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CHILD/ADOLESCENT PATIENT INFORMATION FORM

Patient Name:_____Date: _____
Patient Address: _____
City:_____State:_____Zip:_____
Phone: (Home)_____(Work)_____(Cell) _____
Date of Birth: _____Social Security # _____ Sex: M/F
Emergency Contact Name & Phone Number: _____

FAMILY INFORMATION

Father's Name: _____ Occupation: _____
Employer: _____Social Security # _____
Business Phone: _____Cell Phone: _____ Home Phone: _____
Father's Home Address (If different from patient): _____
Father's Email Address: _____
Mother's Name: _____ Occupation: _____
Employer: _____Social Security # _____
Business Phone: _____ Cell Phone: _____ Home Phone: _____
Mother's Home Address (If different from patient): _____
Mother's Email Address: _____
Legal Guardian(s) of patient: _____
Custody arrangements (If Applicable): _____

List the members of the patient's family and all others *residing in the patient's home(s)*:

Name	Age/Sex	Relationship	Occupation

PRESENTING PROBLEM INFORMATION:

Presenting issues: (behaviors most concerned about, how long have they been going on, contributing factors, how does this problem (s) affect the child/family's daily life)

_____
_____
_____
_____

Discipline techniques: What methods have you used to deal with problems, what has worked and what has not worked)

_____

_____

_____

_____

Primary areas of improvement needed:_____

_____

_____

_____

Has the patient been treated for this problem before? Yes ____ No___ If yes, When, Where, and treated by whom:

_____

_____

_____

Has the patient ever been hospitalized for psychiatric or substance abuse problems? If yes, When, Where, and by Whom_____

_____

_____

HISTORY

Please circle any of the following problems which pertain to the patient:

Glasses/Contact Lenses	Ear Problems	Hearing Aid	Diabetes
Epilepsy	Fainting Spells	Seizures	Head Injuries
Allergies	Other Medical Issues:		

Patient referred By: _____

Patient's Physician (s): _____

Patient's Physician and when last examined: _____

List any major health problems for which the patient currently receives treatment:

_____

_____

_____

List any prescribed and over the counter medications and dosages the patient is now taking:

_____

_____

_____

Describe patients overall present health condition:

_____

_____

Please circle any of the following problems which pertain to the patient:

Nervousness	Depression	Fears	Shyness
Sexual Problems	Separation	Divorce Issues	Suicidal Thoughts
Drug Use	Alcohol Use	Friends	Anger
Self Control	Unhappiness	Habits	Stress
Headaches	Tiredness	Legal Matters	Memory
Ambition	Energy	Sleep Difficulty	Making Decisions
Loneliness	Inferiority Feelings	Concentration	Education
Health Problems	Temper	Nightmares	Relationships
Appetite	Loss of Pleasure	Loss of Interest	Forgetfulness
My Thoughts	Academic	Social Skills	Sibling Issues
Family Issues	Anxiety	Communication	Inappropriate Behaviors

Other: _____

_____

_____

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

Please note any problems during pregnancy and birth (maternal illness, medication, alcohol and/or drugs during pregnancy, planned or unplanned pregnancy, complications during birth-pre-maternity or post-maternity, low birth weight, use of forceps and/or Cesarean delivery, etc.

_____

_____

_____

_____

_____

_____

Describe patients sleep cycle (regular, irregular, nightmares, sleep terror, bed wetting, bedtime)

_____
_____
_____
_____

EDUCATIONAL

Name of School Attending: _____

Name primary classroom teacher: _____

Current grade placement and last grade report scores:_____

Briefly describe any school problems regarding the patient:

_____
_____
_____
_____

Describe any special education placement and/or tutoring (IEP, 504 Plan, Resource Room, etc)

_____
_____
_____
_____

Has the patient seen a school counselor (describe timeframe and issues for school counseling)

_____
_____
_____

Describe any school suspensions, detentions, or attendance issues

_____
_____
_____
_____

Indicate any educational testing or previous psychological evaluations (list reason for evaluation as well as approximate date of evaluation(s) and recommendations)

_____
_____
_____
_____

Additional information you would like to note:

CONSENT TO TREAT A MINOR

1. ***Dr. Recor generally requires the consent of both parents prior to providing services to a minor child***. If any question exists regarding the authority of a parent or caregiver to give consent for psychotherapy, psychological evaluation or any other treatment services, I will require copies of supporting legal documentation, such as a custody order, prior to commencement of services.

