anxiety, behavior problems, learning difficulties, attentional problems, substance abuse, etc.
- 3) To report the child's need for treatment or treatment progress to parents or the appropriate agency, attorney, juvenile court, etc.
- 4) The testing may be used to provide ongoing research data to help better understand individuals who may have psychological problems. Any data that may be used will not be linked personally to any client. All data will be coded with assigned research numbers rather than names.

**Fees:**

The fee for this evaluation is \_\_\_\_\_. This covers up to \_\_\_\_\_ hours of work. If additional hours are needed, the evaluator will discuss this with you.

Additional testing, expert testimony in court, conferences with schools, attorneys or court officials, and telephone consultation about the report will be charged at \$200 per hour. The appropriate fees must be paid before service is rendered.

Clinical services may be provided by a clinician who is seeking licensure under the supervision of a licensed clinician on staff. If this applies in your case, you will be notified of this at the time of the service.

I understand that by signing this Informed Consent Form, I agree to all terms and conditions contained herein and hold harmless Medlin Treatment Center. I also understand that no test results will be released from this clinic without my express written consent. If you would like for the test results to be released, please fill in and sign the Release of Information form attached.

My signature below indicates that I have read and understand the above-stated conditions of testing, payment, and information release.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

As the legal guardian, I give permission for this evaluation to be conducted, and I accept responsibility for all fees incurred. I have read the above information and agree to all terms and conditions contained herein and hold harmless Medlin Treatment Center.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date



General & Specialized Psychological Services

### AUTHORIZATION TO RELEASE INFORMATION

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_  
Client: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**Need for Release:** to obtain information necessary to conduct an evaluation and to release a copy of the report \_\_\_\_\_

**Information to be disclosed:**

- |  |  |
|--|--|
| _____ Results of psychological testing | _____ Recommendations for therapy      |
| _____ Diagnosis                        | _____ Medication                       |
| _____ Treatment Plan                   | _____ Physical Status                  |
| _____ Statement of Progress            | _____ All Protected Health Information |
| _____ Other: _____                     |  |

I hereby authorize \_\_\_\_\_ to \_\_\_ obtain and \_\_\_\_\_ release the above information regarding myself or my dependent, above named. It is further understood that this authorization is subject to revocation at any time in writing. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that MTC generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_ Please expect a telephone call from the above named therapist to discuss these matters.

\_\_\_\_\_ Please send information to 110 Eagles Walk Ste 100 Stockbridge, GA 30281.

SIGNED: \_\_\_\_\_  
Date: \_\_\_\_\_  
Expires: \_\_\_\_\_

Witness: \_\_\_\_\_  
Date: \_\_\_\_\_



## Medlin Treatment Center-Patient Services Agreement

Welcome to Medlin Treatment Center (hereinafter referred to as “MTC”). This document (the Agreement) contains important information about MTC’s professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new 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. HIPAA requires that MTC provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that MTC obtain your signature acknowledging that MTC has provided you with this information during this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on MTC unless MTC has taken action in reliance on it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

### **PSYCHOLOGICAL SERVICES**

Psychotherapy and psychological evaluation are not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems you are experiencing. There are many different methods the clinicians at MTC may use to deal with the problems that you have to address. Psychotherapy and psychological evaluation are not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy and/or evaluation to be most successful, you will need to play an active role in the process.

### **LIMITATIONS OF SERVICES**

I understand that psychological services are limited to psychological evaluation, assessment, consultation and intervention. I understand that evaluation and assessment services may also include the use of psychological and neuropsychological tests. I understand that intervention services may include counseling and brief psychotherapy. I understand that the undersigned therapist is not warranting a cure or offering any guarantee of results or improvement of any condition.

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110 Eagles Walk, Ste. 100  
Stockbridge, GA 30281  
Voice (770) 507-6044  
Fax (770) 507-5284

698 N. Marietta Pkwy.  
Marietta, GA 30060  
Voice (770) 919-9088  
Fax (770) 919-8708

30-C Fox Chase  
Cartersville, GA 30120  
Voice (678) 721-2249  
Fax (678) 721-2424

3320 Old Salem Road  
Conyers, GA 30013  
Voice (770) 507-6044  
Fax (770) 507-5284

### **ASSUMPTION OF RISKS**

I understand that the potential benefits of undergoing psychological services may include obtaining a professional opinion and an increased understanding of myself. I understand that potential risks may include limited predictive validity of psychological assessment procedures and possible emotional distress concerning my situation. I understand that alternative procedures include services provided by another psychologist, psychiatrist, or mental health professional.

### **APPOINTMENTS**

If psychotherapy is begun, MTC will usually schedule at least one session (one appointment hour of 45 to 60 minutes in duration for individual therapy and one appointment 1.5 to 2 hours for group therapy) per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours [1 day] advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, MTC will try to find another time to reschedule the appointment.

### **PROFESSIONAL FEES**

MTC's hourly fee for individual therapy is \$55 for a Masters-level clinician and \$115 for a Licensed Psychologist. MTC's fees for group therapy are \$30 when group therapy is conducted in addition to individual therapy and \$50 when group therapy is the only clinical service provided. In addition to weekly appointments, MTC charges the following rates for other related services: \$80 an hour for court testimony, depositions, or related court work by a Masters-level clinician; \$150 an hour for court testimony, depositions, or related court work by a licensed psychologist; \$0.05 per page copied of a client's Protected Health Information (only after one copy has already been provided to the client within a 12 month period); \$15 for writing a personal check that is returned by the bank due to insufficient funds; \$15 for client workbooks for adults; \$20 for workbooks for children; \$22 for workbooks for adolescents; \$7 for guidebooks for parents of adolescents in treatment; or, an amount equal to that charged for individual therapy for other professional services you may need, though MTC will break down the hourly cost if MTC work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries for third parties not involved with your case initially, and the time spent performing any other unspecified service you may request of me that is above and beyond the normal course of treatment. If you become involved in legal proceedings that require your MTC clinician's participation, you will be expected to pay for all of your MTC clinician's professional time, including preparation and transportation costs, even if your MTC clinician is called to testify by another party.

### **CONTACTING MTC**

Due to work schedules, your therapist is often not immediately available by telephone. While MTC's offices are open between 9 AM and 9 PM, your MTC clinician will probably not answer the phone when he or she is with a patient. When your MTC clinician is unavailable, your telephone call will be answered by an administrative professional directly employed by MTC. MTC will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. In the case of emergencies (when there is an immediate threat to someone's safety), please page the MTC representative on-call at 770-589-0726. If you are unable to reach your therapist and feel that you can't wait for your therapist to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If MTC will be unavailable for an extended time, MTC will provide you with the name of a colleague to contact, if necessary.

**LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a psychologist. In most situations, MTC 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, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- MTC may occasionally find it helpful to consult other health and mental health professionals about a case. For example, MTC therapists may consult with each other during treatment team meetings. If an MTC therapist consults with another professional outside of MTC, the therapist will make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, MTC will not tell you about these consultations unless MTC feels that it is important to our work together. MTC will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that MTC is a group practice with other mental health professionals and that MTC employs administrative staff. In most cases, MTC will need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- As required by HIPAA, MTC has formal business associate contracts with all independent contractors (licensed psychologists on staff) and businesses (cleaning service, attorney serving as general counsel to MTC, accountant) that may have contact with your confidential information to the most limited extent possible for MTC to operate, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, MTC can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, MTC 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 MTC is 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 MTC's professional services, such information is protected by the psychologist-patient privilege law. MTC cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order MTC to disclose information.
- If a government agency is requesting the information for health oversight activities, MTC may be required to provide it for them.
- If a patient files a complaint or lawsuit against MTC or their MTC clinician, MTC may disclose relevant information regarding that patient in order to defend MTC or the MTC clinician.

- Where the validity of a will of a former patient is contested.
- If a patient files a worker's compensation claim, and MTC is providing treatment related to the claim, MTC must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which MTC is legally obligated to take actions, which MTC believes are necessary to attempt to protect others from harm and MTC may have to reveal some information about a patient's treatment.

- If MTC has reason to believe that a child has been abused, the law requires that MTC file a report with the appropriate governmental agency, usually the Department of Human Resources, Division of Family and Children Services. Once such a report is filed, MTC may be required to provide additional information.
- If MTC has reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, MTC must report to an agency designated by the Department of Human Resources. Once such a report is filed, MTC may be required to provide additional information.
- If MTC determine that a patient presents a serious danger of violence to another, MTC may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, MTC will make every effort to fully discuss it with you before taking any action, unless the therapist deems that sharing this information may cause harm, such as in the case of suspected child abuse. MTC will limit any disclosures to what is necessary.

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 now or in the future. The laws governing confidentiality can be quite complex, and MTC and its staff are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

## **PROFESSIONAL RECORDS**

You should be aware that, pursuant to HIPAA, MTC keeps Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself or others, or makes reference to another person (unless such other person is a health care provider) and MTC believes that access is reasonably likely to cause substantial harm to such other person, or if information is supplied to MTC confidentially by others, you or your legal representative may examine and/or receive a copy of your Clinical Record, if you request it in writing. HIPAA allows MTC 30 days to prepare and provide a copy of your Clinical Record, with the option of an additional 30 days if the extension is asked for in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, MTC recommends that you initially review them in the presence of your MTC clinician, or have them forwarded to another mental health professional so you can discuss the contents. For more than one copy of your Clinical Record per 12 month period, MTC is allowed to charge a copying fee of \$ 0.05 per page (and for any special shipping or delivery requests). The exceptions to this policy are contained in the attached Notice Form. If MTC

refuses your request for access to your records, you have a right of review (except for information provided to MTC confidentially by others), which MTC will discuss with you upon request.

In addition, MTC also keeps a set of Psychotherapy Notes. These Notes are for the use of your MTC clinician and are designed to assist him or her in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations with your therapist, analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal in therapy that is not required to be included in your Clinical Record [and information supplied to your therapist confidentially by others]. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

### **PATIENT RIGHTS**

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

### **MINORS & PARENTS**

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

### **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. For MTC to provide services related to a court case you are involved in and your clinician will be involved in as a result, MTC requires you to pay a retainer fee equal to five (5) hours spent on the case before MTC's involvement begins.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, MTC has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require your therapist to disclose otherwise confidential information. In most collection situations, the only information MTC releases regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

**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 your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. MTC will fill out forms and provide you with whatever assistance MTC can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of MTC's fees. In the case of utilizing out-of-network insurance benefits, it is MTC's policy to require you to pay for the full cost of services at the time of service. At that point, MTC will file or help you file (at your choosing) the insurance claim forms to get you reimbursed by your insurance carrier. 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, MTC will provide you with whatever information MTC can, based on our 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, MTC will call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become 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 to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow your therapist to provide services to you once your benefits end. If this is the case, MTC will do its best to find another provider who will help you continue your psychotherapy.]

You should also be aware that your contract with your health insurance company requires that MTC provide it with information relevant to the services that MTC provides to you. MTC is required to provide a clinical diagnosis. Sometimes MTC is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, MTC will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, MTC has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. MTC will provide you with a copy of any information MTC releases, if you request it. By signing this Agreement, you agree that MTC can provide requested information to your carrier.

Once we have all of 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 your sessions. It is important to remember that you always have the right to pay for MTC services yourself to avoid the problems described above [unless prohibited by contract].

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

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Signature of Client (or Guardian)

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Date



## ***Notice of Medlin Treatment Center's Policies and Practices to Protect the Privacy of Your Health Information***

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Medlin Treatment Center (hereafter referred to as "MTC") may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when MTC provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when MTC consults with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when MTC obtains reimbursement for your healthcare. Examples of payment are when MTC discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of MTC's practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within MTC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of MTC, such as releasing, transferring, or providing access to information about you to other parties.

### **II. Uses and Disclosures Requiring Authorization**

MTC may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written

110 Eagles Walk, Ste. 100  
Stockbridge, GA 30281  
Voice (770) 507-6044  
Fax (770) 507-5284

698 N. Marietta Pkwy.  
Marietta, GA 30060  
Voice (770) 919-9088  
Fax (770) 919-8708

30-C Fox Chase  
Cartersville, GA 30120  
Voice (678) 721-2249  
Fax (678) 721-2424

3320 Old Salem Road  
Conyers, GA 30013  
Voice (770) 507-6044  
Fax (770) 507-5284

permission above and beyond the general consent that permits only specific disclosures. In those instances when MTC is asked for information for purposes outside of treatment, payment or health care operations, MTC will obtain an authorization from you before releasing this information. MTC will also need to obtain an authorization before releasing your Psychotherapy Notes. “*Psychotherapy Notes*” are notes your clinician at MTC has made about conversations during a private, group, joint, or family counseling session, which MTC has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) MTC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage’ law provides the insurer the right to contest the claim under the policy.

### **III. Uses and Disclosures with Neither Consent nor Authorization**

MTC may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If MTC has reasonable cause to believe that a child has been abused, MTC must report that concern to the appropriate authority.
- *Adult and Domestic Abuse* – If MTC has reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, MTC must report that concern to the appropriate authority.
- *Health Oversight Activities* – If your clinician at MTC is the subject of an inquiry by the Georgia Licensing Board with jurisdiction over that clinician’s license, MTC may be required to disclose protected health information and psychotherapy notes regarding you in proceedings before the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services MTC provided you or the records thereof, such information is privileged under state law, and MTC will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If your clinician at MTC determines, or pursuant to the standards of their profession should determine, that you present a serious danger of violence to yourself or another, MTC may disclose information in order to provide protection against such danger for you or the intended victim.
- *Worker’s Compensation* – MTC may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s

compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

#### **IV. Patient's Rights and MTC's Duties**

##### Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, MTC is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a clinician at MTC. On your request, MTC will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. MTC may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, MTC will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. MTC may deny your request. On your request, MTC will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, MTC will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically.

##### MTC's Duties:

- MTC is required by law to maintain the privacy of PHI and to provide you with a notice of MTC's legal duties and privacy practices with respect to PHI.
- MTC reserves the right to change the privacy policies and practices described in this notice. Unless MTC notifies you of such changes, however, MTC is required to abide by the terms currently in effect.
- If MTC revises its policies and procedures, MTC will provide you with an updated notice at your next scheduled visit to our facilities. MTC will also post this notice in a public area at its office and on its website.

**V. Complaints**

If you are concerned that MTC has violated your privacy rights, or you disagree with a decision MTC made about access to your records, you may contact Jay Hall, Vice President/Privacy Protection Officer, (770) 507-6044.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

**VI. Effective Date and Changes to Privacy Policy**

This notice went into effect on Monday, April 14, 2003.

MTC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that MTC maintains. MTC will provide you with a revised notice in person at the time of your next scheduled visit to our facilities.

\_\_\_\_\_  
Signature of Client Acknowledging Receipt of Notice

\_\_\_\_\_  
Date