IPCI
INTEGRATED PSYCHOLOGICAL CENTER OF INDIANA

50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
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Maria P. Hanzlik, PsyD, HSPP-Clinical Psychologist
Jessicah D. Walker, PhD, HSPP-Counseling Psychologist
Josie Gronbach, PsyD-Post-Doctoral Resident

ACKNOWLEDGMENT: RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of HIPAA Notice of Privacy Practices from IPCI effective July 1, 2015.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

(For couples)
Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Notice of Privacy Practices from IPCI effective July 1, 2015.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

FOR OFFICE USE ONLY:

Notice of Privacy Practices effective July 1, 2015 was given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

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Consent for Treatment-Child/Adolescent Psychological Evaluation

A psychological assessment (also referred to as psychological testing or evaluation) usually takes considerable time, often over the course of several days or weeks. During the first session, your clinician will meet with you, the parents/guardians, without your child present, to discuss your current and past family and relationship history, any problems or symptoms your child is experiencing, any past treatment and its outcome, and other general background information. Over the course of several meetings, your clinician will complete a number of different tasks with your child. Your clinician will probably ask you, the parents/guardians, to also complete a number of forms and questionnaires on your own. Your clinician may ask you to distribute various forms to your child's teacher(s) as well. When you have completed all the tasks, your clinician will review, score and interpret the results. It is important to note that we will need to have all the parent and teacher forms in our possession prior to scheduling a feedback session. Occasionally, after reviewing some of the material, your clinician determines that an additional test(s) would be helpful. If that is the case, we will call you to inform you of this. Most patients want to meet with me for a feedback session to hear about the results of the evaluation. We schedule this appointment with the parents/guardians approximately 3 weeks from the time of the last testing appointment to provide me with enough time to complete scoring, interpretation, and report writing. It is important to understand that your clinician will not be engaging in psychotherapy with your child. Nonetheless, your clinician is still bound by the ethical and legal limitations and laws that any psychologist must follow.

Scheduling: Scheduling presents a special problem, because once testing time is blocked out, it typically cannot be filled again on short notice. As a result, we ask that you provide at least **48-hours** notice if you need to cancel an appointment. Failure to do so (except in cases of serious illness or emergency) will result in you being billed a cancelation fee as outlined in the Office Policies form. Please be aware that fees for missed visits are not covered by insurance.

FINANCIAL AGREEMENT

General: In consideration of the psychological evaluation being rendered to _____ (Name of patient) by my clinician, I, _____the undersigned parent/guardian , hereby agree to pay for services provided in accordance with the estimated cost of the evaluation as outlined below. I understand that my clinician bills for psychological evaluations at the fee outlined in the office policies. This rate applies to all telephone calls to any other parties for whom I give my clinician permission to speak. I will also be billed for all time in which my clinician: meets with me to complete testing; reviews, scores and interprets the tests; writes the professional report; and meets

with me to provide feedback about the results of the evaluation. The balance of the evaluation will be due at the last testing appointment (prior to scheduling feedback). My clinician cannot meet with me, nor complete the assessment, including feedback to myself or other professionals, until I have paid the full balance of our bill for the assessment.

For insurance clients: In some cases, my clinician may determine that additional testing could be useful that insurance does not cover. She will discuss this with me prior to completing more hours, and together, we will decide whether we will eliminate some of the tasks or agree to pay a higher cost. If I agree to further testing for my child, my clinician will provide me with an amended financial agreement outlining the cost of the additional services. I understand that if the assessment takes considerably longer than usual, and I chose not to have my child complete all the tasks rather than incur more expense, the assessment results may not be valid. My clinician will discuss what, if any conclusions, can be drawn from an abbreviated evaluation in a valid manner.

There are also times when insurance companies decide they will not pay for the cost of a completed evaluation based on certain diagnoses or if the evaluation results indicate my child does not meet criteria for a mental health diagnosis. I understand that, even in these situations, I am ultimately responsible for the full cost of the evaluation.

