CONSENT FOR SERVICES, POLICIES,

AND FEE AGREEMENT

NeuroBehavioral Concepts | llc
Tax ID 26.2350260
NPI 1851574404
www.neurobx.com
503.803.9361

Responsible Party's Name:_____

Client Name: _____ DOB: _____

Address:_____

_____

Welcome to Neurobehavioral Concepts or as we like to call it, NBx. We are pleased you have chosen us for services and will do everything possible to help make your experience positive and helpful. Please read the information below, sign and date the form.

GENERAL FINANCIAL POLICES

NBx does not contract with any private health plans. This means financial agreements are established directly between NBx and clients/families, and not between NBx and any privately-owned third-party companies or entities. The client therefore assumes financial responsibility for professional fees accrued over the course of psychological services.

OFFICE HOURS

Our office hours are from 7:00 a.m. to 5:00 p.m. Monday through Friday. If you leave a voice message and we haven't gotten back to you within 24 hours, please assume we have been unable to connect with you and call again.

COMMUNICATION VIA VOICE MAIL/EMAIL

Voice mail and email should be utilized for setting/changing appointment times. Email may be used as a form of data collection, in consultation with your therapist, if you wish but we are unable to respond to issues of a therapy nature via email or voice mail.

CRISIS SITUATIONS

NBx is not a crisis facility. If a life threatening or other crisis situation arises, please take the following steps: (1) call 911, (2) call your local mental health crisis line, or go to the nearest emergency room, (3) call your counselor to make them aware of the situation.

SCHEDULING APPOINTMENTS/CANCELLATION/NO SHOW POLICY

Scheduling appointments is your responsibility and is done online at www.NeuroBx.com/calendar. For the consideration of your therapist and other clients, you are expected to keep scheduled appointments or cancel at least 24 hours in advance. If you do not attend nor cancel an appointment with your therapist at least 24 hours ahead of the appointed time, you will be charged for the missed session,

which is not covered by any insurance. Allowances are made for emergencies. 1ST no show or less than 24 hour cancellation: $75.00, 2nd no show or less than 24 hour cancellation: Full fee.

COUNSELING/THERAPY SESSIONS

Therapy sessions usually last 45 to 50 minutes. Their frequency will be determined between you and your therapist according to your need. Extened Sessions usually last two hours depending on the type of treatment. Parents who bring their children to NBX are responsible for their supervision at all times in the waiting room and/or the property at large.

NOTICE OF CONFIDENTIALITY AND LIMITATIONS

Federal and state laws and regulations protect the confidentiality of mental health records maintained by us. Violation of such is a crime. No information is released to any source outside the agency without your written permission or a court order, a medical emergency, or audit. Crimes committed against the NBX staff, property, or confidentiality laws do not protect threats of crimes. Suspected child/elder abuse or neglect is not protected and must be reported to proper authorities. If you have questions or concerns about confidentiality, please discuss these with your therapist. You will also be provided with a Notice of Privacy Practices that covers how your health information is used and disclosed.

PARENTS OF MINOR CLIENTS: It is very important that children have a sense of privacy in their counseling in order for them to be open and honest. A child's right to confidentiality will be honored within the limits of state law. Although parents generally have an unlimited right to information involving their children, the counselor will attempt to disclose information to parents based on the counselor's judgment of what is in the child's best interest from a therapeutic standpoint. Because the therapeutic relationship is vital to change and support, we actively discourage parents from including the counselor in any court proceedings involving the children. At this time we do not provide child custody evaluations.

CONFIDENTIALITY FOR COUPLES/FAMILIES/GROUPS: Discuss with your counselor how you will handle spouse phone calls, scheduling, or individual sessions and the limits of confidentiality where couples, families and groups are involved.

CANCELLATION/NO SHOW POLICY

Insurance will not reimburse for missed appointments, and these charges are your responsibility.

FEES AND PAYMENT

Intake session payments are due at the time of service, subsequent sessions will be invoiced monthly as described below. We accept cash or check made payable to NBx. We also accept Credit Card payment with a 5.0% fee.

