KENT PSYCHOLOGICAL ASSOCIATES

Thank you for choosing Kent Psychological Associates, LLC for your family's needs. 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 your for your first appointment.
    - All adults (18 and over) who will be attending, will fill out the Adult Background Information and the PHQ-9/GAD-7.
    - All children (with the help of parent/guardian if needed) who will be attending, will fill out the Child Background Information as well as the RCADS-25 (8yrs old to 17 years old).
    - The parent/guardian will fill out the RCADS-P-25.
    - If the child is under 8yrs old, we ask that the parents fill out the RCADS-P-25 only.

- Arrive 20 minutes early for your appointment. There will be additional paperwork to fill out at the office.

- Please be prepared to pay your co-pay at the time of each visit.

- All family members must bring with them their proof of insurance.

- 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 questions or concerns you can reach our business office Monday through Friday between the hours of 9am and 4pm. We look forward to meeting you.

Kent Psychological Associates, LLC

DATE _____

ADULT BACKGROUND INFORMATION

NAME _____ DOB _____ AGE_____SSN____-___-_____
GENDER _____ PRONOUNS: ☐ he/him/his ☐ she/her/her ☐ they/them/theirs ☐ ze/hir/hirs
ADDRESS _____ CITY _____ ZIP _____
PHONE (H) (___) _____ (W) (___) _____
EMERGENCY CONTACT: _____ PHONE _____ RELATION_____
FAMILY PHYSICIAN: _____ PHONE _____
REFERRED BY: _____

HOUSEHOLD INFORMATION: *Who do you live with?*

NAME	RELATIONSHIP	AGE	GENDER	OCCUPATION

Other important people in your life _____

DEVELOPMENTAL HISTORY:

Please check the following which were problems in the family of origin:

____Frequent moves
____Parents divorce
____Parents remarriage
____Parents separated
____Family illness
____Other _____
____Other issue (You wish to discuss with counselor in person)

____Alcohol/Drugs
____Legal problems
____Parent conflict
____Parent job loss
____Financial stress

____Death of family member
____Physical abuse/Neglect
____Sexual abuse
____Domestic violence
____Emotional problems

Clarify information about your development up to age 18. *Check those that apply.*

____Premature birth
____Nervous
____Eating problems
____Learning problems
____Poor coordination
____Visual difficulties
____Leaving loved one
____Small for age

____Avoiding others
____Fidgety/restless
____Talking/refusing
____Speech problems
____Trouble w/ police
____Fear leaving home
____Behavioral prob.
____Ran away

____Bedwetting
____Head injury
____Picked on
____Sleepwalking
____Feeling rejected
____Repeated grade
____"Worry wart"
____Fighting

____Birth Defect
____Abuse/neglect
____Bad dreams
____School behavior
____Strong willed
____Few friends
____Overweight
____Shy

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

Spouse/Significant Other/Partner	____Good	____Fair	____Poor	____Problem for you	____N/A
Father	____Good	____Fair	____Poor	____Problem for you	____N/A
Mother	____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
Son	____Good	____Fair	____Poor	____Problem for you	____N/A
Daughter	____Good	____Fair	____Poor	____Problem for you	____N/A
In-Laws	____Good	____Fair	____Poor	____Problem for you	____N/A
Employer	____Good	____Fair	____Poor	____Problem for you	____N/A

EDUCATIONAL HISTORY

High school attended _____ Highest grade completed_____
College/vocational/technical training yes ____ no ____ #year's ____ Degree _____

OCCUPATIONAL HISTORY

Are you presently employed? ____ yes ____ no Type of work _____ How long? _____
Have you had problems gaining employment? ____ yes ____ no
How many jobs have you held in the last 5 years? _____
Are you a veteran? ____ yes ____ no If yes, what branch of service? _____
Date entered _____ Date discharged _____ Type of discharge _____

RELATIONSHIP HISTORY

Sexual Orientation _____

A) In a relationship☐ *If not in a relationship please see section B*

____ Married ____Significant Other ____ Remarried ____Other _____

Are you considering separation or divorce? ____yes ____no
Are you a divorced custodial parent? ____yes ____no
Are you married raising minor children? ____yes ____no

Do you and your spouse/significant other/partner:
Agree on the methods of discipline of the children ____yes ____no
Share common values in the rearing o the children ____yes ____no
Feel the parent/child interaction is positive ____yes ____no
Spend quality time as a family ____yes ____no

