KENNETH A. DE LUCA, Ph.D. & ASSOCIATES, INC.

CHILD AND ADOLESCENT REQUEST FOR SERVICES

****The following is vital information in helping us to help you. Thank you!****

DATE:_____

CHILD'S NAME:_____
(LAST) (FIRST) (MI)

BIRTHDATE:_____ AGE:_____ SEX:_____ S.S.NO:_____

ADDRESS:_____
(STREET) (CITY) (ZIP CODE)

BEST EMAIL: _____

MOTHER'S NAME:_____ S.S.NO:_____
(LAST) (FIRST) (MI)

BIRTHDATE:_____ AGE:_____ PHONE:_____

ADDRESS (if different from child):_____
(STREET) (CITY) (ZIP CODE)

OCCUPATION:_____ EMPLOYER:_____

BEST NUMBER TO REACH YOU AT 1._____ 2._____ 3._____

FATHER'S NAME:_____ S.S.NO:_____
(LAST) (FIRST) (MI)

BIRTHDATE:_____ AGE:_____ PHONE:_____

ADDRESS (if different from child):_____
(STREET) (CITY) (ZIP CODE)

OCCUPATION:_____ EMPLOYER:_____

BEST NUMBER TO REACH YOU AT 1._____ 2._____ 3._____

Please describe the reason for your child's visit:_____

_____

_____

List all immediate family and significant relationships not listed above:

Name	Relationship	Age & DOB	Health Issues (specify)

Parent/Guardian Marital Status (as applicable):

Parents' Marital Status:

☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If child's parents are married to each other, Years married:_____ Child's age when divorce occurred:_____

If child's parents are separated or divorced, Years Separated:_____ Years divorced:_____

Who does child currently live with: _____

Who is the child's legal guardian?_____

Describe the custody agreement:_____

Location of noncustodial parent and extent of contact/visitation:_____

Additional Information:_____

_____

_____

_____

School:_____ City:_____ Phone:_____
Grade:_____ Teacher(s):_____
Placement: ☐ Mainstream ☐ Special education (IEP) type:_____
☐ Gifted/Honors ☐ Retention, what grade? _____ ☐ Other services:_____
Describe strength and problem areas:_____

Please list any stressors that your child or family has experienced recently (i.e. job change or loss, family illness or injury, accidents, death, moves, violence, crime victimization, etc.):_____

Please describe and PAST or PENDING legal matters including visitation/custody proceedings:

Please list any mental health services or chemical dependency; including counseling, your child or a family member has previously received:

Name	Provider/Agency	Dates	Reason	Outpatient/Inpatient

CURRENT MEDICATIONS

Name	Dosage	Purpose	Prescribing Doctor	Side Effects?

- **ALLERGIES TO MEDICATIONS:**_____
- **EMERGENCY CONTACT:**_____
  (Name) (Phone) (Relationship)
- **REFERRAL SOURCE or why, how, did you select us:**_____

- I understand that my records are protected by laws governing confidentiality and cannot be disclosed without my written consent. I understand that I can revoke my consent at any time except when disclosure has already occurred. This consent will automatically expire twelve months from the date signed.

- Please check one: _____Please release any applicable information to our primary care/referring physician.
  ___Do not release any information to our physician. _____We do not have a primary care physician.

- **Primary Care Physician's Name, Address, & Telephone Number:**

I agree and consent to the participation of my child in mental health services offered and provided by Kenneth A. De Luca, Ph.D. & Associates, Inc. I have reviewed a copy of the Ohio Notice Form: Notice of Psychologist, Counselor, and Social Worker Policies and Practices to Protect the Privacy of Your Health Information for the group of Kenneth A. De Luca, Ph.D. & Associates, Inc.

- **SIGNATURE of custodial parent:**_____ Date:_____

CLINICIAN'S SIGNATURE:_____ Date:_____

KENNETH A. DE LUCA, Ph.D. & ASSOCIATES, INC.

FINANCIAL POLICY FOR OUR INSURED PATIENTS

The associates and staff of Kenneth A. De Luca, Ph.D. & Associates, Inc., are pleased to have you as a patient and welcome you to their care. We believe it is important that you are aware of our payment policies prior to your treatment. This will avoid any future misunderstanding.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

(Please Read and Initial All)

_____ All professional charges are billed to my insurance company, on my behalf, as a courtesy. **Initial Session $190.00, Individual Session $160.00, Family Session $160.00, Testing Session $160.00**

_____ I will provide all insurance and managed care information, including referral and/or authorization, for the purpose of filing insurance claims. **I will be responsible for payment in full if I do not.**

_____ Some services provided might not be covered benefits by my insurance plan. I will know the contents of my health insurance plan and will be responsible for my payments as per my insurance plan.

_____ **If my insurance company does not make payment, after two attempts have been made to obtain payment, the payment for services rendered becomes my responsibility regardless of the fact that I have insurance.**

_____ I will assume responsibility for contacting my insurance company to help resolve problems.

_____ The custodial parent bringing a minor client for services is responsible for paying any deductible, co-payment and/or co-insurance **at the time of service**. Unaccompanied minors shall come prepared to make payment.

_____ **I will give 24 hours notice if an appointment needs to be rescheduled or pay $50.00 for each missed appointment that another person in need could have had.**

_____ I will pay any deductible, co-payment and/or co-insurance **at the time of service** (This is a requirement of your insurance company). **A $5.00 charge will be added to each date of service that I do not make my co-payment.**

_____ To secure reimbursement on my behalf, I authorize the provider of services to disclose only that information that is necessary to the insurance company/companies I have.

_____ **I understand that for any Psychological Evaluation there is a $60.00 charge for the Comprehensive Report NOT BILLABLE TO INSURANCE that must be paid in full at the first session before a full evaluation can be scheduled.**

_____ I understand that all copays, deductibles and co-insurance **must be paid in full** before any reports will be released.

_____ I understand that a $30 fee will be charged/added to my account for a Return/ Non-Sufficient check.

_____ **I understand and agree that if my therapist (or my minor child or dependent's therapist) is required to appear in court or a deposition to testify relating to my (or my minor child or dependent's) treatment, then I am responsible for paying the therapist's regular session rate for all time required in connection with such testimony, including preparation time, travel, and time spent in the courthouse. I further understand that this expenditure is not covered by health insurance and that I am fully responsible for payment.**

_____ I understand that any type of electronic recording is **strictly prohibited** at any location within these offices.

_____ _____

Signature of Patient or Responsible Person Date

KENNETH A. DE LUCA, Ph.D. & ASSOCIATES, INC.

OUTPATIENT SERVICES CONTRACT (MINOR)

Welcome to our practice. Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a patient in psychotherapy, you have certain rights and certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our first meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the mental health provider and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks, and there are no guarantees as to what you will experience. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, 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.

APPOINTMENTS

I normally conduct an initial evaluation that will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule a 45- to 55-minute session at the frequency of between once per week and once per month. If you are unable to attend an appointment, you must

provide 24 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. There will be a $50 charge for any missed appointments or appointments that were not cancelled within the 24-hour window. After two missed appointments, it will be at the therapist's discretion to schedule another appointment. You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If the appointment is for a minor, parents and/or guardians must attend the first appointment alone, so that the therapist can obtain a detailed and accurate history.

PROFESSIONAL FEES

My hourly fee is $190 for the first session and $160 for subsequent sessions. If you have insurance, a lower negotiated rate is often established depending upon our contract with the insurance company. If we meet longer than the usual time, I will charge accordingly. In addition to scheduled appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include, but are not limited to, letter or report writing, telephone conversations lasting longer than 10 minutes, and attendance at meetings with other professionals you have authorized. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $250 per hour for professional services I am asked or required to perform in relation to your legal matter, which is not covered by your insurance. I will forward one copy of your records at no charge, but any copies after that will require a $10 copying fee.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan.

If you have not made any payment for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court.

Our office will not carry balances over $300. If your balance is over $300 and you are not making payments, we will not schedule any further appointments until some payment is made. As long as you are making regular payments on your balance, we are happy to continue scheduling appointments.

INSURANCE REIMBURSEMENT

In order for us 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 some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

CONTACTING ME

I am often not immediately available by telephone. Office staff is available to take your calls between 8 AM and 5 PM weekdays and 8 AM to 12 PM on Saturday. If you leave a message, I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If it is an urgent matter, please ensure that you inform the office staff of the urgency of the call. When the office is closed, our answering service is available 24/7 by calling the following number: (888) 638-8034. Please contact this number only for after-hours emergencies. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room.

AFTER HOURS EMERGENCY

In general, our office does not provide after-hours emergency care. If you feel as though you are at risk of harming yourself or others, it is recommended that you call 911 or go to the nearest emergency room. However, as a courtesy to our patients, our therapists will attempt to be available if you feel at risk of harming yourself or others. We provide an after-hours calling service that will attempt to connect you with your therapist. Although we cannot guarantee that your therapist will be available, we will connect you with a trusted resource if your therapist is unable to respond to your call. This service should be reserved for true emergencies—specifically feelings that you are at risk of harming yourself or someone else. Non-emergency calls will be relayed to your therapist with the expectation that your therapist will return your call within 24 hours, or on the next business day if you call on a weekend.

In general, I prefer not to communicate via email. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

I do not communicate with, accept friend requests, or contact any of my current or former patients through social media platforms like Twitter and Facebook. I believe that adding patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. The practice, Kenneth A. DeLuca, Ph.D. and Associates, Inc., has a Facebook Page and a website to allow our organization to share information, blog posts and practice updates with others. You are welcome to view the practice Facebook Page and read or share articles posted there. The Facebook page is not a place to contact me regarding clinical concerns or engage in any communication related to our therapy.

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age, there is an incredible amount of information available about individuals on the internet, much of which may not actually be known to that person and some of which may be inaccurate. If you encounter any information about me through web searches, or in any other fashion, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.

- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm and/or the police.

- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.

- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the mental health provider and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you may not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of Ohio may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records. Records of the treatment dates, diagnosis and treatment plans are always available to the parent.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

_____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

_____ _____

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____