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: _____
Home Address: _____
Referred By: _____ Relationship: _____
Is child adopted or in foster care? Yes / No If so, since what age? _____

Mother's/Guardian's Name: _____ Age: _____
Mother's Address (if different from child): _____
Occupation: _____ Employer: _____
Phone (C): _____ OK to leave message? ☐ Yes ☐ No
Phone (H): _____ OK to leave message? ☐ Yes ☐ No
Phone (W): _____ OK to leave message? ☐ Yes ☐ No
Email: _____ OK to use? (note: email is **not** secure) ☐ Yes ☐ No

Father's/Guardian's Name: _____ Age: _____
Father's Address (if different from child): _____
Occupation: _____ Employer: _____
Phone (C): _____ OK to leave message? ☐ Yes ☐ No
Phone (H): _____ OK to leave message? ☐ Yes ☐ No
Phone (W): _____ OK to leave message? ☐ Yes ☐ No
Email: _____ OK to use? (note: email is **not** secure) ☐ Yes ☐ No

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

Family Composition: List child's immediate family and significant relationships

Name	Relationship	Age	Location	Health Issues

Please describe the reason for your visit: _____

How long has this been occurring? _____

What have you tried? _____

Please check all concerns that apply to your child:

Depressed mood	☐	Inattention	☐
Grades dropping	☐	Excess energy	☐
Sleep problems	☐	Disorganization	☐
Weight loss/gain	☐	Difficulty completing tasks	☐
Withdrawal/isolation	☐	Anxiety	☐
Suicidal thoughts	☐	Panic attacks	☐
Suicide attempt	☐	Obsessions/Compulsions	☐
Behavior problems	☐	Cutting/self-injury	☐
Tantrums/meltdowns	☐	Victim of bullying	☐
Anger/defiance	☐	Bullying others	☐
Social/friendship problems	☐	Promiscuity	☐
Violence	☐	Sexual orientation	☐
Trauma/Abuse	☐	Gender identity	☐

Alcohol and Drug Use:

Cigarettes	☐	Vape	☐
Alcohol	☐	Marijuana	☐

Other drugs (specify): _____

Describe how alcohol/drug use has affected your child and/or family: _____

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

School: _____ City: _____ Phone: _____
Grade: _____ Teacher(s):_____
Placement: ☐ Mainstream ☐ Gifted ☐ Learning Plan ☐ Special Education ☐ Retention History
Please provide relevant information: _____

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

Has your child ever received inpatient treatment for psychiatric or substance-related reasons? Please describe: _____

Medical History: Pediatrician: _____ Phone: (_____)_____
Please describe any serious injuries, illnesses or surgeries (including concussions and seizures): _____

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 information: _____

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SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask me any questions you may have as this document will represent an agreement between us.

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 approaches which I find to be effective and which have support in the psychological literature. Some of the approaches I draw from include family systems, cognitive, behavioral, Gestalt, psychodynamic and mindfulness. A variety of factors outside the therapy session can influence the change process (e.g., stressful environment, motivation and health); therefore, I cannot guarantee the success of your treatment. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and outside of them.

Therapy has been shown to have significant benefits for the majority of people who commit themselves to it. It often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. 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. If you have questions or doubts about any aspect of our work together, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Initial Consultation: The initial consultation, or diagnostic assessment, is an opportunity for you to share your concerns and goals. It is also an opportunity for you to learn about therapy with me and what to expect, so I encourage you to ask any questions that occur to you. At the end of the first 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. Therapy often involves a commitment of time, money and energy so you should be careful about the psychologist you select.

Rates:	Initial visit/Diagnostic assessment (55 minutes)	$190
	Office visit (45 minutes)	$140
	Office visit (55 minutes)	$170

I charge at the rate of $170 per hour for other professional services you may need. Other services include telephone conversations totaling more than 15 minutes in a week, review of records or test data, report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request of me. Charges are pro-rated by the quarter hour when work periods are less than one hour.

