3-C Family Services Forms

3-C Family Services, P.A.

Complete psychological care for children and families

Client Information Form

Client # _____

First Name _____ Last Name _____

Address _____ City _____ State ____ Zip _____

Billing Address (if different) _____ City _____ State ____ Zip _____

E-Mail Address _____ Birthdate _____

Primary Phone _____ Cell Phone _____

Financial Responsibility (If different from above)

Parent/ Legal Guardian Name _____ Phone # _____

Employer/Occupation _____ Birthdate _____

Insurance Information Form

Insurance Co Name _____ Policy Group # _____

Subscriber/ Policy Holder's Name _____ Subscriber/ ID Policy # _____

Relationship to Subscriber _____ Policy Holder's Birthdate _____

Please select one of the following options:

_____ I want 3-C Family Services to assist in filling my insurance claim using "Out of Network" options. I authorize 3-C Family Services to communicate with my insurance provider regarding treatment. I understand that 3-C Family Services will follow HIPAA compliance guidelines regarding confidentiality and only provide the necessary information requested by my insurance provider. I understand that if I am 18 years or older 3-C Family Services reserves the right to speak with the policy holder/guardian about any insurance issues.

_____ I do not want 3-C Family Services assistance with filling my insurance claim. By signing below I acknowledge that I have read and fully understand 3-C Family Services Insurance Fact Sheet. I understand that my individual insurance policy is a contract between the insurance company and myself, and 3-C Family Services is not a party to that contract. I understand that not all services may be covered by my policy. By presenting for care, I agree that I am responsible for all services and charges, regardless of my insurance status. 3-C Family Services will not alter my claim, change my diagnosis, or report a different service than what was performed in order for my insurance to cover the charge.

_____ _____

Client's Signature (Required for all clients 18 years or older) **DATE**

_____ _____

Parent's/Legal Guardian's Signature (Required for all clients 17 years or younger) **DATE**

1901 North Harrison Avenue, Suite 100 Cary, NC 27513 • Phone (919) 677-0101 • Fax (919) 677-0113
www.3cfs.com • familyservices@3cfs.com

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Insurance Fact Sheet

To ensure prompt correspondence from insurance companies, clients should:

- Contact their insurance company to setup precertification or preauthorization for services.
- Inform the Billing and Insurance Coordinator on the status of claims, both problems and successes, in a timely manner.
- Keep up with the number of visits insurance authorizes.

- **Behavioral health member IDs and claims filing information may be different from your medical insurance information. Please verify your behavioral health benefits on the back of your card prior to completing this form. We will ONLY file to the insurance provider you provide to us. We do not back file.**

3- C Family Services is out-of-network, but as a courtesy to our clients we will:

- Correctly input the Client's insurance information into our system.
- Provide a one-time per date-of-service courtesy file to the primary insurance company within 5-7 business days.

Please note:

- If you are 18 years or older and under a Guardian's insurance policy, 3-C Family Services reserves the right to speak with the Guardian/Policy holder in regards to any insurance issues.
- 3-C Family Services will only file to the primary insurance company.

Resources:

- 1-800 numbers on the back of your insurance card
- Billing and Insurance Coordinator:
    - billing@3cfs.com OR 919-677-0101 extension 513
    - Commonly used procedure (CPT) codes
        - 90791: Initial Intake Evaluation
        - 90834: Individual or Family Therapy Session, lasting 45-50 minutes
        - 99214: Medication Management, lasting 20-30 minutes
        - 99215: Medication Management, lasting 45-50 minutes
        - 90853: Group Therapy

Client Contract

This contract contains information about our services and the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The law requires that we obtain your signature acknowledging that we provided you with this information. Signing this agreement also represents an agreement between us. You may revoke this contract in writing at any time which will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process claims; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Family Services provides a range of services, including but not limited to: individual therapy, family therapy, marital therapy, group therapy, psychological testing, and medication management. We work within a multi- disciplinary team approach, and have on-staff professionals from many disciplines. Our therapists are doctoral, licensed, and masters-level psychologists, clinical social workers, and licensed professional counselors. Our psychiatrists assess and monitor client's need and use of psychotropic medications. Therapy groups are run by a combination of any of the professionals mentioned above.

When you call to make an appointment with us, we will schedule an intake appointment with one of our therapists that will last at least 45 minutes. The first session will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan. You should evaluate this information along with your own opinions of whether you feel comfortable working with 3-C Family Services. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide **24** hours advance notice of cancellation. Therapy involves a large commitment of time, money, and energy, so you should weigh the decision to begin therapy carefully. If you have questions about our procedures, we should discuss them whenever they arise in order to best serve your needs.

PROFESSIONAL FEES

Please refer to the fee schedule as our fees vary depending on the service being provided. We reserve the right to change fees at any time; however you will be notified before such a change occurs. Please be aware that you can be charged for other services including report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, emergency after-hour face-to-face or phone consultation, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time, including preparation and transportation costs, even if we are called to testify by another party.

CONTACTING YOUR THERAPIST

Due to the work schedule, therapists are often not immediately available by telephone. While normally in the office during our posted business hours, 8:00 am through 7:00 pm Monday through Thursday, they will not answer the phone when with a client. When unavailable, telephones are answered by voice mail or by the receptionist. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave times when you will be available. If you are unable to reach your therapist and feel that you can't wait for him or her to return your call contact your family physician, the nearest emergency room and ask for the Mental Health Professional on call.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a clinician. In most situations, we only release information about your treatment to others if you sign a written authorization form. There are other situations that require that you provide written, advance consent. Your signature on this contract provides consent for those activities, as follows:

- ✓ At 3CFS it is common to have a child seen by one practitioner and the parents to be seen by another or for a client to be seen by both a psychiatrist and a psychotherapist. In these cases, the two practitioners would schedule time to review their treatment approach and coordinate goals and strategies to maximize the effectiveness of the interventions. We also hold weekly case conferences to learn from one another and to present difficult cases for the process of group consultation. This is

just one of the ways all of the practitioners at 3CFS stay on the cutting edge of treatment approaches for our clients. At all times in all of these processes, the client's confidentiality and dignity are preserved.