- Our current fee for the intake or inital diagnostic session is $450.
- Our current fee per session thereafter is $175 for 50 minute (family or individual psychotherapy) session.
- Extended sessions are $350 per 110 minute session.
- The fee for telemedicine (sessions via video conferencing devices) is $225 per session.
- Report review, evaluation and report writing is billed at $150 per hour.
- Expert/ Witness Testimony is billed at $600 per hour. This includes preparing for such legal action, including, but not necessarily limited to, traveling to and attending a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of my involvement in such legal action. This fee is due one week prior to the court proceeding. Additional fees will incur for each additional hour the therapist is required t o be retained at court.

CREDIT CARD AUTHORIZATION AND PAYMENTS

We request that you complete the attached Credit Card Payment authorization. We will retain your credit card information to secure payment. We send invoices by the 5th of each month and payment is expected on or before the 15th of each month. You may mail in your check, money order, or electronic check. If we do not receive payment in full within thirty (30) days of the invoice date on any invoice you receive from us, and you do not make contact with us to make payment arrangements or provide notice of your intention to contest our fees pursuant to this Consent For Services, Policies, and Fee Agreement, you authorize us to bill your credit card for the full amount past due plus a 5% credit card fee. If a balance is owed and remains unpaid after the due date of the invoice, you will be asked to postpone further sessions until your account is brought to a "zero" balance. Any failure or delay in exercising our rights under this paragraph does not constitute waiver or preclude any later exercise of such rights or any exercise of any other right. Such reserved rights include but are not limited to the right to release a client's name and address to a collection agency, to charge a monthly interest fee of 10% for unpaid balances, or a $25.00 service charge will be levied on all checks returned by a bank for insufficient funds. You consent to billing pursuant to these terms and to our storage of your credit card information. No additional authorization is required, and you agree that you will not contest or reverse ("charge-back") the charges, if we are unable to process your payment by credit card, we will notify you immediately. You will then be responsible for arranging an alternate form of payment in full within five (5) business days.

By executing the Credit Card Payment Authorization below, you agree to such automatic charges, and you agree to promptly inform us of any changes to your credit card or billing information.

INSURANCE COVERAGE FOR PSYCHOTHERAPEUTIC SERVICES

Although NBx has opted to be an out-of-network provider with private insurance plans, many health plans include out-of-network benefits. If available, such benefits can provide families with some level of financial reimbursement, and many clients therefore opt to utilize these benefits to defray part of the costs for psychological services. Please note that private health plans vary widely in their reimbursement rates and payment practices. For example, most insurers and health plans categorize struggles with academic issues as educational in nature, rather than as health-related. They therefore may consider them "not medically necessary," and might not provide reimbursement for testing focused on such matters.

Additionally, many insurance companies will reimburse for therapies if "coded" in particular ways. Please note that we code services based on what actually occurs in a session. We produce a high standard of professional services and our invoices reflect those services, we feel that it is unethical to change codes so ensure reimbursement. In that light, we encourage families to retain the invoices sent, as we are not responsible to make copies of invoices after they have been received.

The undersigned has read and understands the forgoing Consent For Services, Policies, And Fee Agreement and hereby accepts and agrees to the terms and conditions set forth therein concerning the engagement of NeuroBehavioral Concepts, LLC, for the performance of clinical and consultative services.