Payment: Payment is due at each office visit. I accept checks and cash. Written documents cannot be released until accounts are paid in full. A fee of $20 is charged for returned checks. Treatment may be suspended if account balances exceed $500 and there is no payment arrangement in place.

Insurance: My services are provided on a private-pay basis. I have not contracted with any insurance companies or managed care panels; therefore, I am considered an out-of-network provider. If you want to use your health insurance to cover part of the cost of therapy, I recommend that you contact your carrier to determine your policy's provision for out-of-network providers. You will be responsible for balances not covered by insurance and for obtaining necessary authorizations and re-certifications. I will provide you a statement at each visit that includes the information insurance companies need to process claims. It is your responsibility to submit the statement to your insurance company for any reimbursement you are owed.

You should be aware that your insurance company may require you (or me) to provide them with a clinical diagnosis and they may ask that I provide additional clinical information such as treatment plans or summaries. 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 such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Collections: In the unlikely event you do not reduce your balance in a 60-day period and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is name, nature of services provided, and amount due. If such legal action is necessary, its costs will be included in the claim. Please note that collection agencies will report your delinquent account to credit bureaus and thus your credit rating may be affected.

Appointments: Appointments are typically scheduled for 45 minutes or 55 minutes. The time needed to arrange payment and schedule follow-up appointments is considered part of the session. The time period between sessions is for writing progress notes and returning phone calls. You will choose your appointment length when we schedule. Please consider writing your check before our appointment so that we can maximize our use of session time**.** It is important that you arrive on time for your appointment and that we end on time. Regular weekly appointments are reserved for clients who maintain consistent attendance.

Cancellations: If you are unable to keep an appointment, please give at least 24 hours' notice (excluding weekends and holidays) so that I can reschedule the time with someone else. **If you do not provide 24 hours cancellation notice, you will be charged the full cost for that session.** If you have authorized your child or other family member to schedule appointments and they do not cancel more than 24 hours in advance, you will be charged the full cost for that session.

Contacting Me and Availability: I answer phone calls, emails and texts during regular business hours. I am usually able to respond to messages within 24 hours from Monday through Friday. I may not answer weekend messages until the following Monday. Please note, I do not guarantee 24 hours availability. This means that if you are in a crisis, I may not retrieve or be able to reply to your message immediately. **Text messages and emails should not be used for emergencies.** When I am away from the office for an extended time, I may have another therapist provide backup coverage.

Confidentiality: In general, the privacy of all communications between a client and psychologist is considered confidential and protected by law. I can only release information about our work to others if you sign a written authorization form. There are, however, specific situations when I may be required by law to disclose protected health information (e.g., when an identifiable person's safety is at immediate and credible risk). Your rights to privacy and its limits are described in the accompanying HIPAA Notice of Privacy Practices. Your signatures to this Service Agreement and the accompanying HIPAA Notice of Privacy Practices indicate you understand and agree to their terms.

Minors: Confidentiality is often essential for individual therapy to be effective with clients under age 18 - especially with teenagers. It is my policy to request an agreement from parents to respect the confidentiality of communication that occurs during individual therapy with their child; however. I am happy to discuss my general impressions of minor clients' progress and/or their mental status.

Email and text messages: Please be aware that unencrypted email and text messages can be accessed by unauthorized people and may compromise the privacy and confidentiality of such communications. Please notify me if you want to limit or avoid, in any way, the use of and/or content of email, text messages, cell phones, or voicemail. If you choose to communicate confidential information via unencrypted email or text message, I will assume that you have made an informed decision and have agreed to accept the risk that your communication and/or my reply may be intercepted.

Legal Proceedings: I do not provide psychological services for the purpose of providing expert testimony for known or anticipated litigation (e.g., child custody-related matters). If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the significant time and energy associated with legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.

EMERGENCIES: If you are unable to reach me and feel that you cannot safely wait for me to return your call, then use any of the following services:

1. **Call your family physician, pediatrician or psychiatrist.**
2. **Call the Mobile Crisis Team of FrontLine Services.** The Mobile Crisis Team 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: **216-623-6888**
3. **Proceed to the emergency room of your local hospital.** The following hospitals have emergency psychiatric services available for children and adults:
    - **CCF Hillcrest Hospital** Pediatric Emergency Department: 440-312-4600
    - **UH Ahuja Medical Center** Emergency Department: 216-593-5500
4. **Domestic Violence and Child Advocacy Center:** It provides protective shelters and emergency services during family violence crises: 216-391-4357
5. **Cleveland Rape Crisis Center:** 216-619-6192
6. **CALL 911** if you or a family member are having a life-threatening emergency

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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.***

Your Rights*:* When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you. Ask me how to do this.
- I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.

Ask me to correct your medical record
- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
- I may say "no" to your request, but I'll tell you why in writing within 60 days.

Request confidential communications
- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- I will say "yes" to all reasonable requests.

Ask me to limit what I use or share
- You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or my operations with your health insurer. I will say "yes" unless a law requires me to share that information.

Get a list of those with whom I've shared information
- You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why.
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- I will make sure the person has this authority and can act for you before I take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel I have violated your rights by contacting me using the information on page 1. You can also reach me by email at david.steinweg@gmail.com.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling -877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- I will not retaliate against you for filing a complaint.

***Your Choices*:** For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions.

In these cases, you have both the right and choice to tell me to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest. **I may also share your information when needed to lessen a serious and imminent threat to health or safety.**

In these cases I never share your information unless you give me written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

My Uses and Disclosures: How do I typically use or share your health information? I typically use or share your health information in the following ways.

Treat you
- I can use your health information and share it with other professionals who are treating you.
- ***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run my organization
- I can use and share your health information to run my practice, improve your care, and contact you when necessary.
- ***Example:*** *I use health information about you to manage your treatment and services.*

Bill for your services
- I can use and share your health information to bill and get payment from health plans or other entities.
- ***Example:*** *I give information about you to your health insurance plan so it will pay for your services.*

How else can I use or share your health information? I am allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. I have to meet many conditions in the law before I can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues
- I can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- **Preventing or reducing a serious threat to anyone's health or safety**

Do research
- I can use or share your information for health research.

Comply with the law
- I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I're complying with federal privacy law.

Respond to organ and tissue donation requests
- I can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
- I can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
I can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- I can share health information about you in response to a court or administrative order, or in response to a subpoena.

Name of Person Responsible for HIPAA Notification: David A. Steinweg, Ph.D. I can be reached at (216) 283-6852, david.steinweg@gmail.com or at the mailing address listed at the top of page one.

My Responsibilities
- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me I can in writing. If you tell me I can, you may change your mind at any time. Let me know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes To The Terms Of This Notice
- I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request and in my office.
- Effective date – September 1, 2018
- This Notice of Privacy Practices applies to the following organization: David A. Steinweg, Ph.D., Psychological Services, LLC.
- Privacy officer: David A. Steinweg, Ph.D. I can be reached at (216) 283-6852, david.steinweg@gmail.com or at the mailing address listed at the top of page one.

David A. Steinweg Ph.D.

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CONSENT AND SIGNATURES FORM

Child's Name: _____

Parent/Guardian Name: _____

Consent to Treatment: I give permission to David A. Steinweg, Ph.D., Psychological Services, LLC, to provide psychological services to my child.

Signature: _____
Date

Service Agreement: I have received and reviewed the Service Agreement for David A. Steinweg, Ph.D., Psychological Services, LLC. My signature indicate that I understand and agree to the terms it sets forth.

Signature: _____
Date

Acknowledgement of Receipt of Notice of Privacy Practices: I hereby acknowledge that David A. Steinweg, Ph.D., Psychological Services, LLC, has either offered me or provided me with a copy of the Notice of Privacy Practices that describes how psychological and medical information about me may be used and disclosed and how I can access this information. I understand that if I have questions or complaints I may contact David Steinweg, Ph.D. I also understand that I am entitled to receive updates upon request if David A. Steinweg, Ph.D., Psychological Services, LLC, amends or changes the Notice of Privacy Practices in a material way.

Signature: _____
Date