8 Hillside Avenue, Suite 206
Montclair, NJ 07042
www.evolve-ps.com

(917) 723-9986

Biographical Information

Child/Adolescent Information:

Name: ______________________________
Address: ______________________________
____
Home #: ______________________________
Mobile #: ______________________________
Email: ______________________________
School: ______________________________
Grade: ______________________________

DOB: _____________ Age: ______
Gender: ______________________________
Ethnicity: ______________________________
Religion: ______________________________
Language(s): ______________________________

Guardian Information:

Guardian #1: _________________________
Relationship: _________________________
Address: _________________________
____
Home #: _________________________
Work #: _________________________
Mobile #: _________________________
Email: _________________________

Guardian #2: _________________________
Relationship: _________________________
Address: _________________________
____
Home #: _________________________
Work #: _________________________
Mobile #: _________________________
Email: _________________________

Primary Insurance:

Insurance Company: ________________________
Plan Name: ________________________
Insured ID#: ________________________

Cardholder Name: _________________________
Employer: _________________________
DOB: _________________________

Referral Source:

□ Mental Health Provider: _____________________
□ Friend or Family Member
□ www.nicolegarciaphd.com
□ Other: ___________________________________

□ Primary Care Doctor: ________________________
□ Internet (google, yahoo, bing, etc): _____________
□ www.psychologytoday.com

Forms of Communication:

Can psychologist leave messages on the mobile phone(s) provided above?	□ Yes	□ No
Can psychologist leave messages on the home phone(s) provided above?	□ Yes	□ No
Can psychologist communicate with me via text message (for non-clinical matters)?	□ Yes	□ No
Can psychologist communicate with me via the email (for non-clinical matters)?	□ Yes	□ No

____ _________________________

Parent/Guardian Signature *Date*

Evolve Psychological Services, LLC

Client Report of the Problem

Name: ________________________________ Date: _______________________

Description of Presenting Problem(s):
Briefly describe your reason(s) for seeking help for your child/teen.
Hong long has your child/teen had the problem(s)?
What do you think are the causes of the problem(s)?
Are there any kinds of support that make the problem(s) better, such as support from family, friends, others?
Are there any kinds of stresses that make the problem(s) worse, such as difficulties with learning, family problems, problems with friends, medical problems, other kinds of issues?
Briefly describe any significant event(s) and/or change(s) that have occurred within the last year.
What has your child/teen done on their own to cope with the problem(s)?
Why did you decide to seek help for your child/teen now?
Has anything prevented you from getting the help that your child/teen needs?
What kinds of help do you think would be most helpful for your child/teen at this time?

Please check any of the following behaviors/symptoms that apply to your child/teen:	
❐ Thoughts of suicide	❐ Thoughts of harming others
❐ Trouble getting to sleep	❐ History of attempts to kill him/herself
❐ Waking during the night	❐ Cutting or self-injurious behavior
❐ Waking early every day	❐ Feelings of hopelessness
❐ Loss of appetite	❐ Inability to make decisions
❐ Excessive guilt	❐ Trouble controlling temper
❐ Decreased motivation	❐ Large weight gain or loss
❐ Excessive energy	❐ Seeing things others do not
❐ Fidgets or squirms in seat	❐ Hearing voices
❐ Disorganized, loses things often	❐ Violence toward others
❐ Daydreams or "zones out" often	❐ Cruelty to animals
❐ Trouble concentrating	❐ Tingling or numbness
❐ Racing thoughts	❐ Flashbacks
❐ Always worrying about something	❐ Depressed mood
❐ Forgetfulness	❐ Frustrated easily
❐ Obsessional thoughts	❐ Irritability
❐ Compulsive behaviors	❐ Impulsivity
❐ Steals or lies	❐ Expansive/Elevated mood
❐ Disorganized/Disruptive thoughts	❐ Anorectic/Bulimic behavior
❐ Paranoid thoughts	❐ Appears to have low self-esteem
❐ Mood swings	❐ Prefers to be alone
❐ Phobias	❐ Complains of aches and pains
❐ Panic attacks	❐ Learning problems
❐ Anxiety	❐ Problems at school
❐ History of physical abuse	❐ Frequent peer conflicts
❐ History of sexual abuse	❐ Frequent family conflicts
❐ Financial problems	❐ Legal problems
❐ Health problems	❐ Alcohol/substance abuse problems
❐ Other:	❐ Other:

