Dear New Patient,

Thank you for choosing Kent Psychological Associates, LLC as your mental health care provider. If for any reason you are unable to keep your appointment, kindly call 24 hours in advance.

We ask that you please complete the following:

- Complete the paperwork attached to this letter and bring it with you for your first appointment.
- Arrive 20 minutes early for your appointment-there will be additional paperwork to do here.
- Please be prepared to pay your co-pay at the time of each visit.
- Call your insurance, verifying your out-patient mental health coverage including:
  - What is your annual deductible (amount that you are required to pay before your benefits start each year)? Deductible amounts almost always start over on Jan. 1 of each new year.
  - What is your office co-pay (amount you are required to pay at each office visit)?
  - The number of visits allowed per year (out-patient mental health code 90834)?
  - If your visits will be covered by an Employee Assistance Program, please contact your Human Resources Dept. for your referral/authorization.
  - Is a referral required from your primary care physician before your first visit?

If you have concerns or questions you can reach our business office Monday through Friday between the hours of 9 a.m. and 4 p.m. We look forward to meeting you.

Kent Psychological Associates, LLC

DATE _____

CHILD BACKGROUND INFORMATION

NAME _____DOB_____AGE_____SSN_____-____-_____
ADDRESS _____CITY_____ZIP_____
PHONE (H) (____) _____ PARENTS WORK (____) _____
REFERRED BY: _____
EMERGENCY CONTACT: _____PHONE(____)_____RELATION_____
FAMILY PHYSICIAN: _____PHONE (____) _____

PERSON FILLING OUT THIS FORM: (CIRCLE ONE)
MOTHER FATHER STEPMOTHER STEPFATHER GUARDIAN FOSTER PARENT

FAMILY INFORMATION:

NAME	RELATIONSHIP	AGE	SEX	OCCUPATION
_____	_____	_____	____	_____
_____	_____	_____	____	_____
_____	_____	_____	____	_____
_____	_____	_____	____	_____
_____	_____	_____	____	_____

DEVELOPMENTAL HISTORY:

Please check any which are problems in the home of the child:

____Frequent moves
____Parents divorce
____Parents remarriage
____Parents separated
____Family illness
____Personal illness
____Alcohol/Drugs
____Legal problems
____Parent conflict
____Parent job loss
____Financial stress
____Learning problems
____Death of family member
____Physical abuse/Neglect
____Sexual abuse
____Domestic violence
____Emotional problems
____Other

Help clarify a problem the child might have had effecting their development to age 18. Check those that apply.

____Premature birth
____Nervous
____Eating problems
____Learning difficulties
____Poor coordination
____Visual difficulties
____"Worry wart"
____ Overweight
____ Fighting
____Development delays
____Avoiding others
____Fidgety/restless
____Talking/refusing
____Speech problems
____Hearing/ear problems
____Fear leaving home
____ Leaving a loved one
____ Small for age
____Picked on
____Trouble with police
____Bedwetting
____Head injury
____Frequent tantrums
____Sleepwalking/Nightmares
____School behavior
____Behavioral problems
____Toilet training
____ Shy
____Repeated grade
____Engages in dangerous behavior
____Birth Defect
____Abuse/neglect
____Bad dreams
____School behavior
____Feeling rejected
____Strong willed
____Few friends/loner
____Ran away from home
____Did not like to be held as a baby

How would you rate your child's present relationship with the following? If it does not apply put N/A.

Father	____Good	____Fair	____Poor	____Problem for you	____N/A
Mother	____Good	____Fair	____Poor	____Problem for you	____N/A
Stepfather	____Good	____Fair	____Poor	____Problem for you	____N/A
Stepmother	____Good	____Fair	____Poor	____Problem for you	____N/A
Brother	____Good	____Fair	____Poor	____Problem for you	____N/A
Sister	____Good	____Fair	____Poor	____Problem for you	____N/A
Friends	____Good	____Fair	____Poor	____Problem for you	____N/A
Teacher	____Good	____Fair	____Poor	____Problem for you	____N/A

EDUCATIONAL HISTORY

School _____ Location_____
Is your child in a special education class? yes ____ no ____ What kind _____
Does you child received special tutoring or therapy in school? yes ____ no ____

OCCUPATIONAL HISTORY

Is your child presently employed? ___ yes ___ no Type of work _____ How long? _____

PRIOR MENTAL HEALTH HISTORY

Has your child ever had prior mental health treatment? ____yes ____no (If no, skip)
When _____ Who_____
Was this person a: ____Psychiatrist ____Psychologist ____Clinical social worker ____Clinical Counselor
____Minister ____Other
Has your child ever been hospitalized for emotional problems? ____yes ____no (If no, skip)
When _____ Where_____