- ✓ You should be aware that our practice includes numerous mental health professionals and administrative staff. PHI is shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the professionals and staff members are bound by the same rules of confidentiality.
- ✓ We also have HIPAA-bound contracts with 3-C ISD, a research company dedicated to the development of therapy tools for use in professional practice. In this contract, 3-C ISD promises to maintain the confidentiality of data except as specifically allowed in the contract and otherwise required by law. If you wish, we can provide you with a copy of this contract. Participation with any 3-C ISD program will only occur with written consent by the patient or legal guardian.
- ✓ If we believe that a patient presents an imminent danger to his/her health or safety, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information **without** your consent:

* If you are involved in a court proceeding and a request is made for information concerning the services that we provided you, such information is protected by the therapist-patient privilege law. We cannot provide any information without your written authorization, *or* a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

*If a government agency requests information for health oversight activities, we may be required to provide it for them.

*If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

*If a client files a worker's compensation claim and our services are being compensated through workers compensation benefits, we must, upon appropriate request, provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

There are some situations in which we are legally obligated to take action, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a client's treatment. These situations are unusual in our practice.

- ➢ If we have cause to suspect that a child under 18 is abused or neglected, or if we have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that we file a report with the County Director of Social Services. Once such a report is filed, we may be required to provide additional information.
- ➢ If we believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim (if identifiable), and/or calling the police.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit disclosure to what is necessary. While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of the helping profession require that we keep PHI about you in your Medical Record. Except in circumstances that involve danger to yourself and/or others, or the record makes reference to another person and we believe that access is likely to cause harm to such other person, you may examine and/or receive a copy of your Medical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence or have them forwarded to another professional so you can discuss the contents. We charge a copying fee per page. If we refuse your request for access to records you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Medical Records and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your Medical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this contract, the attached NPP form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS

While privacy in therapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents. It is our policy not to provide treatment to a child under 12 unless he/she agrees that we can share whatever information we consider necessary with his/her parents. For children 13 and over, we request an agreement between the client and his/her parents allowing us to share general information about the progress of the child's treatment and his/her attendance at sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Again, please refer to the fee schedule to learn more specifically about fees for service. It is important to note that insurance companies do not provide reimbursement for missed sessions or telephone contact. If your account has not been paid for more than 60 days and arrangements for payment have not been made, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide out-of- Network coverage. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees at the time of service.

You should be aware that insurance companies require that we provide information relevant to the services we provide to you. We are required to provide a clinical diagnosis and are often called to provide treatment plans or copies of your entire Medial Record. We make every effort to release only the minimum information necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep information confidential, we have no control over what they do with it once it is in their hands. We will provide you with a copy of reports we submit per your request.

Please feel free to direct any questions to the front desk staff or to your therapist. Your understanding of this contract is important to us and we are happy to discuss any or all of these conditions with you at any time.We look forward to serving you and your family.

By signing below I acknowledge that I have read and fully understand 3-C Family Services, P.A. Client Contract.

Client Name: _____ Date: _____

Client/ Guardian's Signature: _____

3-C Family Services, P.A.
Complete psychological care for children and families

Client# _____

AUTHORIZATION FOR RELEASE OF INFORMATION
CONFIDENTIAL
OPTIONAL … Only need to complete if you wish to authorize the release of information

Regarding Client: _____ DOB: _____

I consent to allow 3-C Family Services to release and /or exchange information with:
Name of Persons/Agency: _____

Complete Address: _____

Telephone/Fax Number: _____

This information will include:
____ Psychiatric Records
____ Therapy Notes
____ Discharge Summary
____ Testing
____ Treatment Plan
____ Behavioral Observations/ Checklists
____ Laboratory Work
____ All of the Above
____ Other _____

Specific Purpose: _____

This authorization shall remain in effect for one year, ending ____/_____/_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of securing insurance coverage and the insurer has a legal right to contest a claim.

Should you wish us to take any additional action regarding this release of information, please send a separate letter regarding this request.

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

_____ _____
Signature of Patient Date

_____
If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

This is strictly a confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

3-C Family Services, P.A.

Complete psychological care for children and families

FEE SCHEDULE FOR SERVICES

Effective September 01, 2016

3-Family Services, P.A. provides services at the following rates:

Intake Appointments	**Session Time**	**Rates**
Psychiatrist (MD)	75-90 minutes	$350.00
Psychologist (PhD)/ Senior Clinician	50 minutes	$195.00
LPA, LPC, LCSW	50 minutes	$195.00
Individual and Family Therapy	**Session Time**	**Rates**
Psychiatrist (MD)	45-50 minutes	$220.00
Psychologist (PhD)/Senior Clinician	50 minutes	$170.00
LPA, LPC, LCSW	50 minutes	$150.00
Ph.D. / Senior Clinician	20-30 minutes	$135.00
LPA, LPC, LCSW	20-30 minutes	$115.00
Medication Management	**Session Time**	**Rates**
Psychiatrist (MD)	20-30 minutes	$170.00
Psychiatrist (MD)	15 minutes	$120.00
Group Therapy	**Session Time**	**Rates**
SS Grin Group	30-60 minutes	$80.00
DBT Adult Group	90 minutes	$90.00
DBT Multi Family Group	90 minutes	$150.00
Divorce Consulting	**Per Hour**	$225.00
Educational Consulting	**Per Hour**	$200.00
Psychological Testing	**Per Hour**	**** See below**

** The rate for psychological testing is **double the rate for a 45 - 50 minute session** for the type of clinician listed above under **individual and Family Therapy**.

This doubled rate covers 1 hour for client's face-to-face testing with the clinician's time in scoring and report writing.

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FINANCIAL AGREEMENT

The Financial Agreement form must be signed prior to starting any appointment.

To provide the best care, it is important that our clients have a clear understanding of our Financial Policy and fees. We are committed to providing the best possible care and will be happy to answer any questions you may have. We can only file claims to an active and primary insurance company. It is the client's responsibility to update us when insurance information changes.
We do not back file to any insurance company.

3- C Family Services **requires a 24 – hour cancellation notice**. Clinicians reserve the right to charge up to the full amount of your scheduled appointment. Please see the fee schedule for information. These fees will not be sent to insurance as they are not covered. The client is responsible for payment in full. The office would also like to inform our clients that reminder phone calls / or text reminders are a courtesy of this office and are not required.

Clients can be charged for other services performed and or provided by 3-C Family Services (3-CFS) in 15 minute increments for report writing, telephone conversations lasting longer than 11 minutes, consulting with other professionals / clinicians upon client's written consent, preparation of records or treatment summaries, and clinician's time spent performing and / or providing any other professional services requested by the client.

If a client becomes involved in legal proceedings that require participation from his/ her clinician(s), professional time including, but not limited to, preparation time and transportation costs including the clinician's time and cost if called to testify by another party. Because of the complexity of legal involvement, 3- CFS Clinicians charge double the rate for a 50 minute session for the type of clinician listed above in the individual family therapy for preparation and attendance at any legal proceeding.

