



Dear New Patient,

Thank you for choosing Kent Psychological Associates, LLC as your mental health care provider. If for any reason you are unable to keep your appointment, kindly call 24 hours in advance.

We ask that you please complete the following:

- Complete the paperwork attached to this letter and bring it with you for your first appointment.
- Arrive 20 minutes early for your appointment-there will be additional paperwork to do here.
- Please be prepared to pay your co-pay at the time of each visit.
- Call your insurance, verifying your out-patient mental health coverage including:
  - What is your annual deductible (amount that you are required to pay before your benefits start each year)? Deductible amounts almost always start over on Jan. 1 of each new year.
  - What is your office co-pay (amount you are required to pay at each office visit)?
  - The number of visits allowed per year (out-patient mental health code 90834)?
  - If your visits will be covered by an Employee Assistance Program, please contact your Human Resources Dept. for your referral/authorization.
  - Is a referral required from your primary care physician before your first visit?

If you have concerns or questions you can reach our business office Monday through Friday between the hours of 9 a.m. and 4 p.m. We look forward to meeting you.

Kent Psychological Associates, LLC

DATE \_\_\_\_\_

**CHILD BACKGROUND INFORMATION**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE (H) (\_\_\_\_) \_\_\_\_\_ PARENTS WORK (\_\_\_\_) \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ PHONE(\_\_\_\_) \_\_\_\_\_ RELATION \_\_\_\_\_  
FAMILY PHYSICIAN: \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

PERSON FILLING OUT THIS FORM: (CIRCLE ONE)

MOTHER      FATHER      STEPMOTHER      STEPFATHER      GUARDIAN      FOSTER PARENT

**FAMILY INFORMATION:**

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>SEX</u>	<u>OCCUPATION</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DEVELOPMENTAL HISTORY:**

Please check any which are problems in the home of the child:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Frequent moves     | <input type="checkbox"/> Alcohol/Drugs     | <input type="checkbox"/> Death of family member |
| <input type="checkbox"/> Parents divorce    | <input type="checkbox"/> Legal problems    | <input type="checkbox"/> Physical abuse/Neglect |
| <input type="checkbox"/> Parents remarriage | <input type="checkbox"/> Parent conflict   | <input type="checkbox"/> Sexual abuse           |
| <input type="checkbox"/> Parents separated  | <input type="checkbox"/> Parent job loss   | <input type="checkbox"/> Domestic violence      |
| <input type="checkbox"/> Family illness     | <input type="checkbox"/> Financial stress  | <input type="checkbox"/> Emotional problems     |
| <input type="checkbox"/> Personal illness   | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Other                  |

Help clarify a problem the child might have had effecting their development to age 18. Check those that apply.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Premature birth       | <input type="checkbox"/> Avoiding others      | <input type="checkbox"/> Bedwetting                    | <input type="checkbox"/> Birth Defect                      |
| <input type="checkbox"/> Nervous               | <input type="checkbox"/> Fidgety/restless     | <input type="checkbox"/> Head injury                   | <input type="checkbox"/> Abuse/neglect                     |
| <input type="checkbox"/> Eating problems       | <input type="checkbox"/> Talking/refusing     | <input type="checkbox"/> Frequent tantrums             | <input type="checkbox"/> Bad dreams                        |
| <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Speech problems      | <input type="checkbox"/> Sleepwalking/Nightmares       | <input type="checkbox"/> School behavior                   |
| <input type="checkbox"/> Poor coordination     | <input type="checkbox"/> Hearing/ear problems | <input type="checkbox"/> School behavior               | <input type="checkbox"/> Feeling rejected                  |
| <input type="checkbox"/> Visual difficulties   | <input type="checkbox"/> Fear leaving home    | <input type="checkbox"/> Behavioral problems           | <input type="checkbox"/> Strong willed                     |
| <input type="checkbox"/> "Worry wart"          | <input type="checkbox"/> Leaving a loved one  | <input type="checkbox"/> Toilet training               | <input type="checkbox"/> Few friends/loner                 |
| <input type="checkbox"/> Overweight            | <input type="checkbox"/> Small for age        | <input type="checkbox"/> Shy                           | <input type="checkbox"/> Ran away from home                |
| <input type="checkbox"/> Fighting              | <input type="checkbox"/> Picked on            | <input type="checkbox"/> Repeated grade                | <input type="checkbox"/> Did not like to be held as a baby |
| <input type="checkbox"/> Development delays    | <input type="checkbox"/> Trouble with police  | <input type="checkbox"/> Engages in dangerous behavior |  |

How would you rate your child's present relationship with the following? If it does not apply put N/A.