In your present relationship do you:
Enjoy good communication with each other ____yes ____no
Feel satisfied with your sexual relations ____yes ____no
Spend private couple time with each other ____yes ____no
Share similar interests and values ____yes ____no

B) Not in a relationship☐
____ Single ____ Separated ____ Divorced ____ Widowed ____Other_____

PRIOR MENTAL HEALTH HISTORY

Have you ever had prior mental health treatment? ____yes ____no (If no, skip)
Date _____
Was this person a: ____Psychiatrist ____Psychologist ____Clinical social worker ____Clinical Counselor
____Minister ____Other
Have you ever been hospitalized for emotional problems? ____yes ____no (If no, skip)
Name of hospital _____ Location _____ Date_____ How long _____
Doctor who treated you_____ Medications given _____
Do you still take any psychotropic medications? ____yes ____no Which ones? _____

ALCOHOL/DRUG HISTORY

Do you have a history of alcohol/drug abuse? ____yes ____no (If no, skip)
If you are using alcohol or drugs has this resulted in:

____Marital problems	____Memory Blackouts	____Legal problems
____Problems w/family, friend's	____Periods of abstinence	____Physical problems
____Preoccupation w/alcohol, drugs	____Financial problems	____Loss of control
____DUI or DWI charges	____Withdrawal symptoms	

LEGAL HISTORY ____yes ____no

Check those that apply to you:

____Trouble with law as a juvenile
____Trouble with the law as an adult
____Have legal matter pending
____Have you ever been in jail?

MEDICAL HISTORY

Date of last physical exam _____ Family physician _____

Describe your chief medical/physical complaint(s) _____

_____

Do you have any special problems with hearing, speech, vision? ____yes ____no
If yes, please explain _____

_____

Are you on any medications? ____yes ____no
If so, please list: _____

_____

Describe any side effects _____

_____

Do you have any allergies? ____yes ____no
If yes, please describe _____

List any 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	_____	____Cancer	_____
____Allergies	_____	____Diabetes	_____
____Developmental Disabilities	_____	____Epilepsy	_____
____Obesity	_____	____High blood press.	_____
____Degenerative dis.	_____	____Heart trouble	_____
____Mental health probs.	_____	____Other	_____
____Suicide	_____		

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now		Past/Now		Past/Now	
___	___ Arthritis	___	___ Can't work under pressure	___	___ Distractibility
___	___ Anxiety	___	___ Color Blind	___	___ Laxatives used
___	___ Anger Outbursts	___	___ Exhaustion	___	___ Leg Cramps
___	___ Asthma	___	___ Fainting spells	___	___ Loose bowel/gas often
___	___ Backaches	___	___ Fast pulse	___	___ Loses temper easily
___	___ Binging	___	___ Heart medicine	___	___ Moody often
___	___ Barbiturates	___	___ Hormones	___	___ Memory problems
___	___ Epilepsy	___	___ Poor digestion	___	___ Muscle twitching
___	___ Cancer	___	___ Poor appetite	___	___ Much sweating
___	___ Chronic Pain	___	___ Treated for a mental cond.	___	___ Moist palms
___	___ Chest Pain	___	___ Other drugs, alcohol	___	___ Nervous breakdown
___	___ Constipation	___	___ Shaking	___	___ Nervousness
___	___ Depression	___	___ Smoking packs/day ___	___	___ Nerve Medication
___	___ Diabetes	___	___ Craving for sweets	___	___ Overeating
___	___ Diarrhea	___	___ Fatigue	___	___ Overworked
___	___ Depersonalization	___	___ Headaches	___	___ Pain medication
___	___ "Going Crazy" sensations	___	___ Heart trouble	___	___ Palpitation
___	___ Difficulty going to sleep	___	___ Hallucinations	___	___ Perfectionist
___	___ Difficulty staying asleep	___	___ Hearing voices	___	___ Stomach medicine
___	___ Dizziness	___	___ Hypertension	___	___ Worries, feels insecure
___	___ Drug reactions	___	___ Hand tremors	___	___ Reduced sex drive/lack of
___	___ Early morning wakening	___	___ Hay fever	___	___ Upset stomach
___	___ Emotional upsets	___	___ Insulin medication	___	___ Itchy skin

CURRENT SOURCES OF STRESS

Please list your most significant sources of stress or worry.

1. _____

2. _____

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

_____

Envision how your life would be different if you could manage some of these problems better.

