Autism Counseling and Behavior Consultation, Inc.

Minor Aged Client Information

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Date ___________________

Client Name ____

Address ____ **City** ___________________________ **State** __________ **Zip** ________

Date of Birth _______________________ **Current Age** _______________________

Legal Guardian Status (check one)

___ Biological Parent	___ Adoptive Parents	___ Family & Children Services
___ Biological Mother	___ Adoptive Mother	___ Court (Specify) _____________________
___ Biological Father	___ Adoptive Father	___ Court (Specify) _____________________

Marital Status of Parents (check one)

___ Married	___ Single	___ Married but Living Apart

___ Divorced (check custodial status)

___ Joint Custody

___ Sole Custody ____ Mother ____ Father Does the child have visitation with non-custodial parent? ___ Yes ___ No

___ Other (explain) ____

Custodial Parent/Guardians' Name(s):____
(Physical custody)

_____________________________Telephone #'s: (H) ____________________(W)_____________________(C)________________________
(Name of primary contact)

Email: (optional) ____
Please note: Email correspondence is not considered to be a confidential medium of communication

_____________________________ Telephone #'s: (H) ____________________(W)_____________________(C)________________________
(Name of secondary contact)

Email: (optional) ____
Please note: Email correspondence is not considered to be a confidential medium of communication

How often do you check your email? ____

Non-Custodial Parent Name: ____

Address: ____City:__________________________State: _________Zip: ________

Telephone #'s: (H) _________________________________(W)_________________________________(C)___________________________

Email: (optional) ____
*Please note: Email correspondence is not considered to be a confidential medium of communication

How often does this person see the patient? ____

Other Female caretaker: ____ Relationship: ____

Other Male caretaker: ____ Relationship: ____

Father's Occupation: ____ Mother's Occupation: ____________________________________

Stepparent's Occupation: _____________________________________

List the names and ages of all people living in your child's residence (not including your child):

Name	Relationship to You	Date of Birth	Age	Level of Education	Occupation

______________________ ____________________ _______________ __________ _________________ ______________

Mental Health Concerns and History

Please briefly list your child's symptoms/behaviors of concern: ____

____

____

____

____

____

____

What is your primary goal for this appointment: ____

____

____

Has your child had any previous treatment for mental health symptoms? ___ Yes ___ No

Has your child ever been given a mental health diagnosis (i.e. ADHD, Depression, Autism)? ___ Yes ___ No

If Yes, what diagnosis? If No, what diagnosis do you suspect? ____

____

List all outpatient clinics, mental health centers or therapists that your child has visited for the treatment of mental health symptoms within the past two years:

Clinic /Center/Therapist	**Reason for Visits**	**Estimated # of Visits**	**Dates Started/Stopped**

Has your child ever had inpatient or residential treatment for mental health symptoms? ___ Yes ___ No

If Yes, list below:

Facility	**Reason for Placement**	**Dates of Stay**	**Length of Stay**

List all **current medications** used for **emotional** or **behavioral problems** below: (attach additional sheet if necessary)

Medication Name	Dose (how much & how often)	Date Started	Prescribed By

List all **past medications** used for **emotional** or **behavioral problems** below: (attach additional sheet if necessary)

Medication Name	**Dose (How much & how often?)**	**Date Started**	**Date Stopped**	**Why Stopped?**

Has your child ever taken vitamins, nutritional supplements or other non-prescription medications to treat mental health concerns? ___ Yes ___ No

If yes, list any treatments ever taken below: (attach additional sheet if necessary)

Medication Name	**Dose (how much & how often)**	**Date Started**	**Date Stopped**	**Why Stopped?**

Current alternative therapies (e.g. Gluten-free diet, Casin-free diet, RDI, Hypnotherapy, Art Therapy, Bio-Med)

____

____

____

____

Potential stress history for child (check all that apply):

___ Parental Divorce
___ Domestic Violence
___ Parent Separation or marital problems
___ Serious Illness in the Family
___ Loss of parent employment
___ Moved from one home to another
___ Arrest/Conviction of family members
___ Exposure to firearms
___ Death in the family
___ Financial Hardship
___ Other (please list)_______________
___ Other (please list)_______________

Has your child ever been in a natural disaster? ___ Yes ___ No

Has your child ever had legal problems? ___ Yes ___ No

Are there any biological family members of the child who have had any of the following?