3- C Family Services reserves the right to alter and update the fee schedule at any time. All current clients will be notified of changes in fees at least 2 weeks prior to the change occurring through a notice mailed to the client's current mailing address on file.

Divorced / separated parents of minors who bring in the child(ren) for the appointment is financially responsible for the appointment(s). 3-C Family Services will not be involved with the separation or divorce disputes pertaining to payment. You are responsible for payment in a timely manner. Outstanding accounts may be sent to a collection agency. If this should occur, you will be responsible for any fees associated with our contacting and sending the account to collections. Dates of service with an outstanding balance will then no longer be filed to insurance as a courtesy.

Your understanding of these policies is important to our professional relationship. We look forward to answering any of your questions about our Financial Agreement.

Client's Name: _____

Client's Signature: _____ Date: _____
Required for all client's 18 years or older

Parent/ Guardian's Signature: _____Date: _____
Required for client's 17 and younger

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Client #_____

CREDIT CARD AUTHORIZATION AGREEMENT

All fields are required to be completed on this form

Optional….only need to complete if you wish to put a credit card on file.

Client's Name (Please Print) _____

Credit Card Information: (as shown on credit card)

Credit Card Type __ VISA __ MASTERCARD __ DISCOVER __ AMEX

Card Holder Name (as shown on credit card): _____

Card # _____ EXP Date: _____/_____ CCV#_____

Billing Address of Credit Card Holder: _____
Street Address

_____
City State Zip Code

Phone Number of Credit Card Holder: (____) _____ (_____) _____

This agreement will be in effect from: _____/_____/_____ through _____ /_____/_____
MM DD YYYY MM DD YYYY

Authorization:

I hereby authorize 3-C Family Services, P.A.(3-CFS) to charge the indicated credit card on a periodic basis to collect payment due for services rendered by 3-CFS in accordance with the 3-CFS fee schedule for the above listed client. I also authorize 3-CFS to charge my credit card the price of a scheduled session, in accordance to the 3-CFS Fee schedule, should the above listed client fail to attend their scheduled appointment or fail to give a 24 hour notice to cancel their appointment.

If 3-CFS is unable to process my payment, I will be responsible for an alternate payment arrangement and all late fees that occur. I understand that this agreement shall remain in force unless I cancel it in writing.

I will not dispute 3-CFS's charges to my credit card so long as the amount in question is for services rendered prior to my canceling my agreement in the manner required.

I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement with 3-CFS. I acknowledge that I have read and agree to all of the above terms and conditions.

_____ _____
Signature of Credit Card Holder (Required) Date

3-C Family Services, P.A.

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ADULT SUPPLEMENTARY INFORMATION

To be completed by clients ages 18 years or older

Client: _____ Date of Birth: _____ Today's Date: _____

MEDICAL HISTORY:

Primary Care Provider: _____ Phone: _____

Please list any significant childhood illnesses:

_____

_____

Please list any current medical conditions:

_____

_____

Please list any surgeries and when they were performed:

_____

_____

_____

Have you ever had a seizure, head trauma, or loss of consciousness? Yes No
If yes, please describe:

_____

_____

_____

Have you ever had an EEG or CT / MRI of your head? Yes No
If yes, please describe:

_____

_____

Have you ever been hospitalized for a medical reason? Yes No
If yes, please describe:

_____

_____

_____

Have you ever been seen in the emergency room? Yes No
If yes, please describe:

_____

_____

_____

If female, do you have regular menses? Yes No

Date of the most recent physical exam:_____(MM/DD/YYYY)

Is your vision within normal limits without correction? Yes No

Is your hearing within normal limits without correction? Yes No

Please list any medication and doses you are taking currently, including over-the-counter, herbal or vitamins.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes No
If yes, please list the medication and the reaction:

_____

_____

_____

Have you had a pharmacogenetics profile performed? Yes No
If so, please bring results with you to your appointment.

PLEASE CHECK ANY SYMPTOMS BELOW THAT YOU ARE CURRENTLY HAVING:

_____ weight changes
_____ nausea or vomiting
_____ changes in vision or hearing
_____ chest pain/heart palpitations
_____ dizziness
_____ easy bleeding or bruising
_____ stomach discomfort
_____ Headaches
_____ headaches
_____ menstrual problems or suspicion of pregnancy (female)

_____ Fever
_____ Constipation
_____ problems with urination
_____ muscle or joint pain
_____ numbness or weakness
_____ trouble breathing
_____ hair loss
_____ Fainting
_____ skin problems

FAMILY HISTORY:

Please list any blood relative with the following: (Specify relationship to you)

Substance abuse	
Attention deficit	
Learning problems or mental retardation	
Depression	
Bipolar disorder (manic-depression)	
Other Anxiety	
Diabetes	
Hypertension or heart disease	
Liver disease	
Migraines	
Genetic syndromes (please specify)	
Neurologic disorders (Parkinson's, multiple sclerosis, Alzheimer's, etc.)	
Schizophrenia	
Autism	
Obsessions/Compulsions	
Panic	
Eating disorders	
Suicide	
Cancer (specify type)	
Thyroid disease	
Kidney disease	
Tics	
Epilepsy	
Sudden Unexplained death before age 40	

SOCIAL HISTORY: Please list name and ages of all persons living in your home:

_____ _____ _____

_____ _____ _____

_____ _____ _____

EMPLOYMENT HISTORY:

_____

_____

_____

EDUCATIONAL HISTORY:

_____

_____

Are there guns in your home? _____

Please list any current or previous legal problems:

_____

_____

Do you use recreational drugs or alcohol? Yes No
If yes, please estimate frequency and quantity of use:

_____

_____

How would you describe your social life? Are you satisfied with your relationships?

_____

_____

_____

PREVIOUS TREATMENT:

Is this your first mental health consultation? Yes No *If no, please list the following where applicable:*

Previous evaluations (evaluator, date of evaluation, recommendations):

_____

_____

_____

Previous psychotherapy (therapist, dates of treatment, type of treatment if known {CBT, DBT, psychoanalysis}):

_____

_____

_____

Previous medication trials (name of medications, dose, how long the medication was taken):
Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled.

_____

_____

_____

Previous psychiatric hospitalizations (hospital name, dates of hospitalization, treatment received during the hospitalization):

_____

_____

_____

Please describe the issues that you would like to address:

_____

_____

_____

_____

_____

_____

Please contact previous provider to request any pertinent medical records and have them faxed to your 3 -C Family Services clinician prior to your first appointment so they may be reviewed prior to your consultation.

3-C Family Services fax # (919) 677.0113

Per the Health Insurance Portability and Accountability Act (HIPAA) this information is strictly confidential

REV 8/2017

3-C Family Services, P.A.

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Client Information Form

Client # _____

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Billing Address (if different) _____ City _____ State _____ Zip _____

E-Mail Address _____ Birthdate _____

Primary Phone _____ Cell Phone _____

Financial Responsibility (If different from above)

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Employer/Occupation _____ Birthdate _____

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Insurance Co Name _____ Policy Group # _____

Subscriber/ Policy Holder's Name _____ Subscriber/ ID Policy # _____

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Please select one of the following options:

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Client's Signature (Required for all clients 18 years or older) **DATE**

_____ _____

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- Inform the Billing and Insurance Coordinator on the status of claims, both problems and successes, in a timely manner.
- Keep up with the number of visits insurance authorizes.

- **Behavioral health member IDs and claims filing information may be different from your medical insurance information. Please verify your behavioral health benefits on the back of your card prior to completing this form. We will ONLY file to the insurance provider you provide to us. We do not back file.**

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This contract contains information about our services and the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The law requires that we obtain your signature acknowledging that we provided you with this information. Signing this agreement also represents an agreement between us. You may revoke this contract in writing at any time which will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process claims; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Family Services provides a range of services, including but not limited to: individual therapy, family therapy, marital therapy, group therapy, psychological testing, and medication management. We work within a multi- disciplinary team approach, and have on-staff professionals from many disciplines. Our therapists are doctoral, licensed, and masters-level psychologists, clinical social workers, and licensed professional counselors. Our psychiatrists assess and monitor client's need and use of psychotropic medications. Therapy groups are run by a combination of any of the professionals mentioned above.

When you call to make an appointment with us, we will schedule an intake appointment with one of our therapists that will last at least 45 minutes. The first session will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan. You should evaluate this information along with your own opinions of whether you feel comfortable working with 3-C Family Services. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide **24** hours advance notice of cancellation. Therapy involves a large commitment of time, money, and energy, so you should weigh the decision to begin therapy carefully. If you have questions about our procedures, we should discuss them whenever they arise in order to best serve your needs.

PROFESSIONAL FEES

Please refer to the fee schedule as our fees vary depending on the service being provided. We reserve the right to change fees at any time; however you will be notified before such a change occurs. Please be aware that you can be charged for other services including report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, emergency after-hour face-to-face or phone consultation, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time, including preparation and transportation costs, even if we are called to testify by another party.

CONTACTING YOUR THERAPIST

Due to the work schedule, therapists are often not immediately available by telephone. While normally in the office during our posted business hours, 8:00 am through 7:00 pm Monday through Thursday, they will not answer the phone when with a client. When unavailable, telephones are answered by voice mail or by the receptionist. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave times when you will be available. If you are unable to reach your therapist and feel that you can't wait for him or her to return your call contacts your family physician, the nearest emergency room and asks for the Mental Health Professional on call.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a clinician. In most situations, we only release information about your treatment to others if you sign a written authorization form. There are other situations that require that you provide written, advance consent. Your signature on this contract provides consent for those activities, as follows:

- ✓ At 3CFS it is common to have a child seen by one practitioner and the parents to be seen by another or for a client to be seen by both a psychiatrist and a psychotherapist. In these cases, the two practitioners would schedule time to review their treatment approach and coordinate goals and strategies to maximize the effectiveness of the interventions. We also hold weekly case conferences to learn from one another and to present difficult cases for the process of group consultation. This is just one of the ways all of the practitioners at 3CFS stay on the cutting edge of treatment approaches for our clients. At all times in all of these processes, the client's confidentiality and dignity are preserved.

- ✓ You should be aware that our practice includes numerous mental health professionals and administrative staff. PHI is shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the professionals and staff members are bound by the same rules of confidentiality.
- ✓ We also have HIPAA-bound contracts with 3-C ISD, a research company dedicated to the development of therapy tools for use in professional practice. In this contract, 3-C ISD promises to maintain the confidentiality of data except as specifically allowed in the contract and otherwise required by law. If you wish, we can provide you with a copy of this contract. Participation with any 3-C ISD program will only occur with written consent by the patient or legal guardian.
- ✓ If we believe that a patient presents an imminent danger to his/her health or safety, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information **without** your consent:

- ❑ If you are involved in a court proceeding and a request is made for information concerning the services that we provided you, such information is protected by the therapist-patient privilege law. We cannot provide any information without your written authorization, *or* a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- ❑ If a government agency requests information for health oversight activities, we may be required to provide it for them.
- ❑ If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.
- ❑ If a client files a worker's compensation claim and our services are being compensated through workers compensation benefits, we must, upon appropriate request, provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

There are some situations in which we are legally obligated to take action, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a client's treatment. These situations are unusual in our practice.

- ➢ If we have cause to suspect that a child under 18 is abused or neglected, or if we have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that we file a report with the County Director of Social Services. Once such a report is filed, we may be required to provide additional information.
- ➢ If we believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim (if identifiable), and/or calling the police.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit disclosure to what is necessary. While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of the helping profession require that we keep PHI about you in your Medical Record. Except in circumstances that involve danger to yourself and/or others, or the record makes reference to another person and we believe that access is likely to cause harm to such other person, you may examine and/or receive a copy of your Medical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence or have them forwarded to another professional so you can discuss the contents. We charge a copying fee per page. If we refuse your request for access to records you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Medical Records and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your Medical Records is disclosed to

others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this contract, the attached NPP form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS

While privacy in therapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents. It is our policy not to provide treatment to a child under 12 unless he/she agrees that we can share whatever information we consider necessary with his/her parents. For children 13 and over, we request an agreement between the client and his/her parents allowing us to share general information about the progress of the child's treatment and his/her attendance at sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Again, please refer to the fee schedule to learn more specifically about fees for service. It is important to note that insurance companies do not provide reimbursement for missed sessions or telephone contact. If your account has not been paid for more than 60 days and arrangements for payment have not been made, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide out-of- Network coverage. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees at the time of service.

You should be aware that insurance companies require that we provide information relevant to the services we provide to you. We are required to provide a clinical diagnosis and are often called to provide treatment plans or copies of your entire Medial Record. We make every effort to release only the minimum information necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep information confidential, we have no control over what they do with it once it is in their hands. We will provide you with a copy of reports we submit per your request.

Please feel free to direct any questions to the front desk staff or to your therapist. Your understanding of this contract is important to us and we are happy to discuss any or all of these conditions with you at any time.
We look forward to serving you and your family.
By signing below I acknowledge that I have read and fully understand 3-C Family Services, P.A. Client Contract.

