Welcome Letter

Dear New Patient,

Thank you for choosing Kent Psychological Associates, LLC, as your mental health care provider.

Before we schedule your initial appointment:

- Click on the link in your email from MyIO to sign up for the Patient Portal.
- **Once in the MyIO Patient Portal, click on "Fill Required Forms" in the top-right to find your initial paperwork. Your initial appointment can not be scheduled until all your forms are completed.**
- **Please upload a photo of your Insurance Card and Photo ID to the Patient Portal, or email the photos to info@kentpsychological.com**
- If you have difficulty with the forms, contact our office for assistance.
- You can access the Crisis Resource List, Notice of Patient Rights and Responsibilities, Notice of Privacy Policies, and the Doxy links for telehealth sessions in the Resources tab of your Patient Portal or directly on our website at www.kentpsychological.com

Day of your appointment:

- Arrive 15 minutes early for your in-office appointment.
- Log-on 15 minutes early for your telehealth appointment to ensure all technology is working properly.
- Your credit card on file will be charged for co-pays and high deductibles at the time of service.

If for any reason you are unable to keep your appointment, kindly call 24 hours in advance.

- We are committed to providing care to as many patients as possible. When a patient cancels without sufficient notice, this prevents another patient from being seen.
- **You will be charged a $75 fee for No-Show appointments and a $60 fee for Late Cancel appointments.**
- We do waive fees for cases of sudden-onset contagious/impairing illnesses or true emergencies. Please speak with our Office Manager or your clinician in these circumstances.

If you have concerns or questions, you can reach our business office Monday through Friday between the hours of 8:00 a.m. and 4:00 p.m.

We look forward to meeting you.

Please sign below indicating your have read the cancellation policy.

Signature: * ×

Date:

Adolescent Background Info

Name of person completing the form and relationship to minor patient: *

Minor patient's name: *

Date of Birth: *

Gender and Pronouns:

Race/Ethnicity/Culture: *

Who is/are the primary caregiver/guardian(s) of the patient? *

Emergency contact (name, relationships, phone number) *

What are your main reasons for seeking mental health treatment/evaluation for the patient at this time? *

HOME ENVIRONMENT AND HISTORY

Who lives with the patient? Please provide their names, ages, genders and relationships to the patient below.

Name, age, gender, relationship: *

Name, age, gender, relationship:

Name, age, gender, relationship:

Name, age, gender, relationship:

Please list any other members of the patient's household along with their names, ages, genders, and relationships to the patient:

Which of the following factors have been part of the patient's home environment? (Please check all that apply, past and present.) *

- [ ] Frequent moves
- [ ] Parents' divorce; Parents' remarriage
- [ ] Parental/family conflict
- [ ] Parent/family alcohol or drug use
- [ ] Family illness
- [ ] Death of a family member
- [ ] Financial issues
- [ ] Foster care
- [ ] Homelessness/housing instability
- [ ] None

DEVELOPMENTAL HISTORY

Which of the following factors were part of the patient's development? (Please select all that apply, past and present.) *

- [ ] Premature birth
- [ ] Birth defects
- [ ] Inconsolable (does not like to be held)
- [ ] Delayed walking
- [ ] Poor coordination
- [ ] Delayed speech
- [ ] Toilet training issues
- [ ] Difficulty playing independently
- [ ] Difficulty playing with others
- [ ] Eating non-edibles
- [ ] Other eating problems
- [ ] Sensory sensitivity
- [ ] Austism spectrum disorder diagnosis
- [ ] Other developmental delay/disability
- [ ] Difficulty with age appropriate hygeine
- [ ] None

EDUCATIONAL HISTORY

In what school and grade is the patient currently enrolled? *

Which of the following factors have been part of the patient's language and learning history? (Please check all that apply, past and present.) *

- [ ] Difficulty with attention, focus, distractability
- [ ] Difficulty listening
- [ ] Difficulty with transitions
- [ ] Impulsive
- [ ] Hyperactive
- [ ] Poor judgement
- [ ] Poor handwriting
- [ ] English as a second language
- [ ] Stuttering
- [ ] Other speech/language problems
- [ ] Dyslexia
- [ ] Other reading problems
- [ ] Resistence to school
- [ ] ADHD
- [ ] Other learning disabilities/problems
- [ ] None

SOCIAL HISTORY

What is the patient sexual orientation and relationship status? *

Does the patient work/volunteer outside of school? (If yes, please describe.): *

Which of the following social concerns do you have about the patient? (Please check all that apply, past and present.) *

- [ ] Problems getting along with family
- [ ] Problems getting along with peers
- [ ] Hard time talking to peers in some situations
- [ ] Hard time talking to non-family adults
- [ ] Difficulty understanding jokes
- [ ] Poor eye contact
- [ ] Self-conscious, shy
- [ ] Sensitive to crowds
- [ ] Stubborn
- [ ] Distrustful, secretive
- [ ] Lying, sneaking
- [ ] Frequent arguing
- [ ] Oppositional/defiant
- [ ] Temper tantrums; Explosive episodes
- [ ] Difficulties with work/volunteer performance
- [ ] Dating difficulties
- [ ] Victim of bullying
- [ ] Social media issues
- [ ] Other Internet/technology-related issues
- [ ] None

Please describe any other social concerns present for the patient (e.g., peer pressure, questioning sexual orientation). *

MENTAL HEALTH HISTORY

Does the patient have any history of mental health treatment, such as counseling, hospitalization, or medication? (If yes, please describe.) *

Does the patient have any history of self-harm, such as suicide attempts, cutting, or other purposeful self-injury? (If yes, please describe.) *

Does anyone close to the patient have a history of self-harm or suicide? (If yes, please describe.) *

MEDICAL HISTORY

Does the patient currently have a primary care provider, family/general practitioner, or pediatrician? (If yes, please provide their name.) *

When was the last time the patient met with their medical provider? *

Does the patient have any current medical concerns, such as chronic medical issues or new physical health symptoms? (If yes, please describe.) *

Please list all of the patient's current medications with their dosages or bring/upload the patient's medication list.

Please list any allergies (e.g., medication, food, environmental). *

PAST SIGNIFICANT STRESSORS

Please describe any history of significant stressors or traumas in the patient's life (e.g., loss, neglect, physical abuse, major accident/injury, sexual abuse).

CURRENT CONCERNS AND SOURCES OF STRESS

Please list the patient's most significant sources of stress currently: *

Which of the following anxiety concerns do you have for the patient? (Please check all that apply.) *

- [ ] Anxiety
- [ ] Panic attacks
- [ ] Obsessions or compulsions
- [ ] Perfectionism
- [ ] Worries too much
- [ ] Fears (e.g., animals, doctors, separation from parents)
- [ ] None

Which of the following disruptive/behavioral concerns do you have for the patient? (Please check all that apply.) *

- [ ] Acting violently
- [ ] Fire setting
- [ ] Rule breaking
- [ ] Property destruction
- [ ] Stealing
- [ ] Cruelty to animals
- [ ] Running away
- [ ] Risk taking behaviors
- [ ] Alcohol abuse
- [ ] Other substance abuse
- [ ] Hurting others
- [ ] Bullying others
- [ ] Concerning sexual behaviors
- [ ] None

Which of the following mood concerns do you have for the patient? (Please check all that apply.) *

- [ ] Self-esteem problems
- [ ] Immaturity
- [ ] Anger/irritability
- [ ] Depression/depressed mood/sadness
- [ ] Tearful; crying spells
- [ ] Feeling hopeless, helpless, and/or worthless
- [ ] Lack of energy; fatigue
- [ ] Withdrawn
- [ ] Lack of motiviation
- [ ] Not enjoying usual activities
- [ ] Overwhelmed/stressed
- [ ] Feeling guilty
- [ ] Moods change quickly
- [ ] Sleep difficulties
- [ ] Body image concerns
- [ ] None

EXPECTATIONS FOR TREATMENT/EVALUATION

How would the patient's life be different if they could better manage some of these problems and stressors? *

What are the main goals for participating in mental health treatment/evaluation at this time? *

Any other information you would like us to know before we meet:

Signature: * ×

Credit Card on File Policy

Thank you for choosing Kent Psychological Associates. We are committed to providing exceptional mental health care as well as providing access to care by remaining in-network with the majority of insurance companies in NE Ohio. To maintain this commitment, our insurance billing must be as simple and efficient as possible. Therefore, it has become necessary for our practice to have a guaranteed form of payment on file in our office.

Effective February 12, 2024, Kent Psychological Associates requires all non-Medicaid patients to keep an active credit card on file with us. Circumstances when your credit card would be charged include:

· Co-pays, co-insurance, and deductibles

· Any non-covered services and/or denial of services that your insurance company lists as "patient responsibility" on the Explanation of Benefits

· Missed or cancelled appointments without sufficient notice as detailed in our office policy

How my credit card information will be collected:

You have three options for providing your credit card information. With all options, the information will be immediately encrypted in the payment processing system and not stored in our office.

· Provide information over the telephone when you schedule your intake appointment.

· Provide your credit card information in-person at your first appointment in our office.