I, _____ (parent/guardian name[s]), consent to have my child _____participate in a psychological assessment conducted by my clinician. I have been informed by my clinician of the nature of this evaluation, and I understand that a report will be written based on the results of the evaluation. My clinician has informed me that this is considered a medical record document that cannot be disclosed to third parties without consent, unless under special circumstances (e.g., possibility of harm to self or others, abuse or neglect of children or vulnerable adults, court-order). I understand that this testing is voluntary, and that I can choose to not have my child tested or to stop testing at any time.

My signature below indicates that I have fully discussed with my child's clinician the various aspects of our contract for a psychological evaluation. My clinician has discussed with me scheduling, the nature of the fee and policies regarding missed appointments, and I agree to proceed with the evaluation.

Please initial after the following statements:

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered for in-network benefits. _____

Initial

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. I understand that if collection proceedings are necessary, I will pay all fees with collecting this bill. _____

Initial

I authorize communication between my clinician and referring physician/clinician _____ to inform that I have initiated services (separate release is required for further exchange of information). _____

Initial

I would like to be contacted for appointment reminders and other correspondence via the following ways (check all that apply):

☐ Telephone (please provide preferred number): _____

☐ Voicemail Message _____

☐ Text Message (if different than above):_____

☐ Email: _____

☐ Postal Mail (include address if other than provided): _____

_____ _____
Patient Signature Date

_____ _____
Printed Name Date

_____ _____
Witness Signature Date

_____ _____
Witness Printed Name Date

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Child/Adolescent Patient Information Form

Child's Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Gender: _____ **Gender Pronouns:** _____ **Age:** _____

Grade: _____ **School:** _____ **Race/Ethnicity:** _____

Other Important Demographic Information/Identities: _____

Parent/Guardian Name 1 & Relationship: _____

Parent/Guardian Name 2 & Relationship: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Preferred Phone Number (home/work/cell): _____

Referring Provider: _____

Current Medications: _____

Previous Mental Health Services: _____

Presenting Concerns: _____

Contact Information in Case of Emergency

Name:_____ **Relationship to Patient:** _____ **Phone:** _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name:_____ **Phone#:**_____

Policy Holder's Name:_____**Date of Birth:**_____

Relationship to Patient:_____ **Name of Policy Holder's Employer:**_____

ID#:_____ **Group#:**_____

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CREDIT CARD AUTHORIZATION FORM

NAME OF PATIENT: _____
NAME ON CARD:_____
BILLING
ADDRESS:_____
_____

Circle one: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

ACCOUNT #: _____

EXPIRATION DATE: _____

CVC # (ON BACK OF CARD): _____

By signing this form, I authorize IPCI and my clinician to charge this card. I may choose to use other forms of payment such as cash, check or an HSA account. I understand that, should my account be **30 days overdue**, I authorize IPCI and my clinician to automatically charge this card.

I hereby grant permission to charge my credit card after every ____ session(s) _____ (initials)

or

I hereby grant permission to charge my credit card if my balance reaches $100 without further authorization.

AUTHORIZED
SIGNATURE:_____

DATE: _____

AUTHORIZED
SIGNATURE:_____

DATE: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____do hereby consent and authorize my provider and/or IPCI,

TO DISCLOSE to: _____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): _____

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
___ Other: _____
___ Progress Notes
___ Psychological Evaluation

I understand that this information is to be used for the purpose of: _____

_____ _____
Patient/Guardian Signature Witness Signature

_____ _____
Printed Patient/Guardian Name Witness Printed Name

_____ _____
Date Date

I, _____do hereby consent and authorize my provider and/or IPCI, **TO DISCLOSE to:**

_____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): _____

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
__ Other: _____
___ Progress Notes
___ Psychological Evaluation

I understand that this information is to be used for the purpose of: _____

_____ _____
Patient/Guardian Signature Witness Signature

_____ _____
Printed Patient/Guardian Name Witness Printed Name

_____ _____
Date Date

Patients may revoke releases at any time by informing my clinician verbally or in writing. Unless otherwise specified by this patient, this release will remain valid for **1 year** from the time of signing.