X_____ Date: _____
Client Signature (Parent/Guardian if minor)

X_____ Date: _____
Client Signature (2nd Parent/Guardian if minor)

Credit Card Payment Authorization
HSA cards not accepted

Client Name:		
Card Type:	☐ Visa ☐ Mastercard ☐ Other	
Credit Card #:		
Exp. Date on Credit Card (mm/yr):		
Card Verification Code: (the 3 or 4 digit code on the back of your credit card):		
Name as it appears on card:		
Company name on Card (if applicable):		
Credit Card Billing Address:		
City:	State:	Zip:
This authorization is given subject to the terms of the attached Engagement Letter and Consent For Services, Policies, And Fee Agreement, the terms of which are incorporated by reference herein. By signing this authorization, I acknowledge that I have read and agree to all of the terms contained in the Engagement Letter and Standard Terms of Representation and warrant all information given is true.		
Signature of Card Holder:		Date:

Email communication provides for a fast and easy way to communicate with your healthcare team for those issues that are non-emergent, non- urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider/team relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard email communication services, such as AOL, Yahoo and Hot Mail are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your email address will not be used for external marketing purposes.
- You may receive a group emailing from the practice (in the event of the clinician being ill or some other scheduling issue), however, the recipients email addresses will be hidden.

Healthcare Team Responsibilities

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider may route your email messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your email.
- Every attempt will be made to respond to your email message within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of emails sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For emergent or time sensitive situations, you should contact the practice by phone.
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- Please include your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return email to the sender.

Electronic Communication Consent

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my healthcare team.

I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

I have been given the opportunity to discuss electronic communication with a representative of NBx and have had all my questions answered.

In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my healthcare team, I herby consent to electronic communication via non-secure email services.

I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the address below, but if I do, the revocation will not have an affect on actions my healthcare provider or team has already taken in reliance on my consent.

I agree and release my provider and practice from any and all liability that may occur due to electronic communication over a non-secure network.

I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

PATIENT

_____ Patient Authorized Email Address (please print)

_____ Patient Name (Print)

_____ Patient Signature Date

PARTNER/ PARENT (if applicable)

_____ Patient Authorized Email Address (please print)

_____ Patient Name (Print)

_____ Patient Signature Date

CONSENT TO TREAT

I request and authorize NeuroBehavioral Concepts | llc (hereinafter collectively referred to as "NBX") and their respective agents and employees who may attend to me during my treatment to perform routine tests and procedures and to provide certain services as prescribed for my health and well-being in accordance with applicable laws and regulations. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by NBX, nor have I relied upon any such representations, warranties, or guarantees.

Furthermore, I authorize NBx to provide the following: diagnostic assessment, outpatient psychotherapy/counseling. My participation is voluntary. I understand that my treatment plan will be individualized to meet my needs and goals. I will participate in the development of my treatment plan and keep my account current. I have received a copy of this form.

_____ _____

Patient Signature or Legal Guardian Signature if patient is a minor Date

If signed by Legal Guardian, state relationship to patient: _____

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of the NBX Patient Admission Packet, which includes but is not limited to the Notice of Privacy Practices ("Notice"). I understand that I may obtain a written copy of this Notice at any time upon request or via the website at NeuroBx.com

_____ _____

Patient Signature or Legal Guardian Signature if patient is a minor Date

PATIENT REGISTRATION FORM

INTAKE FORM

Today's date: _____

Patient Information:

Individual Name: _____Date of Birth: ____ Age: _____
(first) (last)

Gender M/F Ethnicity (optional): _____

Name of Person completing this form (if different from "Patient"): _____

Relationship to individual: _____ Years known: _____

Residence of child: (circle) Biological parents Adoptive parents Foster parents PCS Home

Other: _____

Patient Contacts (if Minor):

Mother's name: _____Age: _____
(first) (last)

Father's name: _____Age: _____
(first) (last)

Marital Status of Parents: (circle) Married Divorced Separated Widowed

Mother's Address: _____
(street) (city) (state) (zip code)

Father's Address: _____
(street) (city) (state) (zip code)

Contact phone numbers:
Name/Relationship: _____Number: _____

Who has legal/physical custody? _____Type: _____
(please provide legal documentation)

Patient's School: _____Grade: _____

Patient's Siblings Names and Ages: _____

_____

Support Services:

Does this individual receive services from Health and Welfare? Yes ☒ No ☐
Case Worker (name): _____Phone: _____
Services Received: _____Region: _____

Referral Information:

Who referred you to this clinic?