· Log-in to our Patient Portal and enter your credit card information yourself in the Card Manager. This can be completed while filling out the initial forms.

FAQ's about our new Credit Card on File Policy:

Why the change? The financial burden for the cost of healthcare has shifted more towards the patient in the form of higher deductibles and co-pays. We collect more money directly from patients, instead of insurance companies, than ever before. While many of our patients are very good at paying for their services in a timely manner, this is not always the case. We understand that your life is busy and complicated. Our goal is to make the collection of fees streamlined and simple for patients and our office.

What are my options for the card on file?

· Credit card (Visa, Mastercard, American Express or Discover)

· Debit card

· HSA card

· FSA card

· HRA card

*Please note that we do not except Care Credit

How will I know how much you are going to charge me?

We verify insurance coverage and benefits when a patient initiates services with us. Please check with your insurance company or ask us about your benefits if you have questions about your specific coverage. We will be able to give you an estimate of your per visit cost based on information provided by your insurance company. Insurance companies provide us with copay, co-insurance, and deductible amounts.

How do I know my credit card information is safe in your office?

We do not store your full credit card information in our office or in our computer system. Once our administrative staff enters your credit card information, it is “tokenized” and meets Payment Card Industry (PCI) Security Standards. Our staff no longer have access to anything other than the last 4 digits of your credit card.

What if I need to dispute my bill?

We will always work with you and your insurance company to determine if there has been a billing error. If a billing error is identified, refunds will be issued back to the credit card in a timely manner. You can contact our office and ask to speak with the office manager if you have any questions about your account.

Our staff is happy to speak with you about your account at any time. Please contact our office during business hours with any additional questions.

Thank you!

Signature: * ×

GAD 7 Adolescent

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item.**

During **the PAST 7 DAYS**, I have...

Felt moments of sudden terror, fear, or fright *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Felt anxious, worried, or nervous *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Had thoughts of bad things happening, such as a family tragedy, ill health, loss of a job, or accidents *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Felt a racing heart, sweaty, trouble breathing, faint, or shaky *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Avoided, or did not approach or enter, situations about which I worry *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Left situations early or participated only minimally due to worries *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Spent lots of time making decisions, putting off making decisions , or preparing for situations due to worries *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Sought reassurance from others due to worries *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time - 3
- ◯ All of the time - 4

Needed help to cope with anxiety (e.g. alcohol or medication, superstitious objects, or other people) *

- ◯ Never - 0
- ◯ Occasionally - 1
- ◯ Half the time - 2
- ◯ Most of the time -3
- ◯ All of the time - 4

Signature: * ×

Payment Policy

Thank you for choosing us to be a partner in your mental health treatment. We are committed to providing you with the highest quality professional services. We have developed this payment policy to clarify some of the common questions we receive regarding client and insurance responsibility. Please read it, ask us any questions you have, and sign in the space provided. A copy will be provided to you upon request.

1. Credit Card on File. All non-Medicaid clients must keep an active credit card on file. Credit cards will be charged for co-pays, co-insurance, deductibles, non-covered services, denied services, missed appointments, or appointments cancelled without sufficient 24 hour notice. Ask for a copy of our full Credit Card on File Policy if you have any questions.

I understand that my payment information will be maintained in a secure encrypted format for future use by the practice. **I authorize the collection of payment for all charges listed above.** I understand that I will not be provided with advance notice of authorized transactions up to the amount of $300. Transaction receipts will be sent through the Patient Portal, with an alert to the email address I provided. Authorization will remain in effect until I provide written notice of cancellation to the practice.

2. Missed appointments. There is a $75 fee for missed appointments and a $60 fee for appointments cancelled without sufficient prior notice of 24 hours. This fee will be your responsibility and cannot be billed to your insurance company. This fee must be paid in full prior to your next scheduled appointment or your appointment may be rescheduled. Please help us to serve you better by keeping your regularly scheduled appointment. Clients who develop a pattern of frequent missed or cancelled appointments may be discharged from the practice.

3. Insurance. We participate in most insurance plans. If we do not participate with your insurance, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

4. Preauthorization. If your insurance plan requires preauthorization before your first visit from you or your family doctor (PCP), this is your responsibility to secure as a member of your insurance plan. Such requirements will usually be stated on your health insurance identification

card, with a special phone number listed to receive such authorization for mental health or substance abuse services.

5. Co-payments. All co-payments will be charged to the credit card on file at the time of service. Unpaid co-pays, due to declined or expired credit cards, must be paid in full prior to your next appointment or your appointment may be rescheduled.