Please check any of the following settings/situations where your child/teen has difficulty:			
□ When getting ready for school	□ Rarely	□ Sometimes	□ Frequently
□ When separating at morning school drop-off	□ Rarely	□ Sometimes	□ Frequently
□ When at school	□ Rarely	□ Sometimes	□ Frequently
□ When transitioning into the home after school	□ Rarely	□ Sometimes	□ Frequently
□ When doing homework	□ Rarely	□ Sometimes	□ Frequently
□ When eating at the dinner table	□ Rarely	□ Sometimes	□ Frequently
□ When playing by him/herself	□ Rarely	□ Sometimes	□ Frequently
□ When playing with siblings	□ Rarely	□ Sometimes	□ Frequently
□ When playing with friends/peers	□ Rarely	□ Sometimes	□ Frequently
□ When engaging in physical activity/sports	□ Rarely	□ Sometimes	□ Frequently
□ When with a babysitter/other caregiver	□ Rarely	□ Sometimes	□ Frequently
□ When in public places	□ Rarely	□ Sometimes	□ Frequently
□ When in the car	□ Rarely	□ Sometimes	□ Frequently
□ When told to do something he/she doesn't like	□ Rarely	□ Sometimes	□ Frequently
□ When watching TV	□ Rarely	□ Sometimes	□ Frequently
□ When playing a video game	□ Rarely	□ Sometimes	□ Frequently
□ Other:	□ Rarely	□ Sometimes	□ Frequently
□ Other:	□ Rarely	□ Sometimes	□ Frequently

Please describe your child's/teens strengths and talents (artistic, musical, athletic, etc):

Mental Health Treatment History:
Is your child/teen currently under the care of a psychiatrist? □ Yes □ No If yes: What is the name of the psychiatrist? What are the diagnoses? What medications, if any, are currently prescribed? Does your child/teen consistently take the medication prescribed? What are the positive and/or negative effects of the medication?
Has your child/teen ever received outpatient mental health treatment? □ Yes □ No If yes: For what reasons did your child/teen need help? Did it help? With whom was your child/teen in treatment? How long was your child/teen in treatment? Was your child/teen prescribed any medication?
Has your child/teen ever received inpatient mental health treatment? □ Yes □ No If yes: For what reasons did your child/teen need help? Did it help? In what hospital did your child/teen receive treatment? How long was your child/teen in treatment? Was your child/teen prescribed any medication?

Alcohol and Drug Use History (please check any of the following substances that your child/teen is currently using and provide information regarding usage)**:**

Substance	Age first used	Weekday use	Weekend use	Monthly use	Last used
❐ Beer					
❐ Liquor					
❐ Wine					
❐ Marijuana					
❐ Cocaine/Crack					
❐ Methamphetamine					
❐ Heroin					
❐ Barbituates (downers)					
❐ PCP, LSD (hallucinogens)					
❐ Tobacco (any form)					
❐ Other:					

Has your child/teen ever felt like he/she should cut down on his/her use? □ Yes □ No
Has a friend or relative expressed concern about his/her use? □ Yes □ No
Has your child/teen ever felt guilty about his/her drinking or drug use? □ Yes □ No
Is your child/teen in recovery from abusing alcohol or drugs? □ Yes □ No
Is there a history of problems with drug or alcohol use in your family? □ Yes □ No