Father	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Mother	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Stepfather	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Stepmother	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Brother	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Sister	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Friends	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A
Teacher	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Problem for you	<input type="checkbox"/> N/A

### **EDUCATIONAL HISTORY**

School \_\_\_\_\_ Location \_\_\_\_\_  
Is your child in a special education class? yes  no  What kind \_\_\_\_\_  
Does your child received special tutoring or therapy in school? yes  no

### **OCCUPATIONAL HISTORY**

Is your child presently employed?  yes  no Type of work \_\_\_\_\_ How long? \_\_\_\_\_

### **PRIOR MENTAL HEALTH HISTORY**

Has your child ever had prior mental health treatment?  yes  no (If no, skip)  
When \_\_\_\_\_ Who \_\_\_\_\_  
Was this person a:  Psychiatrist  Psychologist  Clinical social worker  Clinical Counselor  
 Minister  Other  
Has your child ever been hospitalized for emotional problems?  yes  no (If no, skip)  
When \_\_\_\_\_ Where \_\_\_\_\_

### **ALCOHOL/DRUG HISTORY**

Does your child have a history of alcohol/drug abuse?  yes  no (If no, skip)  
Has your child ever been hospitalized for drug/alcohol abuse?  yes  no  
When \_\_\_\_\_ Where \_\_\_\_\_

### **MEDICAL HISTORY**

Date of last physical exam \_\_\_\_\_ Family physician \_\_\_\_\_  
Where located? \_\_\_\_\_  
Are immunizations up to date?  yes  no

Does your child have any special problems with hearing, speech or vision?  yes  no Please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Is your child taking any medications?  yes  no  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Describe any side effects of medication(s) \_\_\_\_\_  
\_\_\_\_\_

Please list any allergies, serious illnesses, injuries or surgeries? \_\_\_\_\_  
\_\_\_\_\_

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

Alcoholism \_\_\_\_\_  
 Allergies \_\_\_\_\_  
 Mental retardation \_\_\_\_\_  
 Obesity \_\_\_\_\_  
 Degenerative dis. \_\_\_\_\_  
 Mental health probs. \_\_\_\_\_  
 Schizophrenia \_\_\_\_\_  
 Bi-Polar \_\_\_\_\_  
 Depression \_\_\_\_\_  
 Anxiety \_\_\_\_\_  
 Attention Deficit \_\_\_\_\_

Cancer \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Epilepsy \_\_\_\_\_  
 High blood press. \_\_\_\_\_  
 Heart trouble \_\_\_\_\_  
 Suicide \_\_\_\_\_  
 Other \_\_\_\_\_

**MEDICAL CONDITIONS AND SYMPTOMS**

Past/Now

Academic underachievement  
  Argumentative  
  Bedwetting  
  Broken sleep  
  Cries easily  
  Difficulty going/staying asleep  
  Dizziness  
  Easily distracted  
  Excessive sexual interest  
  Food craving for sweets  
  Headaches  
  Hospitalization(s)  
  Itchy skin  
  Loses temper easily  
  Masturbation  
  Moody often  
  Nervousness  
  Over dependent  
  Poor appetite  
  Sleepwalking  
  Suicide attempt  
  Vomiting

Past/Now

Anxiety  
  Asthma  
  Body aches  
  Constipation  
  Demands for attention  
  Difficulty concentrating  
  Eats non-edibles  
  Encopresis (soiling clothes)  
  Fainting spells  
  Frequent sex play w/ other children  
  Hears voices  
  Immature for age  
  Leg cramps  
  Loss of consciousness  
  Memory problems  
  Much sweating  
  Nightmares  
  Overeating  
  Poor nutrition  
  Stealing  
  Temper tantrum  
  Worries, insecurity

Past/Now

Anger Outbursts  
  Baby Talk  
  Broken bones  
  Convulsions  
  Depression  
  Dieting  
  Emotional upsets  
  Encephalitis  
  Fatigue  
  High fever  
  Injuries to head  
  Loose bowel/gas often  
  Lying  
  Mental condition  
  Muscle twitching  
  Operation(s)  
  Perfectionistic  
  Rebellious  
  Stomach upsets  
  Thumb sucking

**MEDICAL ILLNESS HISTORY**

Briefly describe your child's current difficulties. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How long has this problem been a concern to you? \_\_\_\_\_  
 \_\_\_\_\_

Describe any unusual fears, habits, or behaviors. \_\_\_\_\_  
 \_\_\_\_\_

What is the main goal you wish to attain in seeking services for your child? \_\_\_\_\_

\_\_\_\_\_

**ADDITIONAL INFORMATION**

Please add any special information you feel might be helpful in assisting in your child's treatment.

\_\_\_\_\_

\_\_\_\_\_

Your signature below indicates that you understand the questions and could ask for assistance if needed.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date





### **Payment Policy: Regarding Divorced/Separated Parents**

We are aware that various legal agreements between parties may state which parent of a child is to pay medical bills.

However, we are a small office and have found it impossible to enforce the payment of co-pays and other bills by parties who have never been in our office.

***Therefore, our policy is that the parent who brings the child in for treatment will be obligated to pay any bills arising from that treatment.***

We are happy to provide receipts for these expenses which can be used to prove these expenses and request reimbursement from another responsible party.

We prefer, when possible, that both parents attend the first session with the child to sign required financial agreement forms.

If you have any questions or concerns about this policy, please contact the Clinical Director, Dr. Leslie McClure.

Mother signature \_\_\_\_\_ Date \_\_\_\_\_

Father signature \_\_\_\_\_ Date \_\_\_\_\_



## **PSYCHOLOGICAL TREATMENT FOR CHILDREN**

It is always preferable to have the consent of both parents when initiating psychological treatment with a child. This increases the likelihood that both parents will view the therapist as a neutral party, and it helps to create a safe, balanced treatment environment for the child. Parents often have very divergent views about their child's problems and about what is in their child's best interests. It is ideal for both parents to meet with the therapist together to discuss their concerns about the child, so that both participate in formulating the child's treatment plan and goals.

If it is not feasible for both parents to meet together with the therapist for this purpose, the other parent should be offered the opportunity to meet with the therapist to share their concerns about the child. In this case, the parent bringing the child to the office will be asked to provide contact information, so that we can request input from the other parent and so that they can facilitate the treatment process by their informed consent. When one or both parents are seen to discuss the child's problems and treatment, this session is considered to be family counseling for the child, as they are the focus of treatment.

### **FOR DIVORCED OR SEPERATED PARENTS**

It is not ethical for a treating mental health professional to offer an expert opinion regarding custody and visitation issues in court. Your child's therapist is a treating professional who is an expert on your child's mental health diagnosis and treatment. Any expert opinion regarding custody and visitation matters is properly performed by a court-appointed examining professional, who conducts a balanced child and parent evaluation separate from the child's treatment needs. In addition, a therapist's involvement in parental disputes creates potentially serious role conflicts that negatively impact a child's treatment.

### **REGARDING FEES**

With respect to payment for psychological services rendered to a child with divorced or separated parent, we have no standing in court actions which allocate financial responsibility for the child's health needs, and we are not in a position to enforce existing court orders. If the parent do not initially appear together and concur on an arrangement for sharing these expenses, the parent that initiated the treatment and that brought the child to the office will be responsible to us for these costs.



**Authorization for Release of Health Information Pursuant to HIPAA  
Kent Psychological Associates, LLC**

***Dear Client: Your health insurance requires us to request consent to coordinate care with your primary care provider. We consider coordination of care an important part of providing high quality care. Please complete the following authorization that allows us to exchange information with your primary care provider. If you are uncomfortable with such exchange of information, please check the box below indicating your refusal to allow us to exchange information with your primary care provider.***

- I prefer NOT to allow exchange of information between Kent Psychological Assoc. and my primary care provider.  
 I do not have a primary care provider.

CLIENT \_\_\_\_\_ DOB \_\_\_\_\_ Last four SSN # \_\_\_\_\_

**I THE UNDERSIGNED AUTHORIZE THE EXCHANGE OF INFORMATION BETWEEN:**

My Behavioral Health Provider:  
Kent Psychological Assoc. LLC  
190 Currie Hall Parkway, Suite A  
Kent, Ohio 44240  
Phone: 330-673-5812 Fax: 330-673-7162



My Primary Care Provider:  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**INFORMATION TO BE RELEASED BY KENT PSYCHOLOGICAL ASSOCIATES INCLUDES THE FOLLOWING:**

Diagnosis	Service/Treatment Plan
Recommendations	Summary of Treatment
Discharge Summary	

**REQUESTED INFORMATION FROM PRIMARY CARE PROVIDER INCLUDES THE FOLLOWING:**

History and Physical	Medical Evaluation
Service/Treatment Plan	Current Medications/Medication History
Treatment/Office Visit Notes	

**THE EXCHANGE OF INFORMATION IS FOR THE SPECIFIC PURPOSE OF:**

Ensuring proper coordination of care with your primary care provider.

**I UNDERSTAND:**

1. This authorization will expire on \_\_\_\_\_ (date, event, or condition not to exceed 1 year). If not dated, then this authorization will automatically expire 1 year from the date of signing.
2. I may revoke this authorization at any time by signing the "Revocation of Authorization" portion of this form, below, and providing a copy to the releasing party or by providing any other form of written revocation to the releasing party. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
3. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
4. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of records designation above, which may include treatment for mental illness (ORC5122.31), alcohol/drug abuse (42 CRF Part 2), and/or Human Immune Deficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC3701.24.3).

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

**REVOCAION OF CONSENT:**

**I hereby withdraw my consent for any further release of information as of the date indicated below:**

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error please notify Kent Psychological Associates, LLC immediately.



Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

- I give my permission for Kent Psychological Associates to call and if necessary leave a reminder message for upcoming appointments.

I would like reminders by (choose one):

- Text to: \_\_\_\_\_
- Phone call to: \_\_\_\_\_
- Email to: \_\_\_\_\_

- I do not want reminder calls.

Reminder calls are a courtesy only. Any missed appointments remain the client's responsibility. Reminders are made the day before the appointment including Sundays.

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

For your information:

Phone calls will come from 949-298-4668

Texts will come from 695-29

Emails will come from ValantApptReminder@reminderXchange.com

(You cannot reply back to these numbers.)