2. When working with an individual child, I respect his/her right to confidentiality. I will consult with you about your child's progress. Both parents are entitled to know the nature and progress of the child's therapeutic services. ***If I am treating your child in individual sessions, I appreciate you telling me at the beginning of the session whether there have been any unusual happenings since out last session or issues of concern you wish to discuss prior to the child's session. This interchange must be brief so as not to interfere with the child's therapy session.*** If a more extended time is needed, please call for a separate appointment or request a telephone session (not covered under insurance plans-see Telephone Calls in Consent).

3. Some children need to know that their parent is present for them in the waiting room and sometimes we involve the parent in a special session. ***Please inform the office is you plan to leave the office while your child is in session. If you do leave, please make sure you get back in time to pick up your child. Children should not be left unsupervised in the office at any time.***

4. Since we often use art and play materials in therapy with children, ***please dress your child in clothing appropriate for messy play.***

I, the undersigned parent/person having legal custody or guardianship/authorized care provider of _____ (the "minor"), do hereby authorize Richard D. Recor, Ph.D., Licensed Psychologist, to provide behavioral health services to the Minor. Such services may include, but are not limited to psychological assessment and evaluation, psychological testing, and psychotherapy services.

I understand this authorization may be revoked, in writing, at any time. If not previously revoked, this authorization shall remain effective from the date of signature below.

_____ _____

Signature Parent/Guardian/Authorized Care Provider **Date**

Patient Consent and Rights

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of patient consent and rights, this document is required as part of your medical record. In addition, ***Dr. Recor feels providing this information to you in advance of your receiving services will clarify our office policies and alleviate any misunderstanding regarding what you should expect from us and what we expect from you***. If you have any questions, please do not hesitate to contact Anita, Office Manager, (949) 720-0167.

Confidentiality: All aspects of services provided to you are held in the strictest confidence, in accordance with legal and ethical practice. Generally, no information will be released without your signed consent (or the consent of a legal guardian regarding a minor child in treatment). ***However, there are some situations in which we are required to break confidentiality.*** These situations are: suspected abuse of a child or elderly individual, imminent threat of harm to yourself or identifiable others, or when a court of law orders disclosure of the clinical record. When mental health is raised as an issue by a patient, in a legal proceeding, all confidentiality is waived. ***A written comprehensive Notice of Psychological Policies and Practices to Protect the Privacy of Your Patient Health Information is available upon request and is posted in the office waiting room for review.*** Please discuss any concerns you have about confidentiality with Dr. Recor at the initial session.

Insurance Billing: Your insurance policy, if any, is a contract between you and the insurance company, we are not part of the contract with you and your insurance company. As a service to you, ***we will only bill the insurance companies where Dr. Recor is a contracted provider***, but cannot guarantee such benefits or the amounts covered and are not ultimately responsible for the collection of such payments. ***Any person with an insurance company that Dr. Recor is not contracted with will be handled as a self-payment account, a super-bill will be provided for your submission to your insurance company for any out of network benefits to be directly reimbursed to you***. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Dr. Recor charges the usual customary rates for these services provided in our area. Person Responsible for Payment of Account is responsible for payments of any insurance company's arbitrary determination of usual and customary rates or denial of payment for services. ***It is understood that the ultimate responsibility of obtaining any pre-authorization and/or referral required by your insurance carrier is your responsibility as well as payment for any services rendered not covered or not medically necessary.***

Psychotherapy: Psychotherapy is a unique relationship between you (or your minor child) and Dr. Recor, in which you are provided with an environment for enhanced self-understanding. ***The process of psychotherapy works best if you are as open and honest about your thoughts and feelings as possible.*** A treatment plan will be implemented by yourself and Dr. Recor to assure working toward goals in treatment. If for any reason psychotherapy is not working for you, it is important to discuss this with Dr. Recor.