Developmental History

Name: ________________________________ Date: _______________________

Current Household Composition:		
Name	Relationship	Age

Developmental History:
Is child your: □ biological child □ adopted child □ foster child □ other:
Are parents of child/teen currently: □ married □ separated □ divorced □ never married If separated or divorced: Who has legal custody? What is the visitation agreement? How has your child/teen feel adjusted to the separation/divorce? Does your child/teen spend time with any other person not in the home?
Were there any complications with pregnancy or child birth? □ Yes □ No If yes, please explain:
Length of pregnancy (in weeks):
Child's birth weight (pounds, ounces):
During infancy, please describe your child's temperament:

During the first few years of life, please check off any of the following behaviors that were present to a significant degree:	
□ did not enjoy cuddling □ was not easily calmed by being held □ difficult to comfort □ colicky □ excessive irritability □ diminished sleep	□ difficult nursing □ poor eye contact/did not turn toward caregivers □ did not respond to name or speech of caregivers □ fascination with certain objects □ constantly into everything □ frequent head banging

Please indicate the age or age range when your child performed the following milestones:							
Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years
Sat up without help							
Crawled							
Walked alone							
Walked up stairs							
Spoke first words							
Spoke first phrases							
Spoke sentences							
Fully bladder trained							
Fully bowel trained							
Stayed dry all night							

Educational History (please list schools attended and describe your child's/teen's academic and behavioral performance):
Preschool/Daycare:
Elementary School:
Middle School:
High School:

Description of current functioning at school:
How does your child/teen feel about school?
How does your child/teen interact with his/her friends/peers?
How motivated is your child/teen to learn?
How much time does your child/teen spend on homework each night, on average?
How much of a struggle is homework?
What types of grades does your child/teen earn, on average?
What subjects are easier for your child/teen?

What subjects are harder for your child/teen?
Does your child/teen receive special school services (IEP, 504, Gifted/Talented)? □ Yes □ No If yes, please describe:
Does your child/teen receive any tutoring/extra help outside of school? □ Yes □ No If yes, please describe:

Description of current functioning at home:
What is your child's/teen's personality/basic mood at home?
How does your child/teen get along with his/her brothers/sisters?
Which adult would your child/teen prefer to talk with about a problem?
Which family member does your child/teen feel closest to?
Who is primarily responsible for discipline at home?
What are the methods of discipline used for dealing with your child's/teen's misbehavior?
How does your child/teen respond to discipline?
What are your child's/teen's responsibilities at home?
On a school night, how many hours of sleep does your child/teen get on average? On a non-school night?
Does your child/teen eat regularly? What are your child's/teen's preferred foods?

On a school night, how much time does your child/teen spend:	**On a non-school night, how much time does your child/teen spend:**
watching TV? playing video/computer games? texting? on social media? other:	watching TV? playing video/computer games? texting? on social media? other:

Medical History:
What is the state of your child's/teen's current health? ◻ Excellent ◻ Good ◻ Fair ◻ Poor
Is your child/teen currently under the care of a primary care physician? ◻ Yes ◻ No If yes: What is the name of his/her physician? What are the diagnoses? What medications, if any, are currently prescribed? Is your child/teen consistently taking the medication prescribed? What are the positive and/or negative effects of the medication?
List any medical or physical problems and when they were diagnosed:
List any vision or hearing problems:
List any major surgeries your child/teen has had to date:
List any serious illness or injuries including any seizures or head injuries:
List any allergies to foods or drugs:
Date of last physical examination:

Family History (please check any of the following problems and indicate the biological family members with the history):
◻ Emotional problems:
◻ Learning difficulties:
◻ Speech or language difficulties:
◻ Developmental delays:
◻ Medical problems:
◻ Genetic disorders:
◻ School failure:
◻ Alcohol or drug addiction:
◻ Other:
◻ Other:

Thank you for providing this important information about your child/teen!

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the American Psychological Association Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse, neglect, or abandonment; the reporting of the abuse, neglect, or exploitation of an elderly or disabled person; or mandatory government agency audits or investigations (such as the psychology licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer: Nicole Garcia, PhD, Evolve Psychological Services, 8 Hillside Avenue, Suite 206, Montclair, NJ 07042**.**

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. This right includes medical records and billing records but does not include psychotherapy notes. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer: Nicole Garcia, PhD, Evolve Psychological Services, 8 Hillside Avenue, Suite 206, Montclair, NJ 07042, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2008.

Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Name: ___________________________________ DOB: __________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Evolve Psychological Services' Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Dr. Garcia, Owner, Evolve Psychological Services at the address and/or phone number below:

8 Hillside Avenue, Suite 206
Montclair, NJ 07042
(917) 723-9986.

____
Parent/Guardian Signature

____
Relationship

____
Date

Evolve Psychological Services, LLC

Informed Consent for Child/Adolescent Psychotherapy

This form documents that we, ______________________________ and _______________________________,
Name of Parent/Guardian *Name of Parent/Guardian*
hereby give our consent to ______________________________ to provide psychotherapeutic treatment to our child,
Name of Psychologist
____.
Name of Child/Teen

We have fully discussed with the psychologist what is involved in psychotherapy and we have agreed to the policies about scheduling, fees, missed appointments, third party payments and other matters outlined below. Our discussions have included the initial consultation phase of the treatment, provisional diagnostic formulations of our child's problems, the proposed method of treatment, the guidelines for confidentiality, and record keeping. We have been informed and understand the goals of treatment as well as the foreseeable benefits and risks of treatment. In addition, the psychologist has discussed how to reach the psychologist in emergency situations.

We understand that information about psychotherapy is kept confidential and will not be revealed to others without written consent. Some exceptions are:

1. The psychologist is required by law to report suspected child abuse or neglect or suspected abuse of an elderly person to the authorities.
2. In the event that we or our children intend to harm another person or ourselves and there is immediate danger present the psychologist may be required to take steps to warn or protect the person at risk by informing that person, designated family members, the police or other health care providers.
3. The psychologist may need to inform a covering psychologist about some aspects of treatment when the psychologist is away or unavailable.
4. If our health insurance or managed care plan will be reimbursing the client/family for services rendered, it may require that we waive confidentiality and the psychologist to provide them with information about our treatment.

We understand that the sessions will be occurring at an agreed upon time and fee, $______, lasting for 45-minutes and that I will be responsible for payment at the time of each session. Unless the psychologist receives 24 hours' notice of canceling the appointment, we are responsible for the payment of that session at the full fee, $______. Additional clinical face-to-face time will be prorated in 15 minute increments according to the fee above. We also understand that we are responsible for the payment of other services that we may request including report writing, telephone consultations with other mental health providers, teachers, etc, preparation of records or treatment summaries, and time spent performing any other service, and that such services will be prorated in 15 minute increments according to the fee above.

We understand that we can discuss the terms of the psychotherapy agreement with the psychologist including the goals and frequency as well as any financial aspects. By signing below we are attesting to the fact that we have read, discussed, and understood this form and give our consent to treatment.

____	____
Parent/Guardian Signature	*Parent/Guardian Signature*
__________________________	__________________________
Date	*Date*

Evolve Psychological Services, LLC

<u>Consent for Release of Information</u>

Client Name: ______________________ Date: ______________

Address: ______________________ Home #: ______________

______________________ Mobile #: ______________

Nature of information to be disclosed: <u>Emotional, Behavioral, Medical and/or Academic Functioning</u>

Purpose for release of information: <u>Treatment Planning/Care Coordination</u>

Information of professional providing information:

Name: ______________________ Office #: ______________

Institution: ______________________ Fax #: ______________

Information of psychologist receiving information:

Name: ______________________ Office #: ______________

Institution: <u>Evolve Psychological Services</u> Fax #: <u>(973) 744-2054</u>

I hereby authorize the periodic release of the above information to the person identified above as often as necessary to plan for treatment or testing. I understand that I have the right to cancel my permission to release information at any time.

My consent to release information from the Person/Facility identified above will expire when I am no longer receiving services or one year from this date whichever occurs first.

______________________ ______________________ ______________

Signature of Client/Person Acting for Client *Relationship* *Date*