6. Co-Insurance. Your co-insurance balance will be charged to your credit card on file once we receive the explanation of benefits (EOB) from your insurance company. We are able to assist you with an estimate of the per visit co-insurance cost if needed.

7. Deductibles. If you have a high deductible plan, we will contact your insurance company to confirm eligibility and obtain an estimate of your out-of-pocket cost for each visit. **Your credit card on file will be charged for the full estimated out-of-pocket cost at each visit. Any remaining balance will be charged once we receive the EOB from your insurance company.** In the event that a credit balance is due to you, the amount will be refunded within thirty (30) days of our receipt of payment from your insurance company.

8. Non-covered services. Please be aware that some – and perhaps all if your condition is not covered under your policy – of the services you receive may be noncovered or not considered medically necessary by your insurer. Payment is required for these services in full at the time of visit. Other fees that may not be covered by your insurance include letters, extended phone calls, completion of forms, etc. that are beyond standard coordination of care. Please ask your clinician if you have a question about non-covered services.

·A full schedule of fees is available upon request or in the Patient Portal

9. Proof of insurance. All clients must provide photo identification and a current, valid insurance card before being seen by the clinician. If you fail to provide us with the correct insurance information at the time of your first visit, or at any point at which you obtain new insurance coverage, you may be responsible for the balance of your claim.

10. Claims submission. We will submit your claims and assist you in any way reasonably possible to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with your insurance company's request as well as to comply within the given time specified by your insurance company. Please be

aware that the balance of your claim is your responsibility. If your insurance company has not responded within forty-five (45) days, we will require you to contact them, and at that point, your claim balance will become your responsibility.

11. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will need to verify your benefits and verify that your clinician is on panel with your new insurance.

12. Nonpayment. If your account is over thirty (30) days past due, we will be unable to schedule additional appointments except for a clinical emergency. An exception may be made if you contact us and make a payment plan arrangement with terms agreed upon by our office. If your account lapses to ninety (90) days past due, you will receive a letter stating that you have twenty (20) days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have thirty (30) days to find alternative care. During that 30-day period, our clinician will assist you with a referral to another agency.

13. Financial Hardship: If you experience temporary financial difficulties that affect timely payment of your account, please discuss this issue with our billing staff at your earliest possible convenience, before any misunderstandings can develop.

14. Uninsured Clients: We offer a reduced fee for uninsured clients who demonstrate financial hardship based on Federal Poverty Guidelines. If you feel you qualify, an application will be provided. You will be required to produce documentation of income. Eligibility for reduced fee must be updated every 6 months. For clients who do not qualify for a reduced fee, a prompt pay discount is available.

15. Non-sufficient Funds: There is a $25 fee for returned checks.

If you have difficulty understanding your account or billing statements, please contact our office and ask to speak with a member of our billing staff.

Thank you for understanding. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature: * ×

Date:

Release of Information

Kent Psychological Associates

190 Currie Hall Prkwy

Kent, Ohio 44240

Ph: 330-673-5812 Fax: 330-673-7162

Preferences for coordination of care between Kent Psychological Associates (KPA) and my Primary Care Provider (PCP): *

Name and address of PCP: *

I UNDERSTAND:

1. This authorization will expire 1 year from the date of signing.

2. I may revoke this authorization at any time by providing any 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.

5. 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 designated above, which may include treatment for mental illness (ORC 5122.31), alcohol/drug abuse (42 CRF Part 2), and/or Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) test results or diagnoses (ORC 3701.24.3).

Signature: * ×

Permission to Treat and Acknowledgement of Policies

Permission to Treat/Informed Consent: I understand that my treating professional may use any and all customary procedures and treatments employed by psychological outpatient or clinic facilities. I understand that there are risks involved in all treatment modalities and that my therapist can offer **no guarantee regarding the outcome of the therapeutic measures** in a specific case. I understand that my therapist will be using techniques and procedures consistent with prevailing standards and that I will be informed and will be asked for specific written consent for any high risk or "hazardous practice" procedures. I understand that I have **the right to refuse any specific treatment** procedures, but that if I refuse treatment that is in accord with professional standards, my therapist has the right to terminate treatment upon reasonable notice. My treatment professional will answer any and all questions I may have about my treatment plan or services.

Notice of Patient Rights and Responsibilities: The Notice can be viewed or downloaded in the Patient Portal under Resources or on our website. A paper copy can be obtained from the front desk. I have received a copy of the Kent Psychological Associates, LLC's Notice of Patient Rights and Responsibilities, and I agree to and understand its terms regarding my rights and responsibilities as a patient and the grievance procedure that I may utilize if I feel that my rights are being violated.