- Significant medical conditions (i.e. seizures, sudden death)
- Autoimmune disorders (i.e. lupus, multiple sclerosis)
- Psychiatric conditions (i.e. anxiety, depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, ADHD)
- Neurological conditions (i.e. mental retardation, learning problems, language delay, tics, autism, Asperger's, PDD)
- Drug/alcohol problems

Relationship to Child (paternal, maternal, brother, sister, grandmother, cousin, uncle, etc...)	**Name or Description of Condition** Please include all categories listed above

Client Cultural Information

Does the child identify with or follow a specific spiritual/religious tradition? ___ Yes ___ No

Is there anything about the child's spiritual/cultural traditions that we should be aware of that may conflict with services? ___ Yes ___ No

If Yes, please explain: ____

____

What is your child's primary language? ____ Are other languages spoken in the home? ___ Yes ___ No

If so, which language(s)? ____

Client Education Information

Current School System: ____

Name of School: ____

Grade: _____________________ Teacher: ______________________________ Resource/ Special Ed. Teacher: _____________________________

Has your child ever received any special education services at school ___ Yes ___ No

Does your child have an IEP (Individualized Education Plan)? ___ Yes ___ No

Has your child had social problems (i.e. isolated or difficulty getting along with peers)? ___ Yes ___ No

Has your child had significant disciplinary actions (i.e. suspensions, expulsions at school)? ___ Yes ___ No

Have teachers expressed concern about your child's success at school? ___ Yes ___ No

If Yes, please list teacher concerns about your child's success at school:

____

____

____

In school, does the child receive:

		Name of provider:	Frequency:
Speech Therapy	___ Yes ___ No	__________________________________	________________
Occupational Therapy	___ Yes ___ No	__________________________________	________________
Physical Therapy	___ Yes ___ No	__________________________________	________________
Classroom Aid (1:1)	___ Yes ___ No	__________________________________	________________
Other: _________________________	___ Yes ___ No	__________________________________	________________

Client Medical Information:

Has your child ever been diagnosed with a significant medical condition? (i.e. chronic illness, genetic disorders)

___ Yes ___ No

If yes, what is the current diagnosis? ____

Diagnosed by: ____ Approximate Date Diagnosed: ________________________________

Past or Present Treatments: ____

List all **current** medications for **physical illness/conditions** and doses below**:** (attach additional sheet if necessary)

Medication	Prescribed for (i.e. allergy)	Start Date	Dose (how much & how often)	Prescribed by

Name of Primary Care Physician: ____

Has your child ever had, or do they have, any of the following:

Problem	**Past:**	**Present:**	**Explain**
Sleep Problems			
Ear Infection			
Seizures			
Serious accident/trauma			
Staring spell			
Tics			
Rapid weight loss/gain			
Trouble with appetite			
Hearing Problems			
Eating Problems			
Frequent diarrhea/constipation			
Hypo- or Hyper-Sensitivities			
Physical disability			
Extended hospitalizations			
Surgery:			
Other:			
Other:			

List all Out Patient Therapies the child attends outside of school (i.e. speech therapy, occupational therapy, physical therapy)	Name of Provider	Telephone #
____	_________________________	__________________
____	_________________________	__________________
____	_________________________	__________________
____	_________________________	__________________

Please let us know how you were referred to our practice:

___ By primary care physician ___ By another physician involved in my care ___ Television/Radio ___ By my insurance company

___ By a friend ___ By a family member ___ Internet/Website ___ Phone Book

___ Other _________________ ___ Article in the newspaper or local publication ___ Other ________________ ___ Other _________________

Name of Person Referring (optional) ____

Please bring copies of the following information to your first visit if you have them available. We will need to keep these copies for our client files. The information you provide will not be passed on to third parties:
Current IEP, Psych Testing, Doctors Reports and Diagnosis (Mental Health only).

Notice of Privacy Practices
Autism Counseling & Behavior Consultation, Inc.
Effective 4/15/2003

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

1. PURPOSE: Autism Counseling and Behavior Consultation, employees, and trainees follow the privacy practices described in this Notice. Autism Counseling and Behavior Consultation keeps your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all professional staff involved in your treatment and employees involved in the health care operations of Autism Counseling and Behavior Consultation may have access to your records.

2. WHAT ARE TREATMENT, PAYMENT and HEALTH CARE OPERATIONS?
Your treatment includes sharing information among mental health care providers who are involved in your treatment. For example, if you are seeing both a physician (psychiatrist) and a psychotherapist, they may share information in the process of coordinating your care. Information will not be shared with other providers without a signed exchange of information form. We may use and disclose your medical information to bill and collect payment for treatment and services provided to you. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of Autism Counseling and Behavior Consultation operations.

3. HOW WILL AUTISM COUNSELING AND BEHAVIOR CONSULTATION USE MY PROTECTED HEALTH INFORMATION?
Your personal mental health record will be retained by Autism Counseling and Behavior Consultation for approximately seven years after your last clinical contact with the agency. After that time has elapsed, the record will be destroyed or otherwise maintained in a way that protects your privacy.

Until the records are destroyed they may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

- Appointment reminders.
- Notification when an appointment is cancelled or rescheduled.
- Treatment alternatives.
- Research - 1) We may release information about you to researchers preparing to conduct a research project who need to know how many patients have a specific health problems. 2) We may use and disclose medical information about you for research purposes if the research has been subjected to a careful review process conducted by a specially selected and trained committee and received this committee's approval. This process evaluates a proposed research project and its use of medical information, and balances the potential benefit of the research against individual patients' needs for privacy of their medical information. 3) A research project may involve comparing the health and recovery of all patients who received one treatment to those who received another for the same condition. In that situation, you would not be identified or contacted, but your medical information may be used but kept confidential. 4) In other studies, if a provider caring for you believes you may be interested in, or benefit from, a research study, your provider and the committee will approve someone to contact you to see if you are interested in the study. At that time, you would receive more information and you would have the right to authorize continued contact or refuse further contact.
- Workers' Compensation – We may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- As may be required by law.
- For public health purposes such as reporting of child or elder abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law.)
- Mental health oversight activities, e.g., audits, inspections or investigations of administration and management of Autism Counseling and Behavior Consultation.
- Individuals involved in your care or payment for your care. We may release medical information about you to a friend or family member who is involved in your therapeutic care. In addition, we may disclose medical information about you to another entity assisting in disaster relief efforts so that your family can be notified about your condition, status and location. If you do not want this information shared, please let us know in writing.
- Lawsuits and disputes (We will attempt to provide you advance notice of subpoena before disclosing information from your record.)
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred in Autism Counseling and Behavior Consultation facilities; when emergency circumstances occur relating to a crime.
- To prevent a serious threat to health or safety.
- To carry out treatment and health care operations functions through medical transcription services.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.

- National security and intelligence activities.
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- Alcohol and drug abuse information has special privacy protections. Autism Counseling & Behavior Consultation will not disclose any information identifying an individual as being a client or provide any mental health or medical information relating to a client¹s substance abuse treatment unless: (i) the client consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES. Except as described previously, we will not use or disclose information from your record unless you authorize (permit) in writing Autism Counseling and Behavior Consultation to do so. You may revoke your permission in writing, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.
You have the following rights regarding your health information, provided that you make a written request to invoke the right to Autism Counseling and Behavior Consultation.

- Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify in writing how or where you wish to be contacted.
- Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional chosen by Autism Counseling and Behavior Consultation. Autism Counseling and Behavior Consultation will comply with the outcome of the review.
- Right to request record clarification. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. Autism Counseling and Behavior Consultation is not required to accept the information that you propose.
- Right to accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment or health care operations in the last six (6) years, but not prior to April 14, 2003.
- Right to a copy of this Notice. You may request a copy of this Notice at any time, even if you have been provided a copy.

6. REQUIREMENTS REGARDING THIS NOTICE. Autism Counseling and Behavior Consultation is required to provide you with this Notice that governs our privacy practices. Autism Counseling and Behavior Consultation may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for mental health information we have about you as well as any information we receive in the future. Any time you come in to the Autism Counseling and Behavior Consultation facilities for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

7. COMPLAINTS. If you believe your privacy rights have been violated, you may file a written complaint with Autism Counseling and Behavior Consultation. You will not be penalized or retaliated against in any way for making a complaint.

Contact: Autism Counseling and Behavior Consultation through your treatment site if you:

- have a complaint;
- have any questions about this notice
- wish to request restrictions on uses and disclosure for health care treatment or operations.

IMPORTANT NOTICE TO CLIENTS

As required by the HIPAA Privacy Regulations, all clients who receive health care services in my office on or after April 14, 2003, must:

- Receive the attached "Notice of Privacy Practices" Form
- Sign the "Acknowledgement" Form below and return it to me for my records.

Please note that the attached Notice is not a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides my clients with a summary description of (1) how my office will use and disclose medical and billing information for legitimate business purposes, and (2) how my clients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institutions last year.

Please sign the acknowledgement form below and return it to me for my records. Thank you very much.

____

Kelly A. Ernsperger, LCSW

ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received a current copy of the Privacy Notice.

____ Date _________________
Client/Guardian Signature

If signed by Guardian, state relationship to Patient:

____