ALCOHOL/DRUG HISTORY

Does your child have a history of alcohol/drug abuse? ____yes ____no (If no, skip)
Has your child ever been hospitalized for drug/alcohol abuse? ____yes ____no
When _____ Where_____

MEDICAL HISTORY

Date of last physical exam _____ Family physician_____
Where located? _____
Are immunizations up to date? ____yes ____no

Does your child have any special problems with hearing, speech or vision? ____yes ____no Please explain:
_____

_____
Is your child taking any medications? ____yes ____no
If yes, please list: _____

_____

Describe any side effects of medication(s)_____

_____

Please list any allergies, serious illnesses, injuries or surgeries? _____
_____

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

____Alcoholism _____
____Allergies _____
____Mental retardation _____
____Obesity _____
____Degenerative dis. _____
____Mental health probs. _____
____Schizophrenia _____
____Bi-Polar _____
____Depression _____
____Anxiety _____
____Attention Deficit_____

____Cancer _____
____Diabetes _____
____Epilepsy _____
____High blood press. _____
____Heart trouble _____
____Suicide _____
____Other _____

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now			Past/Now			Past/Now	
___	___	Academic underachievement	___	___	Anxiety	___	___ Anger Outbursts
___	___	Argumentative	___	___	Asthma	___	___ Baby Talk
___	___	Bedwetting	___	___	Body aches	___	___ Broken bones
___	___	Broken sleep	___	___	Constipation	___	___ Convulsions
___	___	Cries easily	___	___	Demands for attention	___	___ Depression
___	___	Difficulty going/staying asleep	___	___	Difficulty concentrating	___	___ Dieting
___	___	Dizziness	___	___	Eats non-edibles	___	___ Emotional upsets
___	___	Easily distracted	___	___	Encopresis (soiling clothes)	___	___ Encephalitis
___	___	Excessive sexual interest	___	___	Fainting spells	___	___ Fatigue
___	___	Food craving for sweets	___	___	Frequent sex play w/ other children		
___	___	Headaches	___	___	Hears voices	___	___ High fever
___	___	Hospitalization(s)	___	___	Immature for age	___	___ Injuries to head
___	___	Itchy skin	___	___	Leg cramps	___	___ Loose bowel/gas often
___	___	Loses temper easily	___	___	Loss of consciousness	___	___ Lying
___	___	Masturbation	___	___	Memory problems	___	___ Mental condition
___	___	Moody often	___	___	Much sweating	___	___ Muscle twitching
___	___	Nervousness	___	___	Nightmares	___	___ Operation(s)
___	___	Over dependent	___	___	Overeating	___	___ Perfectionistic
___	___	Poor appetite	___	___	Poor nutrition	___	___ Rebellious
___	___	Sleepwalking	___	___	Stealing	___	___ Stomach upsets
___	___	Suicide attempt	___	___	Temper tantrum	___	___ Thumb sucking
___	___	Vomiting	___	___	Worries, insecurity		

MEDICAL ILLNESS HISTORY

Briefly describe your child's current difficulties. _____
_____
_____

How long has this problem been a concern to you? _____

_____

Describe any unusual fears, habits, or behaviors. _____
_____

What is the main goal you wish to attain in seeking services for your child? _____
_____
_____

ADDITIONAL INFORMATION

Please add any special information you feel might be helpful in assisting in your child's treatment.
_____
_____
_____

Your signature below indicates that you understand the questions and could ask for assistance if needed.

_____ _____
Signature of parent or guardian Date

Dear Client: Please list all of your medications below or provide the office with a copy of your current medication list. Many medications have side effects. It is important for your clinician to be aware of all of your medications (prescription, over-the-counter, and supplements) in order to determine if your medications may be contributing to any of the symptoms you are experiencing.

Medication List

Client name: _____ DOB: _____

Medication	**Dosage**	**Frequency**	Date Added/Discontinued
			This column office use only.

Payment Policy: Regarding Divorced/Separated Parents

We are aware that various legal agreements between parties may state which parent of a child is to pay medical bills.

However, we are a small office and have found it impossible to enforce the payment of co-pays and other bills by parties who have never been in our office.

Therefore, our policy is that the parent who brings the child in for treatment will be obligated to pay any bills arising from that treatment.

We are happy to provide receipts for these expenses which can be used to prove these expenses and request reimbursement from another responsible party.

We prefer, when possible, that both parents attend the first session with the child to sign required financial agreement forms.

If you have any questions or concerns about this policy, please contact the Clinical Director, Dr. Leslie McClure.

Mother signature _____ Date _____

Father signature _____ Date _____

PSYCHOLOGICAL TREATMENT FOR CHILDREN

It is always preferable to have the consent of both parents when initiating psychological treatment with a child. This increases the likelihood that both parents will view the therapist as a neutral party, and it helps to create a safe, balanced treatment environment for the child. Parents often have very divergent views about their child's problems and about what is in their child's best interests. It is ideal for both parents to meet with the therapist together to discuss their concerns about the child, so that both participate in formulating the child's treatment plan and goals.

If it is not feasible for both parents to meet together with the therapist for this purpose, the other parent should be offered the opportunity to meet with the therapist to share their concerns about the child. In this case, the parent bringing the child to the office will be asked to provide contact information, so that we can request input from the other parent and so that they can facilitate the treatment process by their informed consent. When one or both parents are seen to discuss the child's problems and treatment, this session is considered to be family counseling for the child, as they are the focus of treatment.

FOR DIVORCED OR SEPERATED PARENTS

It is not ethical for a treating mental health professional to offer an expert opinion regarding custody and visitation issues in court. Your child's therapist is a treating professional who is an expert on your child's mental health diagnosis and treatment. Any expert opinion regarding custody and visitation matters is properly performed by a court-appointed examining professional, who conducts a balanced child and parent evaluation separate from the child's treatment needs. In addition, a therapist's involvement in parental disputes creates potentially serious role conflicts that negatively impact a child's treatment.

REGARDING FEES

With respect to payment for psychological services rendered to a child with divorced or separated parent, we have no standing in court actions which allocate financial responsibility for the child's health needs, and we are not in a position to enforce existing court orders. If the parent do not initially appear together and concur on an arrangement for sharing these expenses, the parent that initiated the treatment and that brought the child to the office will be responsible to us for these costs.

Authorization for Release of Health Information Pursuant to HIPAA
Kent Psychological Associates, LLC

Dear Client: Your health insurance requires us to request consent to coordinate care with your primary care provider. We consider coordination of care an important part of providing high quality care. Please complete the following authorization that allows us to exchange information with your primary care provider. If you are uncomfortable with such exchange of information, please check the box below indicating your refusal to allow us to exchange information with your primary care provider.

☐ I prefer NOT to allow exchange of information between Kent Psychological Assoc. and my primary care provider.
☐ I do not have a primary care provider.

CLIENT_____DOB_____Last four SSN #_____

I THE UNDERSIGNED AUTHORIZE THE EXCHANGE OF INFORMATION BETWEEN:

My Behavioral Health Provider:
Kent Psychological Assoc. LLC
190 Currie Hall Parkway, Suite A
Kent, Ohio 44240
Phone: 330-673-5812 Fax: 330-673-7162

⇦ AND ⇨

My Primary Care Provider:
Name: _____
Street: _____
City:_____State: Zip:_____
Phone:_____Fax:_____

INFORMATION TO BE RELEASED BY KENT PSYCHOLOGICAL ASSOCIATES INCLUDES THE FOLLOWING:

Diagnosis
Recommendations
Discharge Summary
Service/Treatment Plan
Summary of Treatment

REQUESTED INFORMATION FROM PRIMARY CARE PROVIDER INCLUDES THE FOLLOWING:

History and Physical
Service/Treatment Plan
Treatment/Office Visit Notes
Medical Evaluation
Current Medications/Medication History

THE EXCHANGE OF INFORMATION IS FOR THE SPECIFIC PURPOSE OF:

Ensuring proper coordination of care with your primary care provider.

I UNDERSTAND:

1. This authorization will expire on _____ (date, event, or condition not to exceed 1 year). If not dated, then this authorization will automatically expire 1 year from the date of signing.
2. I may revoke this authorization at any time by signing the "Revocation of Authorization" portion of this form, below, and providing a copy to the releasing party or by providing any other form of written revocation to the releasing party. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
3. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
4. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of records designation above, which may include treatment for mental illness (ORC5122.31), alcohol/drug abuse (42 CRF Part 2), and/or Human Immune Deficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC3701.24.3).

_____ _____ _____
Signature of Client/Parent/Guardian Date Relationship to Client

REVOCATION OF CONSENT:

I hereby withdraw my consent for any further release of information as of the date indicated below:

_____ _____ _____
Signature of Client/Parent/Guardian Date Relationship to Client

TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error please notify Kent Psychological Associates, LLC immediately.

KENT PSYCHOLOGICAL ASSOCIATES

Client Name: _____

DOB: _____

☐ I give my permission for Kent Psychological Associates to call and if necessary leave a reminder message for upcoming appointments.

I would like reminders by (choose one):

☐ Text to: _____

☐ Phone call to:_____

☐ Email to: _____

☐ I do not want reminder calls.

Reminder calls are a courtesy only. Any missed appointments remain the client's responsibility. Reminders are made the day before the appointment including Sundays.

_____ _____

Client/Guardian Signature Date

For your information:
Phone calls will come from 949-298-4668
Texts will come from 695-29
Emails will come from ValantApptReminder@reminderXchange.com
(You cannot reply back to these numbers.)