Notice of Privacy Practices Policy: The Notice can be viewed or downloaded in the Patient Portal under Resources or on our website. A paper copy can be obtained from the front desk. I have received a copy of the Notice of Privacy Practices followed by Kent Psychological Associates, LLC, and I agree to and understand its terms regarding how my personal health information may be used. I understand that I can ask any questions that I may have about these policies at any time.

Confidentiality: I understand that my discussions in treatment will remain confidential as afforded by ethical practice and by Ohio and Federal law, and my consent is required to release my records. I understand that **there are legally mandated exceptions to confidentiality,** such as mandatory reporting of suspected abuse or neglect of a child or older adult, and reporting of specific threats to harm another or oneself. A licensed therapist must also obey a court order to produce or discuss records.

Case Consultation: From time to time, my therapist may consult with colleagues at Kent Psychological Associates, LLC regarding clinical or ethical issues of concern in my case in order to provide the highest quality care. I understand that care with be taken to disclose the minimum necessary information to ensure good clinical decision making.

Authorization for Release of Information: I understand that treatment information, such as diagnosis, will be requested by my insurance company for claims processing, and that information, such as presenting complaints, previous treatment history, special risk factors, and treatment goals may be requested by my managed care organization if I have managed care rather than traditional health insurance. I have the right to refuse my insurance company and/or managed care organization to access to my treatment information; however, if I exercise this right, I will be fully responsible for the cost of services I incur. Furthermore, I grant my permission for dates of service to be submitted electronically, if available, through my insurance carrier.

I hereby authorize Kent Psychological Associates, LLC to release any information in connection to my treatment to my insurance company for the purpose of processing the insurance claim.

Guarantee of Account: I understand that I am financially responsible for charges not covered by my insurance company. **If any payment is due, it is expected at the time that services are rendered.**

Assignment of Insurance Benefits: I hereby authorize payment of the benefits otherwise payable to me by the designated insurance company(ies) directly to Kent Psychological Associates, LLC, the amount not to exceed regular charges.

Telehealth Services: I understand that telehealth services may, at times, be part of my treatment. I understand that there are benefits and risks associated with telehealth services, including but not limited to, disruption of sessions by technology failures, interruption and/or breech of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. Additionally, at any time, my provider can decide that telehealth services are no longer clinically appropriate and recommend alternative options for face-to-face services.

My clinician needs to know my location in case of an emergency. I agree to inform my clinician of my location at the beginning of each telehealth session.

If we encounter technical difficulties resulting in session disruption and are unable to reconnect, my clinician may call me at the following number: *

Emergency Contact: I understand that I must provide an emergency contact person who my provider may contact on my behalf in a life-threatening emergency. (Please list name, phone, and address.) *

Your signature below indicates that you have read and understand this form and agree to its terms. Additionally, your signature indicates that you give your treating professional(s) permission to treat you and that you consent to such treatment.

Signature: * ×

Date:

PHQ-9 Adolescent

Feeling down, depressed, irritable, or hopeless *

- ◯ Not at all
- ◯ Several days
- ◯ Half the days
- ◯ Nearly every day

Little interest or pleasure in doing things? *

- ◯ Not at all
- ◯ Several days
- ◯ Half the days
- ◯ Nearly every day

Poor appetite, weight loss, or overeating *

- ◯ Not at all
- ◯ Several days
- ◯ Half the days
- ◯ Nearly every day

Feeling tired or having litte energy *

- ◯ Not at all
- ◯ Several days
- ◯ Half the days
- ◯ Nearly every day

Feeling bad about yourself or feeling that you are a failure, or that you have let yourself or your family down *

- ◯ Not at all
- ◯ Several days
- ◯ Half the days
- ◯ Nearly every day

Trouble concentrating on things like school work, reading, or watching TV *

- ◯ Not at all
- ◯ Several days
- ◯ Half the days
- ◯ Nearly every day

Moving or speaking so slowly that other poeple could have noticed. Or the opposite---being so fidgety or restless that you were moving around a lot more than usual. *

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Thoughts that you would be better off dead, or of huring yourself in some way *

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

In the past year have you felt depressed or sad most days, even if you felt okay sometimes? *

- ◯ Yes
- ◯ No

If you are experiencing any of the problems listed above, 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 at all difficult
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

Has there been a time in the past month when you have had serious thoughts of ending your life? *

- ◯ Yes
- ◯ No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? *

- ◯ Yes
- ◯ No

**If you have had thoughts that you would be better off dead or hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.

Signature: * ×

Modified with permission for the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Treatment of Minor Children

Treatment of Minor Children

The initial appointment will be for the parent/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.

Signature: * ×

Date:

Signature: ×

Date: