David A. Steinweg Ph.D.

Psychological Services LLC

Gateway Office Park ■ 21625 Chagrin Boulevard, Suite 200 ■ Beachwood, Ohio 44122
tel (216) 283–6852 ■ fax (216) 491–0155 ■ www.davidsteinweg.com

# CHILD AND ADOLESCENT REGISTRATION FORM

**Child's Name:** _____ Today's Date: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Home Address: _____
Home Phone: _____ Social Security Number: _____
**Who is (are) child's legal guardian(s)**? _____
Is child adopted or in foster care? Yes / No If so, since what age? _____
Referred By: _____ Relationship: _____

**Mother's Name**: _____ Age: _____
Mother's Address (if different from child): _____
Occupation: _____ Employer: _____
Phone: Home: (____)_____ Cell/Page : (____)_____ Business: (___)_____

**Father's Name**: _____ Age: _____
Father's Address (if different from child): _____
Occupation: _____ Employer: _____
Phone: Home : (____)_____ Cell/Page : (____)_____ Business: (___)_____

**Parent/Guardian Relationship:**
Parent's Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
If parents are married or in long term relationship: Years together: _____ Years married: _____
If parents are separated or divorced: Years separated: _____ Years divorced: _____
Describe custody agreement: _____
Extent of contact with noncustodial parent: _____

**Family Composition:** List child's immediate family and significant relationships. Under *Location*, place √ for people living with child. Write city/state of residence for people not living with child.

| Name | Relationship | Age | Location | Health Issues (specify) |
|---|---|---|---|---|
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**School**: _____ City: _____ Phone: _____
Grade: _____ Teacher(s):_____
Placement: ☐ Mainstream ☐ Special Education, type: _____
☐ Gifted/Honors ☐ Retention, what grade? _____ ☐ Other services: _____
Other relevant information: _____
_____
_____

**Please describe the reason for your visit:** _____

**Stressors:** List significant stressors your child has experienced (moves, school changes, accidents, family illnesses, deaths, violence, victimization): _____

**Legal Proceedings:** Please describe any pending legal matters (e.g., visitation/custody proceedings): _____

**Mental Health History:** Please list any previous mental health services your child has received:

| Provider/Agency | Dates | Reason |
|---|---|---|
| | | |
| | | |
| | | |

**Medical History:** Pediatrician: _____ Phone: (_____) _____
Please describe any serious injuries, illnesses or surgeries: _____

Please list all medications your child is taking now and psychiatric medications taken in the past:

| Medication | Dosage | Dates | Reason | Prescribed By |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Describe any medication side effects your child is experiencing: _____
Describe any allergies your child has: _____

**Additional Comments:** _____

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# PROFESSIONAL SERVICES AGREEMENT

**Welcome to my office.** Ohio State Psychology Board regulations require that clients be fully informed about the nature and cost of the professional services I provide. Please read this information carefully and raise any questions as needed.

**Initial Consultation:** The initial consultation, or diagnostic assessment, is an opportunity for me to learn about your concerns and how I might be helpful to you. At the end of the visit, I will give you my impressions and treatment recommendations. Please evaluate this information along with your own assessment of whether you feel comfortable working with me. Treatment often involves a commitment of time, money and energy so you should be careful about the psychologist you select. Please note I do not provide psychological services for the purpose of providing expert testimony for known or anticipated litigation.

**Treatment:** The form and content of psychological treatment varies depending on several factors including a client's presenting problem(s), a psychologist's clinical approach, and the personalities of both client and psychologist. There may be several different approaches that could be effective in treating the problems you hope to address. I use the approaches which I find to be effective and which have support in the psychological literature. A variety of factors outside the therapy session (e.g., stressful environment, motivation and health) can influence the change process; therefore, I cannot guarantee the success of your treatment.

Therapy also has risks associated with it and you should be aware of them. These risks may include: recalling painful life events; confronting unpleasant thoughts and beliefs, and/or experiencing uncomfortable levels of sadness, anger, fear or other emotions. With children and adolescents, symptoms may worsen as new treatment strategies are tried and fine-tuned. Sometimes major life decisions are made during therapy such as separating from a partner, developing new relationships or changing lifestyles. These decisions are legitimate outcomes of therapy and result from examining one's beliefs and desires.

| | | |
|---|---|---|
| **Fees:** | Initial visit (50 minutes) | $175 |
| | Office visit (50 minutes) | $125 |
| | Psychological test administration and interpretation (60 minutes) | $150 |
| | Consultation (telephone, e-mail, or on-site) | Office visit rate, pro rated |
| | Report preparation | Office visit rate, pro rated |
| | Educational evaluation | $3,000 |
| | Psychological evaluation | $4,200 |

**Payment:** Payment is requested at each office visit. Evaluations and reports cannot be released until accounts are paid in full. Treatment may be suspended if account balances exceed $250. Account balances over 60 days past due may be submitted to my attorney or collection service.

**Insurance:** My services may be covered, in part, by your insurance policy's provision for "out of network" psychologists. Please check with your insurance carrier so that you are fully informed of your benefits. I will prepare a statement for you at each visit that includes the information insurance companies require to process claims (including mental health diagnosis). It will be your responsibility to submit the statement to your insurance company for any reimbursement you are owed.