Client Name: _____ Date: _____

Client/ Guardian's Signature: _____

3-C Family Services, P.A.

Complete psychological care for children and families

AUTHORIZATION FOR RELEASE OF INFORMATION
CONFIDENTIAL
OPTIONAL … Only need to complete if you wish to authorize the release of information

Regarding Client: _____ DOB: _____

I consent to allow 3-C Family Services to release and /or exchange information with:
Name of Persons/Agency: _____

Complete Address: _____

Telephone/Fax Number: _____
This information will include:
____ Psychiatric Records
____ Therapy Notes
____ Discharge Summary
____ Testing
____ Treatment Plan
____ Behavioral Observations/ Checklists
____ Laboratory Work
____ All of the Above
____ Other
_____

Specific Purpose: _____

This authorization shall remain in effect for one year, ending ____/_____/_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of securing insurance coverage and the insurer has a legal right to contest a claim.

Should you wish us to take any additional action regarding this release of information, please send a separate letter regarding this request?

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

_____ _____
Signature of Patient Date

_____
If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

3-C Family Services, P.A.

Complete psychological care for children and families

FEE SCHEDULE FOR SERVICES

Effective September 01, 2016

3-Family Services, P.A. provides services at the following rates:

Intake Appointments	**Session Time**	**Rates**
Psychiatrist (MD)	75-90 minutes	$350.00
Psychologist (PhD)/ Senior Clinician	50 minutes	$195.00
LPA, LPC, LCSW	50 minutes	$195.00
Individual and Family Therapy	**Session Time**	**Rates**
Psychiatrist (MD)	45-50 minutes	$220.00
Psychologist (PhD)/Senior Clinician	50 minutes	$170.00
LPA, LPC, LCSW	50 minutes	$150.00
Ph.D. / Senior Clinician	20-30 minutes	$135.00
LPA, LPC, LCSW	20-30 minutes	$115.00
Medication Management	**Session Time**	**Rates**
Psychiatrist (MD)	20-30 minutes	$170.00
Psychiatrist (MD)	15 minutes	$120.00
Group Therapy	**Session Time**	**Rates**
SS Grin Group	30-60 minutes	$80.00
DBT Adult Group	90 minutes	$90.00
DBT Multi Family Group	90 minutes	$150.00
Divorce Consulting	**Per Hour**	$225.00
Educational Consulting	**Per Hour**	$200.00
Psychological Testing	**Per Hour**	**** See below**

** The rate for psychological testing is **double the rate for a 45 - 50 minute session** for the type of clinician listed above under **individual and Family Therapy**.
This doubled rate covers 1 hour for client's face-to-face testing with the clinician's time in scoring and report writing.

3-C Family Services, P.A.

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FINANCIAL AGREEMENT

The Financial Agreement form must be signed prior to starting any appointment.
To provide the best care, it is important that our clients have a clear understanding of our Financial Policy and fees. We are committed to providing the best possible care and will be happy to answer any questions you may have. We can only file claims to an active and primary insurance company. It is the client's responsibility to update us when insurance information changes. **We do not back file to any insurance company.**

3- C Family Services requires a 24 – hour cancellation notice. Clinicians reserve the right to charge up to the full amount of your scheduled appointment. Please see the fee schedule for information. These fees will not be sent to insurance as they are not covered. The client is responsible for payment in full. The office would also like to inform our clients that reminder phone calls / or text reminders are a courtesy of this office and are not required.

Clients can be charged for other services performed and or provided by 3-C Family Services (3-CFS) in 15 minute increments for report writing, telephone conversations lasting longer than 11 minutes, consulting with other professionals / clinicians upon client's written consent, preparation of records or treatment summaries, and clinician's time spent performing and / or providing any other professional services requested by the client.

If a client becomes involved in legal proceedings that require participation from his/ her clinician(s), professional time including, but not limited to, preparation time and transportation costs including the clinician's time and cost if called to testify by another party. Because of the complexity of legal involvement, 3- CFS Clinicians charge double the rate for a 50 minute session for the type of clinician listed above in the individual family therapy for preparation and attendance at any legal proceeding.

3- C Family Services reserves the right to alter and update the fee schedule at any time. All current clients will be notified of changes in fees at least 2 weeks prior to the change occurring through a notice mailed to the client's current mailing address on file.

Divorced / separated parents of minors who bring in the child (ren) for the appointment is financially responsible for the appointment(s). 3-C Family Services will not be involved with the separation or divorce disputes pertaining to payment. You are responsible for payment in a timely manner. Outstanding accounts may be sent to a collection agency. If this should occur, you will be responsible for any fees associated with our contacting and sending the account to collections. Dates of service with an outstanding balance will then no longer be filed to insurance as a courtesy.

Your understanding of these policies is important to our professional relationship. We look forward to answering any of your questions about our Financial Agreement.

Client's Name: _____ Date: _____

Client's Signature: _____
Required for all client's 18 years or older

Parent/ Guardian's Signature: _____
required for client's 17 and younger

3-C Family Services, P.A.

Complete psychological care for children and families

CREDIT CARD AUTHORIZATION AGREEMENT

All fields are required to be completed on this form

Optional….only need to complete if you wish to put a credit card on file.

Client's Name (Please Print) _____

Credit Card Information: (as shown on credit card)

Credit Card Type __ VISA __ MASTERCARD __ DISCOVER __ AMEX

Card Holder Name (as shown on credit card): _____

Card # _____ EXP Date: _____/_____ CCV#_____

Billing Address of Credit Card Holder: _____
Street Address

_____
City State Zip Code

Phone Number of Credit Card Holder: (____) _____ (_____) _____

This agreement will be in effect from: _____/_____/_____ through _____/_____/_____
MM DD YYYY MM DD YYYY

Authorization:

I hereby authorize 3-C Family Services, P.A.(3-CFS) to charge the indicated credit card on a periodic basis to collect payment due for services rendered by 3-CFS in accordance with the 3-CFS fee schedule for the above listed client. I also authorize 3-CFS to charge my credit card the price of a scheduled session, in accordance to the 3-CFS Fee schedule, should the above listed client fail to attend their scheduled appointment or fail to give a 24 hour notice to cancel their appointment.

If 3-CFS is unable to process my payment, I will be responsible for an alternate payment arrangement and all late fees that occur. I understand that this agreement shall remain in force unless I cancel it in writing.

I will not dispute 3-CFS's charges to my credit card so long as the amount in question is for services rendered prior to my canceling my agreement in the manner required.

I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement with 3-CFS. I acknowledge that I have read and agree to all of the above terms and conditions.

_____ _____

Signature of Credit Card Holder (Required) Date

3-C Family Services, P.A.

Complete psychological care for children and families

CHILD DEVELOPMENTAL INFORMATION

(Ages 0 – 17)

To be completed by child's parent/guardian

Child's Full Name: _____ Birthdate: _____ Age: ____ Today's Date: _____

Primary Care Physician or Practice:_____

Date of child's last physical exam: _____

MEDICAL HISTORY:

Were there any medical problems during pregnancy? Yes No
If so, please describe: _____

Was your child born naturally, or by C-section? _____ Child's Birth Weight: _____

If delivered naturally, were any assistive devices (forceps, vacuum extraction) used? Yes No

Was your child exposed to medications, toxins, alcohol or cigarettes before birth? Yes No
If so, please list: _____

Was your child born on time? Yes No If not, at how many weeks gestation? _____

Were any birth defects identified? Yes No

List: _____

Were there any problems in the first few days of life? Yes No

List: _____

Did your child spend any time in the Neonatal ICU? Yes No
Has your child had frequent ear infections? Yes No
Did your child have any high fevers (above 102 degrees): Yes No

Does your child have any medical illnesses for which he/she is currently being treated? Yes No
List illnesses & treatments: _____

_____

Has your child had any surgeries? Yes No
If so, please list what type and what age: _____

_____

3-C Family Services, P.A.

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Has your child ever had a seizure, head trauma or loss of consciousness? Yes No

List: _____

Has your child ever had an EEG or head imaging (CT or MRI)? Yes No

List: _____

Has your child ever been hospitalized for a medical condition? Yes No

List: _____

Has your child ever been seen in the emergency room? Yes No

List: _____

Has your child been evaluated for any type of heart condition? Yes No

Describe: _____

Is your child's vision within normal limits (without corrective lenses)? Yes No

Is your child's hearing within normal limits? Yes No

PLEASE CHECK ANY SYMPTOMS BELOW THAT YOUR CHILD IS CURRENTLY HAVING:

_____ weight changes
_____ nausea or vomiting
_____ changes in vision or hearing
_____ chest pain/heart palpitations
_____ dizziness
_____ easy bleeding or bruising
_____ stomach discomfort
_____ Headaches
_____ headaches
_____ menstrual problems or suspicion of pregnancy (female)

_____ Fever
_____ Constipation
_____ problems with urination
_____ muscle or joint pain
_____ numbness or weakness
_____ trouble breathing
_____ hair loss
_____ Fainting
_____ skin problems

PREVIOUS TREATMENT:

Is this your first mental health consultation? Yes No

If not, please provide copies of any reports or evaluations if you have them.

Previous psychiatric hospitalizations (hospital name, dates of hospitalization, treatment received during the hospitalization):

_____

_____

_____

Previous or current psychotherapy: name of therapist/agency, dates of treatment, type of therapy if you know it (CBT, DBT, psychoanalysis):

_____

_____

_____

Previous medication trials (name of medications, dose, how long the medication was taken):
Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled. You may skip this section if you bring a printout of meds generated by your pharmacy at the time of the initial appointment.

Name of Medication	Maximum Dose	Dates Prescribed (from-to)	Reason for Stopping

Please list any medication(s) and the dosage(s) your child is ***currently*** taking, including any over-the-counter medications (*daily vitamins, hormones, herbal supplements, allergy medications and/or frequent dosages of acetaminophens/ ibuprofen*):
***You may skip this section if you bring a printout of meds generated by your pharmacy at the time of the initial appointment**

Name of Medication	Dose/strength	Time(s) of day given

Have your child had a pharmacogenetics profile? Yes No
If so, please bring results with you to your appointment.

Is your child allergic to any medications? Yes No
If yes, please list medication and reaction:

_____

_____

_____

If your child is taking medication, is he/she having any side effects? Yes No
If yes, please list:

_____

_____

3-C Family Services, P.A.

Complete psychological care for children and families

DEVELOPMENTAL MILESTONES:

At what age did your child:

_____ Wean from breast? _____ Wean from bottle? _____ Walk?

_____ Use two-word sentences? _____ Toilet train?

Were there any delays in development (speech, motor)? *If so, please describe:*

-

Please describe what your child was like between ages 0 and 4 with respect to the following:

Ability to soothe him/herself when upset	
Showing initiative and curiosity	
Seemed to be dependent on external rewards to achieve behaviors desired by parents	
Avoiding harm	
Activity Level	

EDUCATIONAL HISTORY

Please list all schools attended and for which grades. Please bring a copy of your child's school transcripts if you have them.

Current School and Grade Level:

Other schools:

Grades on Most Recent Report Card:

Has your child ever repeated or skipped a grade? Yes No If yes, please describe:

Has your child ever had an IEP (Individualized Educational Plan)? Yes No

If so, starting in which grade? _____ In which category (OHI, BED, AU)? _____

Please list any special services your child receives, either in school or privately: (tutoring/resource, speech/ language, advanced/gifted classes, occupational therapy:

Has your child ever been expelled or suspended from school? Yes No If yes, when and why:

3-C Family Services, P.A.

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Has your child ever had educational testing to identify learning problems or giftedness? Yes No
Please provide copies of any reports/ evaluations at your appointment.

Are you concerned about your child's academic performance? If so please describe your concerns:

FAMILY HISTORY: *applies to biological relative(s) only: Where applicable, please specify the relationship to the child.*

Substance abuse	
Attention Deficit Disorder (ADD/ ADHD)	
Learning Disabilities	
Autism	
Anxiety	
Depression	
Bipolar Disorder (Manic-depression)	
Panic	
Eating Disorder(s)	
Post-Traumatic Stress Disorder	
Suicide	
Diabetes	
Neurological Disorder(s) (Parkinson's, Multiple Sclerosis, Alzheimer's)	
Heart Disease (including Hypertension)	
Thyroid Disorders	
Liver Disease	
Kidney Disease	
Migraines	
Tics	
Genetic Syndromes	
Stroke	
Epilepsy	
Anxiety	
Any sudden unexplained death(s) before age of 40	
Cancer(s)	

SOCIAL HISTORY:
Please list the names and ages of everyone who lives in the same home(s) as the child:
Please include the names of parent(s) and guardian(s) *and include if they live separately from the child. If child lives at more than one location, please specify living arrangements.*

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Parents' relationship status: _____

If parents are divorced or separated, please bring any legal documents that pertain to custody

Are there any other regular caregivers (after school program, nanny, relatives)?