Psychological/Neuropsychological Testing: Testing can be very helpful in understanding and clarifying problems and in developing effective treatment plans. ***To be useful, tests must be carefully and truthfully answered and the directions must be clearly understood.*** If you have any questions about testing, please discuss these with Dr. Recor. The billing for psychological and/or neuropsychological testing includes the additional time the doctor spends scoring tests and compiling a comprehensive report of the testing (usually expect that for every hour spent in the office there is an additional one hour spent scoring tests and compiling the report of evaluation). ***A 2 hour follow-up appointment will also be made with the parent/legal guardian/patient to assure a complete understanding of the diagnosis, test results and recommendations. The formal report is released only after this review.*** An estimate of the total cost of the testing is available upon request.

Educational Testing: This is not typically covered under health insurance. ***Anything more than a brief screening of educational concerns will your responsibility and is not billed to insurance.*** An estimate of the cost and degree of warranted educational testing is available upon request.

Services Pertaining to Legal Matters: You are responsible to notify Dr. Recor in advance of any services rendered that are pertaining to legal matters. ***A separate signed Consent of Forensic Services and Policy is required before any services are received.*** A signed consent is also required to speak with your attorney.

Appointments: ***The length of an appointment for psychotherapy is typically 60 minutes in length***. Psychological/Neuropsychological testing is typically scheduled in four to six hour blocks of time, but can vary in length depending upon the particular reason for the testing and the tests to be administered. Please direct questions regarding appointments to Anita, Office Manager.

Cancellations/Missed Appointments: We understand that emergencies can arise that require you to cancel or change your appointment. However, we require a minimum of 48 hour notice for any change in appointment or cancellation of an appointment. ***If the required 48-hour notice is not received, you will be billed for the equivalent of a 60 minute therapy session and this fee will need to be paid in advance of rescheduling any additional appointments***. Missed and/or cancelled appointments are not covered under health insurance plans.

Our Right to Terminate Services: If Dr. Recor determines the treatment is no longer beneficial or determines you would be better served by another professional, or if two appointments are missed or canceled without the required 48 hour notice our policy is to terminate services and make referral to additional providers. ***If any of these situations apply, a certified letter will be mailed to you along with at least three referral sources.*** This policy is strictly adhered to and will be enforced due to the waiting list that is in place for appointments.

Payment: ***All co-payments and deductibles are to be paid at the time of service as payment plans are not currently offered. As a courtesy, we do accept major credit cards.*** After 60 days all accounts in arrears will be turned over to a collection agency and assessed a 15% interest fee effective the date the account became delinquent, as well as all collection fees associated in collecting the debt. It is further understood that no additional services will be provided until the charges have been paid in full.

Telephone Calls: The office policy for telephone calls during office hours is that all pertinent information is given to the receptionist for Dr. Recor**. It is important that regular appointments are made to alleviate the need for telephone calls.** ***All non-emergency telephone calls will be returned as Dr. Recor's schedule allows. After hours emergency calls are returned as soon as possible and you are advised to call 911 immediately. Non-emergency as well as emergency telephone calls are billed in 5 minute increments and will be directly billed to you.*** Telephone calls are not covered by medical insurance.

E-Mails: The office policy for accepting and responding to email is that **it is expressly understood that confidentiality cannot be assured in electronic submission of personal data and Dr. Recor will not be liable for lack of confidentiality of medical and/or personal information expressed electronically.** It is important that regular appointments are made to alleviate the need for emails. ***All emails that require a direct response from Dr. Recor will be directly billed to you in 5 minute increments.*** Emails are not covered by insurance.