**Appointments:** Appointments are scheduled for 50 minutes. The 10 minute period between sessions is for writing progress notes and returning phone calls. It is important that you arrive on time for your appointment and that we end on time. Please write your check before our appointment so that we can maximize our use of session time**.**

**Cancellations:** If you are unable to keep an appointment, please give at least 24 hours notice so that I can schedule the available time-slot. **Should you cancel with less than 24 hours notice (excluding weekends) and I am unable to fill the appointment time, you will be charged for the time reserved.**

**Contacting Me and Availability:** My calls are answered by a confidential electronic voice mail system. I am usually able return calls within 24 hours from Monday through Friday. I may not answer weekend calls until the following Monday. Please note, I do not guarantee 24 hour availability. This means that if you call in a crisis, I may not receive or be able to return your call immediately. When I am away from the office for an extended time, I may have another therapist provide backup coverage.

**Emergencies:** Should you have an emergency and not be able to reach me, please utilize any of the following services:

1. Proceed to the emergency room of your local hospital. The following three hospitals have emergency psychiatric services available for children and adults: Cleveland Clinic Foundation (216-444-2200), University Hospitals: Laurelwood (440-953-3000), and St. Vincent Charity Hospital (216-363-2358).
2. The Mobil Crisis Team (216-623-6888) provides 24 hour crisis intervention services. Services include a suicide hotline and on-site evaluation during a psychiatric emergency. The crisis team may also be able to secure psychiatric hospitalization at an area hospital.
3. The Domestic Violence Center provides protective shelters during family violence crises (216-651-8484).
4. Call 911.

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I have been given a copy of the Professional Services Agreement. I understand and agree to the terms it sets forth. My signature indicates that I consent to treatment and assume full financial responsibility for all services rendered.

**Name**: _____ **Signature**: _____

Relationship: □ Self □ Parent □ Legal Guardian Date: _____

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## NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. This is a formal notice as required by the Health Insurance Portability and Accountability Act (HIPAA) concerning my privacy practices. This notice is effective as of April 14, 2003.
2. I am required by law to maintain the privacy of Protected Health Information (PHI). PHI refers to information in your health record that could identify you. I am required to provide individuals with notice of my legal duties and privacy practices with respect to PHI.
3. I may use, obtain or disclose PHI for the following purposes:
   A. *Treatment:* E.g., I will record session dates, service code, diagnosis and progress in the chart.
   B. *Payment:* E.g, I may disclose the minimum information necessary to your insurance company for the purpose of processing a claim and/or authorizing treatment. I may also disclose the minimum information necessary to a collection agency for the purpose of getting paid.
   C. *Health Operations:* E.g., I work with consultants for computer and bookkeeping services. They may access PHI including: name, address, service date/type, and account status. They agree to maintain the confidentiality of PHI.
4. If PHI is to be used, obtained or disclosed for any purpose other than for treatment, payment or health operations (as described in this notice), then I must have you sign an *Authorization Form*. I will not use, obtain or disclose PHI without your written authorization, except as described in this notice.
5. ***Limits to Confidentiality and Consent:*** I am permitted or required, in some situations, to disclose information without either your consent or authorization. These situations include:
   A. If I have reason to suspect that a person has suffered or faces a threat of suffering abuse or neglect, the law requires that I file a report with the appropriate government agency. Once I file such a report, I may be required to provide additional information.
   B. If I believe a client presents clear risk of imminent harm to self or others, then I must disclose that information to appropriate public authorities, the potential victim, involved professionals, and/or the family of the client.
   C. If a client is involved in a legal proceeding and I receive a request for PHI, then I may disclose the requested information if I am required by court order.
   D. If I have reasonable cause to believe that a client has been the victim of domestic violence, I may note that knowledge and the basis for it in the clinical record.
   E. If a government agency requests information for health oversight activities, I am required to provide it.
   F. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
   G. I am not required to obtain client consent for emergency care and treatment.
6. I am required to abide by the terms of the current Notice of Privacy Practices for PHI. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI I maintain. I will provide you with a revised notice at your first session following a revision or upon request.
7. You have the right to receive confidential communications of PHI.
8. You have the right to ask me not to disclose certain information to family members, other relatives, or other persons identified by you. I am not required to agree with the restriction, but if I do, then I must follow it.
9. You may revoke your authorization for me use, obtain or disclose information except to the extent that action has already been taken.
10. You have the right to see your chart. You have the right to obtain a copy of your chart, but there may be fees for postage and copying. You also have the right to choose how this information is sent to you.
11. You have the right to request (in writing) that changes be made in your chart, if you feel that information is not correct.
12. You have the right to receive an accounting of disclosures of PHI about you.
13. You have a right to receive a paper copy of the notice.
14. If you have a concern or complaint about how your health care information is used, please let me know. I may ask you to put your complaint in writing.
15. If you are not satisfied with my response, you may file a report with: Office of Civil Rights, Regional Manager, Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL, 60601; Telephone #: (312) 886-1807.

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
## [OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION]

I have been given a copy of the *Notice of Privacy Practices for Protected Health Information* that describes how my Protected Health Information (PHI) is used and shared. I have had a chance to review this Privacy Notice as part of the registration process.

**I understand the following:**

- David Steinweg, Ph.D., may use my PHI for treatment, billing and healthcare operations.
- If I refuse to sign this consent, Dr. Steinweg may refuse to provide services to me.
- If I do sign this consent, I may revoke it at any time.
- Dr. Steinweg may change the terms of this notice and that I may obtain a current copy by contacting him.

**I give David A. Steinweg, Ph.D. permission to leave messages:**

| | | |
|---|---|---|
| On my cell phone | □ Yes | □ No |
| On my voice mail at work | □ Yes | □ No |
| On my answering machine at home | □ Yes | □ No |
| With other residents at my home | □ Yes | □ No |
| Via email | □ Yes | □ No |

**My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information.**

**Name**: _____ **Signature**: _____

Relationship: □ Self □ Parent □ Legal Guardian Date: _____