_____

ADDITONAL INFORMATION: Please add any special information you feel which might be helpful in assisting in your treatment. _____

_____

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

_____ _____

Client signature Date

Name _____ **Date** _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 +_____+_____+ _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
D	D	D	D

Name _____ **Date** _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____=_____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Kent Psychological Associates, LLC

DATE _____

CHILD BACKGROUND INFORMATION

NAME _____ DOB _____ AGE _____ SSN ____-____-_____
GENDER _____ PRONOUNS: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ ze/hir/hirs
ADDRESS _____ CITY _____ ZIP _____
PHONE (H) (____) _____ PARENTS WORK (____) _____
REFERRED BY: _____
EMERGENCY CONTACT: _____ PHONE(____) _____ RELATION_____
FAMILY PHYSICIAN: _____ PHONE (____) _____
REFERRED BY: _____

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

HOUSEHOLD INFORMATION *Who lives in the home?*

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 _____
____ Obesity _____
____ Degenerative dis. _____
____ Mental health probs. _____
____ Bi-Polar _____
____Schizophrenia _____
____ Developmental _____
Disabilites
____Attention Deficit _____

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

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		

CURRENT SOURCES OF STRESS

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

Date: _____ Name/ID: _____

RCADS-P-25 Relationship to Child: _____

Please put a circle around the word that shows how often each of these things happens for your child.

1. My child feels sad or empty	Never	Sometimes	Often	Always
2. My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
3. My child feels afraid of being alone at home	Never	Sometimes	Often	Always
4. Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
5. My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
6. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. My child worries what other people think of him/her	Never	Sometimes	Often	Always
8. My child has trouble sleeping	Never	Sometimes	Often	Always
9. My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
10. My child has problems with his/her appetite	Never	Sometimes	Often	Always
11. My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
13. My child has no energy for things	Never	Sometimes	Often	Always
14. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. My child cannot think clearly	Never	Sometimes	Often	Always
16. My child feels worthless	Never	Sometimes	Often	Always
17. My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. My child thinks about death	Never	Sometimes	Often	Always
19. My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
20. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. My child is tired a lot	Never	Sometimes	Often	Always
22. My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
23. My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. My child feels restless	Never	Sometimes	Often	Always
25. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always

Date: _____ Name/ID: _____

RCADS-25

Please put a circle around the word that shows how often each of these things happens to you. There are no right or wrong answers.

1. I feel sad or empty	Never	Sometimes	Often	Always
2. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
3. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
4. Nothing is much fun anymore	Never	Sometimes	Often	Always
5. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
6. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. I worry what other people think of me	Never	Sometimes	Often	Always
8. I have trouble sleeping	Never	Sometimes	Often	Always
9. I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
10. I have problems with my appetite	Never	Sometimes	Often	Always
11. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
13. I have no energy for things	Never	Sometimes	Often	Always
14. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. I cannot think clearly	Never	Sometimes	Often	Always
16. I feel worthless	Never	Sometimes	Often	Always
17. I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. I think about death	Never	Sometimes	Often	Always
19. I feel like I don't want to move	Never	Sometimes	Often	Always
20. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
23. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. I feel restless	Never	Sometimes	Often	Always
25. I worry that something bad will happen to me	Never	Sometimes	Often	Always

KENT PSYCHOLOGICAL ASSOCIATES

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	Prescribed by	Date Added/Discontinued
				This column office use only.

Family Counseling Contract

By signing and dating this document, each party acknowledges that he/she understands and agrees to the provisions that govern the counseling that all individuals are entering into together with their clinician. Please ask your clinician if you have any questions regarding the information presented in this contract.

1. The counseling being provided by the clinician is family counseling. You are being seen for treatment, not forensic evaluation.
2. For the purposes of insurance, a single person is considered the Identified Patient, however the Clients Rights and responsibilities extend to all family members.
3. In family counseling, each participant has all of the rights and privileges afforded to people in individual psychotherapy, as defined by law and ethics and stated in the written information provided to each person prior to the initial counseling appointment.
4. The specifics of what is said and discussed in family counseling sessions is confidential and privileged information and cannot be shared or discussed with anyone without the express, written consent of the individuals involved. Please note that all members of the family must agree to release information related to what was said and discussed in our sessions. I cannot and will not release information about our counseling sessions or, should the situation occur, testify in any legal proceedings, actions or venues, without all of the family members providing written permission for me to do so. The limits of confidentiality can be found in our privacy policy. When minor patients are involved, parents or guardians hold the privilege to the child's information.
5. Since the success of family counseling cannot be predicted or assured, it is possible that one of you may decide during the course of counseling that the best answer to your concerns is dissolution or divorce. You should be aware that once we begin family counseling that it is unethical for me to give any opinion about custody or visitation arrangements, even if I am compelled to be a witness in any legal proceedings, actions, or venues.
6. In some situations I am legally obligated to take actions to protect others from harm. Situations that fall under this category include:
    a. If I know or have reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of a child;
    b. If I have reasonable cause to believe that an elderly adult is being abuse, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation;
    c. If I know or have reasonable cause to believe that a patient has been the victim of a domestic violence, I must note that knowledge or belief and the basis for it in the counseling record;
    d. If I believe that a patient presents a clear and substantial risk of imminent serious harm to him/herself or someone else and I believe that disclosure of certain information may serve to protect that individual, then I must disclose that information to appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client. If such a situation arises, I make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.
    e. With regard to the issues discussed in 5a and 5b, once a report is filed, I may be required to provide additional information to the appropriate agency and/or organization.

7. From time to time, it may be necessary or advisable to have one or more individual counseling sessions with one or more of the family counseling participants. Any and all such individual sessions should be understood to be part of the family counseling process, not an action that establishes and individual counseling relationship with your clinician.
8. I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.
9. This "no secrets" policy is intended to allow me to continue to treat the family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.
10. Any information that the clinician becomes aware of outside of the family counseling sessions or obtains from one of the family counseling participants outside of the presence of other family members that clearly suggests or indicates that the family counseling is compromised, i.e. has no chance of succeeding, is grounds for the clinician to terminate the family counseling.
11. During the course of the family counseling, your clinician may identify individual and/or personal issues that one or more of the participants may have that require individual counseling. If such situation arises, the clinician reserves the right to recommend and/or strongly advise individual counseling with an independent clinician to one or more of the family counseling participants.
12. Should one or several of the participants of the family counseling process decide to discontinue participation in the previously agreed upon family counseling, each family counseling participant, should he/she desire continued individual counseling, will be referred to another clinician for individual counseling.
13. Your signature below signifies that you understand and agree to the information and stipulations identified above.

Client Signature_____ **Date**_____

Client Signature_____ **Date**_____

Client Signature_____ **Date**_____

Client Signature_____ **Date**_____

KENT PSYCHOLOGICAL ASSOCIATES

Treatment of Minor Children

The initial appointment will be for the parental/legal guardian and the child. If you are divorced parents, we ask that you provide us with your court paperwork that indicates the custodianship agreement. If you are not the parent and are the legal guardian, please bring your court approved guardianship papers. If this documentation is not provided at the first appointment, or if someone other than the parent or legal guardian brings the child to the first appointment, the appointment will be rescheduled.

Per our ethics boards, it is best practice to inform both parents when a minor is in treatment. We ask that the parent who is consenting to treatment provide the other parent's information. The clinician seeing your child will attempt to reach out to inform them that their child is in treatment and to gather any further necessary information for the assessment and treatment of your child. Input from both parents is preferable as it 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.

*See ORC 4757-02 B(1-5) and 5122.04 A,B for Ohio laws regarding treatment of minors

Divorced or Separated 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 parents, 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. We prefer, when possible, that both parents attend the first session with the child to sign required financial agreement forms. If the parents do not initially appear together and concur on an arrangement for sharing these expenses, our policy is that the parent that brings the child to session will pay any applicable copay.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

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.)

KENT PSYCHOLOGICAL ASSOCIATES

CRISIS RESOURCES

24 HOUR CRISIS HOTLINES

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555
- Town Hall II- (330) 678-HELP
- Akron Children's Hospital Psychiatric Intake Response Center (PIRC) (330) 543-7472
- Crisis Text Line: Text "4HOPE" to 741741 within Ohio. Free and confidential.

EMERGENCY:

- 911

PSYCHIATRIC EMERGENCY SERVICES (WALK-IN):

Portage County:

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555

Summit County:

- Summa Akron City Hospital Emergency Room- (330) 375-3361
- Akron General Medical Center Emergency Room- (330) 344-6611
- Akron Children's Hospital Behavioral Health Emergency Service - (330) 543-7472

ANSWERING SERVICE:

- Kent Psychological Associates- (330) 376-6801

  (Answering service will take your information for one of our clinicians to call you back.)