Requests for Letters/Reports for Non-Medical Purposes: The time involved in preparing such requests will be directly billed to you and is payable before release of such letter/report.

Office Hours: Regular office hours are as follows: ***Monday thru Thursday 9:00 am -5:00 pm and Friday 9:00-12:00 pm.*** All services provided by Dr. Recor are by appointment only.

I hereby certify that I have read and understand the contents of this document and will abide by the contents contained herewith. The original signed document will be retained as a part of the medical record and a copy of this signed document will be provided to you upon request per HIPAA requirements.

_____ _____

Responsible Party Signature **Date**

ASSIGNMENT OF INSURANCE BENEFITS

Patient Name:_____ Date of Birth: _____

Primary Insurance Co: _____

Name & Phone Number: _____
Mailing Address: _____

Policy Holder Name, Social Security # & Employer: _____
_____

Policy & Group #'s:_____

Secondary Insurance(If Applicable)

Name & Phone Number: _____

Claims Mailing Address: _____

Policy Holder Name, Social Security # : _____

Employer, Policy & Group #'s:_____

We suggest you confirm your insurance benefits with your insurance company(s) to assure your understanding of specific policy provisions. Your insurance Company may not pay for services they consider not medically or therapeutically necessary, or ineligible. If the insurance company(s)denies payment for any provided services, the Person Responsible for Account will be responsible for the balance of account.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my health care provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I _____ ***(Patient/Parent (s)/Legal Guardian)*** hereby authorize

_____ ***(Insurance Co. and/or third-party payer)***
to pay and hereby assign directly to Richard D. Recor, Ph.D., all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I also understand upon 60 days default, I am liable for any and all costs associated in the collection process of said debt as well as 15% interest on balance at time of default. I further acknowledge that any insurance benefits, will be credited to my account, in accordance with the above said assignment. ***In the event Dr. Recor is not a contracted provider with your specific insurance plan, this agreement is void and you will be given a superbill to submit for your direct reimbursement and assignment of benefits to our office does not apply.*** If you have any questions regarding insurance assignment please ask in advance of the service.

_____ _____
Patient Name Date

_____ _____
Signature Patient or Parent/Legal Guardian **Date**

Financially Responsible Party Information

Dr. Recor is committed to providing caring and professional mental health care to all his patients.

As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers as further described in the Patient Consent and Rights Form. The financial policy is designed to clarify the payment policies as determined by the management of Richard D. Recor, Ph.D.

Your insurance policy, if any, is a contract between you and the insurance company, we are not part of the contract with you and your insurance company. As a service to you, we will only bill the insurance companies where Dr. Recor is a contracted provider, but cannot guarantee such benefits or the amounts covered and are not ultimately responsible for the collection of such payments. Any person with an insurance company that Dr. Recor is not contracted with will be handled as a self-payment account, a super-bill will be provided for your submission to your insurance company for any out of network benefits to be directly reimbursed to you. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Dr. Recor charges the usual customary rates for these services provided in our area. Person Responsible for Payment of Account is responsible for payments of any insurance company's arbitrary determination of usual and customary rates or denial of payment for services.

The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 45 days. Payments not received after 60 days are subject to collections. A 15% interest fee effective the date the account became delinquent, as well as all collection fees associated in collecting the debt.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g. if there were previous visits to another mental health provider during the current benefit year), this amount will be collected by our office until the deductible payment is verified by the insurance company or third-party payer. Insurance benefits with contracted insurance companies will be assigned to Dr. Recor. All other insurance benefits will not be assigned to Dr. Recor and the Person Responsible for Payment of Account pays the entire balance each session.

Patients or their parent/legal guardian are responsible for payment at the time of service. ***Unaccompanied minors will be denied non-emergency services unless charges have been preauthorized by the parent/legal guardian of the minor by either credit card or other payment source at the time of service.***

Missed appointments or cancellations less than 48 hours prior to the appointment are charged the equivalent of a 60 minute therapy session and will need to be paid in full before another appointment can be scheduled. Questions regarding this agreement can be directed to either the Office Manager or Dr. Recor.

- I (we) have read, understand, and agree with the provisions of the Financially Responsible Party Information.
- Patient Name:_____
- Person (s) Responsible for Account:_____
- Person Responsible Address:_____
- Person Responsible Social Security # _____ Phone Number:_____
- Preferred Payment Method: Check Cash Visa MasterCard

Credit Card:_____ Expiration Date: _____Sec Code:_____

Signature(s) of Authorized Credit Card Holder:_____

***Signature(s) of Person(s) Responsible for Account_____**

Arbitration Agreement

This agreement made on _____between Richard D. Recor, Ph.D., Licensed Psychologist, 101 Pacifica, Suite 220, Irvine, CA 92618, hereinafter referred to as the "First Party" and

Patient/Parent/Legal Guardian Names: _____

Patient Name: -_____

Address: _____

Herein after referred to as "Second Party"

WHERAS, the business relationship between parties commenced _____ as defined in the original psychotherapy contract, namely Mental Health Services, which is attached and incorporated herein;

AND WHEREAS disputes and differences have arisen between parties;

AND WHEREAS the parties recognize that litigation in court can be time consuming and expensive;

AND WHEREAS the parties have appointed American Arbitration Association as their arbitrator.

NOW IT IS AGREED BETWEEN THE PARTIES HERETO AS FOLLOWS:

The parties hereto agree to the following matters and responsibilities to the Arbitrator:
Any controversy or claim arising out of or relating to this contract, or breach thereof, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator)s) may be entered in any court having jurisdiction thereof.

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not be a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both partied to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

In the event of any dispute, claim, question, or disagreement arising from or relating to this agreement or the breach thereof, the parties hereto shall use their best efforts to settle the dispute, claim, question or disagreement. To this effect they shall consult and negotiate with each other in good faith and, recognizing their mutual interest, attempt to reach a just and equitable solution satisfactory to both parties. If they do not reach such solution within a period of 60 days, then, upon notice by either party to the other, all disputes, claims, questions, or differences shall be finally settled by arbitration administered by the American Arbitration Association in accordance with the provisions of its Commercial Arbitration Rules.

If a dispute arises out of or relates to this contract, or breach thereof, and if the dispute cannot be settled through negotiation, the parties agree to first try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures before resorting to arbitration, litigation, or some other dispute resolution.

In the event there are any disputes or controversies that arise between the parties pursuant to the term is the aforesaid Contract, then the parties are waiving their rights to litigate these issues in court and instead elect to have these disputes resolved through arbitration.

The parties agree that any disputes are to be arbitrated through the American Arbitration Association and that the parties agree to abide by the rules of the Commercial Arbitration Rules of the American Arbitration Association.

WHEREFORE, it is agreed that all claims and disputes arising or relating to the Contract are to be settled by binding arbitration in the State of California. Said arbitration is to be resolved through Commercial Arbitration Rules of the American Arbitration Association and the parties agree to abide by these rules.

Any decision or award as a result of any such arbitration shall be issued in writing and the arbitrator shall be mutually selected pursuant to the Commercial Arbitration Rules or the American Arbitration Association. Any arbitration award may be confirmed in a court of competent jurisdiction.

The Agreement shall be signed by Richard D. Recor, Ph.D., Licensed Psychologist and by

_____, Patient, Parent(s) and/or Legal Guardian(s)

on behalf of _____Patient Name.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature_____Date: _____
(Parent(s) /Legal Guardian(s) and/or Patient)

Signature:_____Date:_____
Richard D. Recor, Ph.D.