Please list other cities where your child has lived and at what ages:

Please list child's extra-curricular activities:

Have there been any legal or custody issues?

Has Child Protective Services ever been involved?

Are there guns in the home?

Has there been any history or suspicion of drug or alcohol abuse?

Any stressful issues your child has had:

3-C Family Services, P.A.

Complete psychological care for children and families

CHILD SUPPLEMENTAL HISTORY

Today's Date: _____ Child's Full Name: _____Date of Birth: _____

In a few sentences, please describe the reason(s) for your visit:

_____

_____

_____

_____

Please rank areas of concern regarding your child's problems: (1 = most concern 6 = less concern)

_____Behavioral _____ Academic _____ Emotional _____ Social

Others (briefly describe)_____

Block I

Rate the following problems: (0 = none, 1 = some, 2 = very much, NS = not sure)

_____ Loses things needed for tasks & activities
_____ Difficulties sustaining attention
_____ Poor attention to details; makes careless mistakes
_____ Easily distracted by external stimuli
_____ Difficulties organizing work
_____ Does not seem to listen when spoken to directly
_____ Often leaves work unfinished
_____ Has difficulties remaining seated
_____ Often interrupts or intrudes on others
_____ Difficulties waiting his or her turn
_____ Often blurts out answers to questions
_____ Avoids tasks/activities that require sustained concentration
_____ Often fidgets or squirms in seat

_____ Often "on the go," as if "driven by the motor"
_____ Runs and climbs excessively
_____ Takes risks and is reckless
_____ Perfectionist and works slow
_____ Prefers sameness; resists changing activities
_____ Often preoccupied with own thoughts
_____ Shy and socially withdrawn
_____ After outbursts, takes a long time to calm down
_____ Extremely stubborn
_____ Often daydreams and stares blankly
_____ Clumsy and uncoordinated
_____ Unusually sensitive to strong stimuli (sudden or loud noises, bright light, itchy clothes, etc.)

Block II

Rate the following problems: (0 = none, 1 = some, 2 = very much, NS = not sure)

Also indicate (M = mom, D = dad, S = school)

_____ Often loses temper (M, D, S)
_____ Often actively defies & refuses rules (M, D, S)
_____ Often blames others for his or her mistakes
_____ Is spiteful and vindictive
_____ Feelings are easily hurt
_____ Gives up easily

_____ Often argues with adults (M, D, S)
_____ Often deliberately annoys siblings or others
_____ Is often angry; screams a lot
_____ Easily frustrated; gets angry
_____ Temper outbursts; explosive behavior

Block III

Answer: Y = yes, N = no, NS = not sure

_____ Has set fire with the intent to cause harm
_____ Committed an illegal act; was arrested
_____ Has stolen items of nontrivial value
_____ Often truant from school
_____ Has been physically cruel to people or animals
_____ Often gets into physical fights; has used a weapon
_____ Has deliberately vandalized others property
_____ Often lies to obtain goods and favors (cons)
_____ Often stays out despite parental prohibition
_____ Often bullies, threatens, intimidates others
_____ Smoked regularly; used alcohol or drugs

Block IV

Tics are involuntary, rapid, sudden, repetitive movements or vocalizations

Rate the following problems: (0 = none, 1 = some, 2 = very much, NS = not sure)

_____ Eye blinking
_____ Grunts
_____ Makes odd noises
_____ Cracks knuckles
_____ Picks skin, nose or other parts of the body
_____ Clears throat
_____ Head jerking
_____ Bites fingernails
_____ Grinds teeth
_____ Facial movement
_____ Snorts
_____ Sucks thumb
_____ Chews on clothes

Block V

Obsessions are recurrent and intrusive thoughts, feelings, ideas or sensations. Compulsions are recurrent behaviors such as counting, checking and avoiding.

Rate the following problems: (0 = none, 1 = some, 2 = very much, NS = not sure)

_____ Cannot get mind off certain thoughts Describe: _____
_____ Fears he/she might think or do something bad Describe: _____
_____ Over conforms to rules Describe: _____
_____ Repeats certain acts over and over Describe: _____
_____ Stores up things he/she doesn't need Describe: _____
_____ Too concerned with order, symmetry or neatness Describe: _____
_____ Has lucky/unlucky numbers, colors, words, etc. Describe: _____

Block VI

Rate the following problems: (0 = none, 1 = some, 2 = very much, NS = not sure)

_____ Always worries
_____ Has panic attacks
_____ Is shy and timid
_____ Have specific fears (dark, animals, bees, etc.)
_____ Is always tense; needs lots of reassurance
_____ Worries excessively what others are thinking of him/her (self-conscious)
_____ Clings to adults; too dependent
_____ Has nervous stomachaches and headaches
_____ Has a history of separation problems
_____ Anxious to please
_____ Afraid of making mistakes

Block VII

Does your child ever feels really down or sad and cannot have fun no matter what? _____
How often? _____How many days does it last? _____

When unhappy your child: (list age):

_____ Was very irritable
_____ Took longer to go to sleep; woke up often/early
_____ Had low energy; fatigue
_____ Dropped any activities he/she liked a lot before
_____ Had a feeling it would never get better
_____ Verbally threatened to kill self
_____ Had weight loss or weight gain
_____ Had excessive sleepiness / felt tired
_____ Stopped seeing friends
_____ Had difficulty making decisions
_____ Cried a lot
_____ Deliberately harmed self

Block VII

How do you describe your child's self-esteem? *Please circle one answer:* High Low Average

Rate the following problems: (0 = none, 1 = some, 2 = very much, NS = not sure).
Your child:

_____ Feels worthless; inferior (e.g. I am stupid)
_____ Feels guilty (e.g. It's all my fault)
_____ Acts like a class clown
_____ Is too hard on self
_____ Felt he/she would be better off dead

Block IX

Rate the following problems: (0 = none, 1= some, 2= very much, NS = not sure). Can you describe distinct periods when:

_____ Becomes unusually excited
_____ Mood was so high he/she couldn't sleep at night
_____ He/she was bullying siblings or others
_____ He/she had uncontrollable rages
_____ Early interest and preoccupation with sex
_____ He/she slept less but did not feel tired
_____ Talked so much and so fast that family became worried
_____ He/she had unusual amounts of energy
_____ He/she was bragging or boasting of being better than others
_____ Young child's tantrums lasted more than 30 min
_____ Drastic mood changes throughout the course of a day

Block X

Rate the following problems: (0 = none, 1 = some, 2 = very much, NS = not sure)

_____ Has or had an imaginary friend
_____ Strange ideas (describe)
_____ Sees things that aren't there
_____ Believes there are special messages on the TV
_____ Believes someone controls his/her mind
_____ Believes he/she can magically put & take away thoughts
_____ Strange behaviors (describe)
_____ Hears voices other people can't hear
_____ Feels others are out to get him/her
_____ Has unusual feelings (e.g. Believes they have special powers)
_____ Believes he/she can read minds; hear one's thinking

Block XI

Did your child wet the bed after age 5? (please circle one) Yes No
Does he/she wet the bed now? (please circle one) Yes No
Does your child soil underwear? (please circle one) Yes No

Rate the following problems: (0 = none, 1 = some, 2 = very much, NS = not sure)

_____ Problems going to bed, sleeping in his/her bed
_____ wakes up in the middle of the night
_____ Night terrors; sleepwalking or talking

Do his/her appetite and/or weight fluctuate from month to month?	Yes	No
Does he/she have unusual diet habits?	Yes	No
Does he/she binge or purge?	Yes	No
Does your child behave like opposite sex?	Yes	No
Have you suspected drug or alcohol use?	Yes	No

If you answered yes, please describe:

Block XII

Answer: Y = yes, N = no, NS = not sure

_____ Has no interest in friends or others
_____ Deliberately hurts him/herself
_____ Has stereotyped and repetitive movements
_____ Treats people as inanimate objects
_____ Does not seem to understand others feelings
_____ More interested in things rather than people
_____ Preoccupied with details

Block XIII

Answer: Y = yes, N = No, NS = not sure

_____ Does your child get along with other children?
_____ Makes friends easily, but cannot keep them
_____ Refuses group activities; prefers to play alone
_____ Prefers friends who get into trouble
_____ Prefers younger or older kids
_____ Disliked by children; gets teased a lot
_____ Aggressive; fights, hits, and punches
_____ Teases and calls names
_____ Is more of a follower than a leader
_____ Interrupts acts bossy / tells others what to do

Please describe any other concerns that you have about your child:

Thank you for taking the time to complete these forms. Your responses will be kept confidential.

Per the Health Insurance Portability and Accountability Act (HIPAA) this information is strictly confidential

3-C Family Services, P.A.

Complete psychological care for children and families

Client #_____

CREDIT CARD AUTHORIZATION AGREEMENT

All fields are required to be completed on this form

Optional….only need to complete if you wish to put a credit card on file.

Client's Name (Please Print) _____

Credit Card Information: (as shown on credit card)

Credit Card Type __ VISA __ MASTERCARD __ DISCOVER __ AMEX

Card Holder Name (as shown on credit card): _____

Card # _____ EXP Date: _____/_____ CCV#_____

Billing Address of Credit Card Holder: _____
Street Address

_____
City State Zip Code

Phone Number of Credit Card Holder: (____) _____ (_____) _____

This agreement will be in effect from: _____/_____/_____ through _____/_____/_____
MM DD YYYY MM DD YYYY

Authorization:

I hereby authorize 3-C Family Services, P.A.(3-CFS) to charge the indicated credit card on a periodic basis to collect payment due for services rendered by 3-CFS in accordance with the 3-CFS fee schedule for the above listed client. I also authorize 3-CFS to charge my credit card the price of a scheduled session, in accordance to the 3-CFS Fee schedule, should the above listed client fail to attend their scheduled appointment or fail to give a 24 hour notice to cancel their appointment.

If 3-CFS is unable to process my payment, I will be responsible for an alternate payment arrangement and all late fees that occur. I understand that this agreement shall remain in force unless I cancel it in writing.

I will not dispute 3-CFS's charges to my credit card so long as the amount in question is for services rendered prior to my canceling my agreement in the manner required.

I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement with 3-CFS. I acknowledge that I have read and agree to all of the above terms and conditions.

_____ _____
Signature of Credit Card Holder (Required) Date

Per the Health Insurance Portability and Accountability Act (HIPPA) this information is strictly confidential

3-C Family Services, P.A.
Complete psychological care for children and families

Client# _____

AUTHORIZATION FOR RELEASE OF INFORMATION
CONFIDENTIAL
OPTIONAL … Only need to complete if you wish to authorize the release of information

Regarding Client: _____ DOB: _____

I consent to allow 3-C Family Services to release and /or exchange information with:
Name of Persons/Agency: _____
Complete Address: _____
Telephone/Fax Number: _____

This information will include:
____ Psychiatric Records
____ Therapy Notes
____ Discharge Summary
____ Testing
____ Treatment Plan
____ Behavioral Observations/ Checklists
____ Laboratory Work
____ All of the Above
____ Other _____

Specific Purpose: _____

This authorization shall remain in effect for one year, ending ____/_____/_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of securing insurance coverage and the insurer has a legal right to contest a claim.

Should you wish us to take any additional action regarding this release of information, please send a separate letter regarding this request.

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

_____ _____
Signature of Patient Date

_____
If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

This is strictly a confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

CONSENT TO PARTICIPATE IN THERAPY VIA ONLINE VIDEO CONFERENCING

Client (please print) _____ DOB: _____

I, _____ hereby give consent to my therapist _____ to engage in a tele-mental health session via an online service, such as Zoom, in lieu of a face-to-face when an in-person session is not feasible. I understand that a tele-mental health session is not a substitute for regular in-person psychotherapy, when possible, and should not be used solely for the sake of convenience. I understand that the initial intake session must be performed in-person.

3C Family Services, P.A. agrees to not record any portion of the session, unless specifically noted and approved by the client. However, 3C Family Services, P.A. is not responsible for information video conferencing programs may retain per their policy and practices. Any information given during the session to 3C Family Services, P.A. will be kept confidential and will not be released without the client's prior approval, except in cases noted on the 3C Family Services, P.A. Client Contract.

In the event that the connection is interrupted and the video conference is lost, I understand that both parties will make attempts to reach once another.

I acknowledge that 3C Family Services, P.A. is not responsible for the maintenance or purchasing of internet service, personal computers, web cameras, microphones or other equipment or software needed to teleconference with the Clinician.

Payment is required at the time of service. The client must either fill out a form for a credit card on file or call the front desk immediately following the session to pay over the phone. Please see the Fee Schedule for pricing.

I understand that this consent must be renewed annually and can be revoked, in writing, at any time.

This authorization shall remain in effect for one year, ending ____/_____/_____

Client Signature: _____ Date: _____

Parent/Guardian (if applicable): _____ Date: _____

Clinician Signature: _____ Date: _____

REV 3/2020