_____
(name) (phone)

_____
(address)

Presenting Problem:

What concerns you most about this individual (or yourself if you are the patient) ?

When did you first notice this problem?

How has this problem affected his/her/your function?

At home:

At school/work:

Community:

Do you have other concerns you want addressed?

What are your goals/expectations for treatment?

Have you recently worried that the individual has (please circle items relevant to the patient):

Yes No DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)

Yes No MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)

Yes No ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc)

Yes No BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)

Yes No ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)

Yes No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

Yes No SOCIAL ANXIETY (shy and/or afraid to be around others)

Yes No REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)

Yes No AUTISM (social and language impairments, rigidity)

Yes No PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

Yes No DISSOCIATION (feeling outside your body or things are not real, etc.)

Yes No Has your child ever harmed themselves intentionally? Attempted suicide? Harmed others? _____

Sleep Patterns:

Total hours of sleep per night: __Usual Schedule: __to ____
Does the individual take naps during the day? Yes No
If Yes, how many hours in a typical day? ___

	Current Problem	Change within last 6 months
Difficulty falling asleep:	Yes No	Yes No
Snoring:	Yes No	Yes No
Frequent awakening:	Yes No	Yes No
Restlessness/Movements:	Yes No	Yes No
Early morning awakening:	Yes No	Yes No
Nightmares:	Yes No	Yes No
Not rested:	Yes No	Yes No

If yes to any of the concerns listed above, please describe:

Past Psychiatric History:

Please list any previous psychiatric hospitalizations, residential or day treatment programs (including any alcohol and drug treatment programs)

Diagnosis	Length of Stay	Treatment	Response

Please list any **current or prior outpatient psychiatrists and therapists** the individual has seen.

Name	Title	Location	How Long?

Please list this individual's current **psychiatric medications**. (You may refer to the list of medications on the next page)

Name	Dosage	Duration	Response

Please list this individual's current **non-psychiatric medications**.

Name	Dosage	Duration	Response

Substance	Date of Last Use	Problems Related to Use	Treatment Required
Benzodiazepines(Valium, Xanax, Ativan)		Yes No	Yes No
Caffeine		Yes No	Yes No
Marijuana		Yes No	Yes No
Cocaine		Yes No	Yes No
Designer Drugs(Club Drugs: G, X)		Yes No	Yes No
Hallucinogens(LSD, Mushrooms)		Yes No	Yes No
Inhalants(Gasoline, Glue, Aerosol)		Yes No	Yes No
Methamphetamines (Speed, Ice, Ritalin)		Yes No	Yes No
Opiates/Methadone (Vicodin, OxyContin, Heroin)		Yes No	Yes No
OTC – Over the counter (Benadryl, Nyquil, Dramamine)		Yes No	Yes No
Tobacco Yes No Amount per day:			
Is there anything else we should know about any drug history?			

Adderall® (dextroamphetamine + amphetamine) Abilify® (aripiprazole) Adipex-P® (phentermine) Ambien® (zolpidem) amitriptyline (Elavil®) Amoxapine Antabuse® (disulfiram) Anafranil® (clomipramine) Aricept® (donepezil) Ativan® (lorazepam) Aventyl® (nortriptyline) Benadryl® (diphenhydramine) Buspar® (buspirone) Carbatrol® (carbamazepine) Catapres® (clonidine) Celexa® (citalopram) Chloral hydrate Clozaril® (clozapine) Cogentin® (benztropine) Concerta® (methylphenidate) Cymbalta® (duloxetine) Cylert® (pemoline) Dalmane® (flurazepam) Depakote®/Depakene® (valproic acid/valproate Dexedrine® (dextroamphetamine) Didrex® (benzphetamine) Dilantin® (phenytoin) Dolophine®/Methadose® (methadone) Effexor XR® (venlafaxine) Elavil® (amitriptyline) Ephedra® Eskalith® (lithium) Evening primrose oil Focalin® (dexmethylphenidate)	Gabitril® (tiagabine) Geodon® (ziprasidone) Ginkgo biloba Ginseng Halcion® (triazolam) Haldol® (haloperidol) imipramine (Tofranil®) Inderal® (propranolol) Keppra® (levetiracetam) Klonopin® (clonazepam) Lamictal® (lamotrigine) Lexapro® (escitalopram) L ibrium® (chlordiazepoxide) Lithobid® (lithium) Loxitane® (loxapine) Luminal® (phenobarbital) Luvox® (fluvoxamine) Melatonin Mellaril® (thioridazine) Marplan® (isocarboxazid) Meridia® (sibutramine) Metadate® (methylphenidate) Methylin® (methylphenidate) Moban® (molindone) Mysoline® (primidone) Nardil® (phenelzine) Navane® (thiothixene) Neurontin® (gabapentin) Norprami (desipramine) nortriptyline (Pamelor) Omega fatty acids Orap (pimozide) Pamelor (nortriptyline) Parnate® (tranylcypromine) Paxil®(paroxetine) Periactin(cyproheptadine) Prolixin®(fluphenazine) propranolol ® (Inderal) ProSom® (estazolam) protriptyline® (Vivactil)	Provigil®(modafinil) Prozac®(fluoxetine) Restoril® (temazepam) ReVia® (naltrexone) Risperdal® (risperidone) Ritalin® (methylphenidate) SAM-e Saint john's wort Sarafem® (fluoxetine) Serax® (oxazepam) Seroquel® (quetiapine) Serzone® (nefazodone) Sinequan® (doxepin) Sonata® (zaleplon) Stelazine® (trifluoperazine) Strattera® (atomoxetine) Subutex® (buprenorphine) Suboxone® (buprenorphine +naloxone) Symbiax ® (olanzapine + fluoxetine) Tegretol® (carbamazepine) Tenex® (guanfacine) Tenuate® (diethylpropion) Thorazine® (chlorpromazine) Tofranil® (imipramine) Topamax® (topiramate) Tranxene® (clorazepate) trazodone (Desyrel®) Trilafon® (perphenazine) Trileptal® (oxcarbazepine) Valerian Valium® (diazepam) Vistaril® (hydroxyzine) Paxil® (paroxetine) Xanax® (alprazolam) Zarontin® (ethosuximide) Zoloft® (sertraline) Zonegran® (zonisamide) Zyprexa®(olanzapine) Zydis®(olanzapine)

Family History:

Consider this individual's immediate family and all of their relatives on both sides (parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins)

Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Uncle") and their treatment history (if applicable). Maternal is mother's side of the family and Paternal is father's side of the family.

__Depression _____
__Anxiety _____
__ADHD _____
__Bipolar (manic depressive) _____
__Schizophrenia _____
__Alcohol/Drug Problems _____
__Learning Disabilities _____
__Autism/Asperger/Pervasive Developmental Disorder _____
__Mental Retardation _____
__"Nervous Breakdown" _____
__Psychiatric Hospitalizations _____
__Suicide (or attempts) _____
__Panic Disorder _____
__PTSD (Post Traumatic Stress Disorder) _____
__OCD (Obsessive Compulsive Disorder) _____
__Seizures _____
__Migraines _____
__Heart or lung problems _____
__Thyroid _____
__Immunological disorders (lupus, scleroderma, inflammatory bowel disease) _____
__Cancer _____
__Other _____

Developmental History:

Did your child achieve the following milestones early (E), average (A), or late (L) compared with others his/her age (please explain if late):

__Language (age at first using words, sentences, etc…)?_____

_____

__Fine motor skills (building towers with cubes, drawing circle)?_____

_____

__Gross motor skills (rolling over, standing, walking)?_____

_____

__Toilet training?_____

_____

Has your child experienced any regression of these? Yes No If yes, explain:

_____

_____

_____

Pregnancy and Birth History:

How old was the individual's biological parents when he/she was conceived? _____

Was this the biological mother's first pregnancy? Yes No

If no, how many times was she pregnant before this pregnancy? _____

Did the biological mother experience any miscarriages before or after this pregnancy? Yes No

If yes, how many? _ During what trimester? _____

When was prenatal care first received (in weeks): _____

How much weight did the biological mother gain during this pregnancy?: _____

Baby's birth weight and length: _____

Length of pregnancy (in weeks): _____

Did the mother have any ultrasounds or amniocentesis? Yes No If yes, please describe the reason for these and the results: _____

Please indicate whether any of the following events/problems occurred during this pregnancy. Please include the trimester in which the event occurred, as well as any other important details.

Event/ Problem	Yes / No	# of months into	Additional details
Infections/Colds	Yes No		
Fevers	Yes No		
Hospitalizations	Yes No		
Vaginal Bleeding, Spotting	Yes No		
Problems with Diet	Yes No		
Pregnancy Induced Hypertension	Yes No		
High Blood Pressure, Excessive Swelling	Yes No		
Diabetes	Yes No		
Rh or Blood Incompatibilities	Yes No		
Trauma (Emotional Stress and/or Physical Injury)	Yes No		

Did the mother take any medications (prescription and over the counter) during this pregnancy? (If yes, please complete the following table.)

Medication	Month(s) taken (1-9)	Dose	Reason for taking

Did the mother consume alcohol during this pregnancy?
Yes No
If yes, how much and how often? _____

Did the mother smoke or use tobacco products during this pregnancy?
Yes No
If yes, please describe how much and how often? _____

Did the mother use any drugs during this pregnancy?
Yes No
If yes, please name drug(s), how much and frequency of use: _____

Labor Information:
Type of delivery (c-section, vaginal): Were forceps used? _____
Were there any problems with the baby's health right before or immediately after delivery? Yes No
If yes, please describe: _____
Were the mother and/or baby separated after birth for more than 24 hours at a time? Yes No
If yes, please explain: _____

Past Medical History:

Primary Care Provider: _____Years Involvement: _____
Phone: _____
Address: _____
Approximate Date of Last Visit: _____
Number of Visits in Last Year: _____
Other Provider(s): _____
Specialty: _____
Name: _____Phone: _____
Address: _____

Other Provider(s): _____
Specialty: _____
Name: _____Phone: _____
Address: _____

Allergies (drug, food, seasonal, environmental etc.)? Yes No If yes, please name and describe your child's reaction: _____

Has the individual ever experienced a head injury, loss of consciousness, or seizure? Yes No
If yes, please describe: _____

Does your child have any chronic medical problems? Yes No If yes, please describe: _____

Does your child have a history of any serious injuries or medical hospitalizations? Yes No
If yes, please describe: _____

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? Yes No
If yes, please describe: _____

Have you recently worried that your child may have problems with:

- ☐ Heart
- ☐ Lungs
- ☐ Kidneys/Bladder
- ☐ Neurological
- Constipation/Diarrhea
- Frequent infections
- Endocrine (i.e., diabetes; thyroid dysregulation; excessive hair growth)
- Immunizations up to date
- Age of first menses _____
- Regular or Irregular cycle _____

Has your child ever had an EEG, MRI, CT SCAN, etc? Yes No _____
If yes, why was it done and were the results normal? _____
If yes, where were the tests performed and who ordered them? _____

Social History:

Is your child your biological child? Yes No
If no, at what age was he/she adopted? _____

Is there any contact with their biological parent(s)? _____
Where was your child born and raised? _____

Has your child moved a number or times? Yes No _____
If yes, please list their age at time of move and location: _____

The following questions are specific to the families of children as patients:

Parents: (Including Step-Mother and Step-Father, if applicable)

Name	Education	Occupation	Hrs/Wk	Relationship with Child (quality)

Please list the other children in the family and other household members who may also be living in your home:

Name	Age	Lives at Home?	Relation to Child	Relationship with Child

Abuse History:

Has your child ever been the victim of abuse or neglect? Yes ☒ No ☐

If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical Emotional Neglect
Accidents Disasters Sexual
Witnessing violence Other: _____

Are you struggling with your marital relationship or parenting? Yes ☒ No ☐

If yes, please describe: _____

Has your child ever been involved with the following and if yes, please explain:

☐ Yes ☐ No Child Protective Services _____
☐ Yes ☐ No Children's Mental Health _____
☐ Yes ☐ No Probation/Juvenile Probation/Detention _____
☐ Yes ☐ No Boys and Girls Club _____
☐ Yes ☐ No Youth Services _____
☐ Yes ☐ No Head Start _____
☐ Yes ☐ No Early Intervention Services (ages 0-3) _____

School:

Where does your child attend school? _____

In what grade level is he/she? _____

What are his/her typical grades? _____

What are your child's academic strengths? _____

_____

Academic weaknesses? _____

_____

Has there been a change in your child's performance at school? Yes No If yes, please describe: _____

_____

_____

Has your child received IQ or Academic testing? Yes No If yes, what were the results? _____

_____

Does or has your child participated in any of the following?

☐ Yes ☐ No Resource (for which classes/how many hours?) _____

_____

☐ Yes ☐ No Accelerated or Honors programs, explain: _____

☐ Yes ☐ No 504 Plan, explain: _____

☐ Yes ☐ No Individual Education Plan (IEP), explain: _____

☐ Yes ☐ No Virtual Academy, explain: _____

Has your child had problems with any of the following?

☐ Yes ☐ No Truancy, explain: _____

☐ Yes ☐ No Fights, explain: _____

☐ Yes ☐ No Absenteeism, explain: _____

☐ Yes ☐ No Detention, explain: _____

☐ Yes ☐ No Suspension, explain: _____

☐ Yes ☐ No School refusal, explain: _____

What are your child's favorite activities? _____

_____

_____

_____

Peers:

Does your child have quality relationships with other children? Yes No If no, please explain: _____

_____

_____

Culture:

Do you have a religious preference in the household? Yes No If yes, what is that preference? _____

_____

Has your child experienced any problems related to race, religion, or culture? Yes No If yes, please explain: _____

TEEN/YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent's friendships? Yes ☒ No ☐

(Please circle all that apply.)

Too old	Too young	Truant	Gang	Fringe
Drug/alcohol use	Violence	Too many	Too few	Sexual Promiscuity
Too much time together	Other _____			

Has your adolescent had a recent change in friendships? Yes ☒ No ☐ If yes, what changes, if any are concerning to you? _____

Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? Yes No If yes, please describe: _____

Are you concerned about your child's sexual activities? Yes No _____

Is your adolescent sexually active? Yes No _____

Does your adolescent have a job? Yes No _____

Has your adolescent's behavior ever resulted in police, detention, or court involvement? Yes No

If yes, please explain: _____

Is there anything else you would like us to know about your child? _____

Mental Status Exam (for your clinician to complete at first interview):

Clinical Interview Notes:

Three wishes

Wants to be when grow up

Happiest time

addest time Scariest time

INITIAL FORMULATION:

INITIAL DIAGNOSES:

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

INITIAL TREATMENT PLAN:

1. MEDICATIONS:

2. PSYCHOTHERAPY:

X

Lonny R. Webb, MSW
Therapist

Signed_____ Date:_____

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

AUTHORIZATION

I authorize NeuroBehavioral Concepts | llc (Healthcare Provider) to use and disclose the protected health information described below to_____
(Individual OR organization that you would ask NBx to share information).

EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from:

a. _____to _____

OR

b. ☐ all past, present, and future periods.

EXTENT OF AUTHORIZATION

a. I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including
- ☐ HIV and AIDS) Alcohol/drug abuse
- ☐ treatment
- ☐ Other (please specify): _____

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

2. This authorization shall be in force and effect until _____(date or event), at which time this authorization expires.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my Authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest my claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative	Printed Name	Date