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Child/Adolescent History Form

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Presenting Concern:
Reasons for seeking services:

Please list current symptoms:

Mental Health History:
How long have these concerns been present?:

Please list past outpatient therapy your child may have received:
(Name of therapist/length of time in therapy/type of work completed/past diagnoses)

Please list past inpatient mental health hospitalization your child may have received:
(Name of hospital/location/length of stay/age of hospitalization/reason for hospitalization)

Please list past and current medications your child has been prescribed/is using:

Medication name	Dosage	Reason for med.	Taking as prescribed? (Y/N)

Educational History:
School Name: Grade: Primary Teacher Name:

Please list/describe any trouble your child may be experiencing at school (academic or behavioral):

What are child's best and worst subjects?:

Has your child ever been diagnosed with a learning disorder?:

Does your child have an IEP/504 Plan in place?: (Y/N)

If Yes, please describe accommodations that have been recommended:

If Yes, are these accommodations, in your opinion, being implemented appropriately?

If No, do you think your child might need an IEP/504 Plan?: (Y/N)

Has your child ever received educational or psychological testing/evaluation in the past? (please describe):

Has your child ever been retained in a grade?: (Y/N) Please list reason for retention:

Has your child ever received special education services?: (Y/N) Please list reason for extra services:

Does your child enjoy school?:

Social Functioning:

Does your child make friends easily?

Does your child seem to have peers in whom your child can confide?:

Please list activities in which your child is currently involved:

Medical History:

Please list any medical conditions your child has and rate how well managed they are (good, fair, poor):

Please list any surgeries your child may have had:

Please list any hospitalizations your child may have had for a medical condition/length of stay:

Developmental History:
If your child was adopted, please indicate age at adoption and any information you know about your child's life before the adoption:

Pregnancy history (please describe the pregnancy with the child including term of pregnancy, any pregnancy-related complications):

Birth process:
Vaginal/Cesarean section?

Please note any complications that occurred during the birth process:

Please describe your child as an infant (cuddly, easy, difficult, colicky, active):
At what age did your child complete the following milestones?:

Smile at others:	*Roll over from stomach to back:*	*Roll over from back to stomach:*
Crawl:	*Walk without holding on:*	*Use single words:*
Form 2-3 word sentences:	*Remain dry during the day:*	*Remain dry at night:*

Have you noticed regression on your child's part in any of those areas?

Did your child have any difficulty with sleeping as an infant/toddler?:

Did your child have any difficulty with eating as an infant/toddler?:

Discipline:
Please list what you have used historically and use presently for discipline with your child:

Are you experiencing any difficulty with consistently implementing effective discipline strategies?:

Family of Origin History:
Place of birth:

Who has cared for your child up to this point?:

Please list who currently lives in your household and the quality of those relationships:

Please list any current family stressors that are occurring:

Please list any family members who have diagnosed or suspected undiagnosed mental health conditions:

Trauma History

Please circle/highlight any of the following your child may have experienced:

Physical abuse *Emotional/verbal abuse* *Sexual abuse*

Witnessing violence (including domestic violence) *Bullying*

Confusing experiences/boundary violations *Peer rejection*

Natural disasters *Loss of a parent or other important caregiver*

Substance Use:

Please check the following substances your child has used or may have used in the past as well as any substances you are aware your child is using currently:

	Past	Current	Suspected
Alcohol			
Wine			
Liquor			
Beer			
Marijuana (any form)			
Cocaine			
Crack Cocaine			
Hallucinogens			
Inhalants			
"Club Drugs" (i.e. Ecstasy)			
Heroin			
Prescription Drugs (not as prescribed)			
Stimulants			
Tobacco			
Caffeine			
Other:			

Have you ever approached your child about your child's substance use? Please describe the outcome:

Please list any prior treatment for drug or alcohol use:
(Inpatient/Intensive Outpatient/Educational/Detox/Date/Location):

Legal History:

Charge	Date of Arrest	Juvenile Detention (Y/N)	Probation (Y/N/Dates)

Strengths and Weaknesses:

Please list three of each to describe your child:

Strengths: *1.* *2.* *3.*

Weaknesses: 1. *2.* *3.*

Other Important Information About Your Child That Your Clinician Should Know:

What Are You Hoping to Gain from the Testing Evaluation Process?: