CURRY
PSYCHOLOGY GROUP

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CHILD INFORMATION FORM

Please allow approximately 30 – 45 minutes to complete this form. Because there are so many potential influences on a child's behavior, we request quite a bit of information from families at the start of therapy. This enables us to better identify the issue at hand and develop the most effective plan possible to support your child. Your family's information will remain confidential, so please answer as openly and honestly as possible. The more information we have, the better equipped we are to help.

Person Preparing this Form: _____ **Today's Date**: _____

Relationship to Child: _____

I. DEMOGRAPHIC INFORMATION

Child's Information

Child's Name: _____ Date of birth: _____ Age: _____

Nicknames: _____

Current Home Address: _____

Phone Number (if applicable): _____ email (if applicable): _____

Custody Status

What was the parents' relationship status when the child was born?

❑ Married ❑ Together but Not Legally Married ❑ Not Together or Married

If parents were *married* or *together*, are they still? ❑ Yes ❑ No: *How old was child when parents split?* _____

Who is the child's primary caregiver? (*May be more than one.*) _____

Who has legal custody of the child (legal authority to make major decisions pertaining to the child)?

_____

Who has physical custody of the child/who does the child live with? (If custody is shared, please describe the custody arrangement) _____

_____

Caregivers

Please list parents and primary caregivers. Use back if additional space is necessary.

Parent/Caregiver Name: _____Date of birth: _____ Age: _____

Relationship to Child _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Home phone: _____

Work phone: _____ email: _____

Employer: _____ Job Title: _____

Parent/Caregiver Name: _____Date of birth: _____ Age: _____

Relationship to Child _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Home phone: _____

Work phone: _____ email: _____

Employer: _____ Job Title: _____

Stepparent/Other Caregiver Name: _____Date of birth: _____Age: _____

Relationship to Child _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Home phone: _____

Work phone: _____ email: _____

Employer: _____ Job Title: _____

Stepparent/Other Caregiver Name: _____Date of birth: _____Age: _____

Relationship to Child _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Home phone: _____

Work phone: _____ email: _____

Employer: _____ Job Title: _____

Phonecalls from Our Office

Calls or e-mail will be discreet, but please indicate any restrictions: _____

May we send a text message appointment reminder the day before your scheduled appointment? ☐ Yes ☐ No

If yes, please provide a cell phone number for the text message to be sent: _____

Insurance Information

Insurance company: _____

Insurance ID # (*For Tricare, enter sponsor's social security #*): _____

Patient's relationship to the sponsor/primary insured: ☐ Self ☐ *Child/Dependent**

Sponsor name: _____ Date of birth: _____

Sponsor insurance ID# (*For Tricare, enter sponsor's Social Security #*): _____

Sponsor job title & employer (*Military, enter branch, MOS & rank*): _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Address: _____

How did you learn about us?

❑ Online Search ❑ Psychology Today ❑ Insurance Directory ❑ Referred by: _____

If referred, may we have your permission to thank this person for the referral? ❑ Yes ❑ No

If referred, how did this person explain how we might be of help to you? _____

_____

_____

II. CULTURE & IDENTITY

Race/Ethnicity

Ethnicity/national origin: _____ Race: _____

Other related way your family or child identifies: _____

Religion/Spirituality

The family's current religious denomination/affiliation: _____

Family's Religious/Spiritual Involvement: ❑ None ❑ Some/Irregular ❑ Active

Child's Religious/Spiritual Involvement: _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Gender Identity

Child's Gender _____

Has your child had any difficulty identifying with their birth gender? ❑ No ❑ Yes

If *yes* (your child has had difficulty), please describe: _____

_____

Sexual Orientation

Is your child's sexual orientation currently an issue or focus for them? ❑ No ❑ Yes

If yes (your child's sexual orientation is currently an issue or focus in their life), please describe: _____

_____

III. Residential and Family History

Residential History: Please list all the places your child has lived.

Year - Year	City, State	Reason for moving	Any issues transitioning?

Household Information: Please list all people living in your child's household (use back for additional people).

Name	Relationship to Patient	Age	Profession

Family Tree:

Please list any immediate family members *who do not live in your child's primary household* (parents, siblings, step-parents, step-siblings). Include non-relatives or extended family members who are primary caregivers (e.g., a grandparent who is responsible for much of the child's care).

Name	**Relationship to Child**	**Age *(if living)***	**Profession**	**City, State**

IV. SCHOOL & RECREATION

Please list all schools your child has attended with the current school listed first:

Grade	**Age**	**School Name**	**Location (City, State)**	**Describe Any Special Education Services Received & Reason Why**

How is your child currently doing in school? _____

Has your child been in trouble at school? ❑ No ❑ Yes (please describe) _____

_____

Please list any special skills your child has (hobbies, sports, recreational, musical, TV & toy preferences, unique interests, etc.) _____

_____

_____

How would you describe your child's social life? Do they have many friends? Few friends? Are they shy? Outgoing? Do they enjoy large groups and parties or prefer to play alone? _____

_____

_____

V. EARLY CHILDHOOD DEVELOPMENT

Pregnancy and Delivery

List any prenatal medical illnesses experienced by the mother: _____

_____

Was the child born premature?

☐ Child was carried to full-term (pregnancy lasted approximately 9 months before delivery)

☐ Child was born premature (indicate how many months/weeks gestation before delivery): _____

Normal birth weight & height? ☐ Yes ☐ No (please describe): _____

Any birth complications or problems? _____

The First Few Months of Life

Breast-fed: ☐ No ☐ Yes (please indicate how long): _____

Allergies: ☐ No ☐ Yes (please list):_____

Sleep problems: ☐ No ☐ Yes (please describe): _____

Describe the child's personality during infancy: _____

Milestones

To the best of your knowledge, at what age did the child do each of the following:

Walked without support: _____

Potty trained: _____

Helped when being dressed: _____

Spoke first word (other than "yes" or "no" and "mom" or "dad"): _____

Spoke first sentence: _____

Responded to being called by name: _____

Any speech, hearing, or language difficulties? _____

_____

Any issues with child recognizing and responding to his/her own name in first years of life (looking in direction of caller, coming when called, etc.)? _____

_____

Any issues with child making eye contact with caregiver during infancy and first few years of life? _____

_____

VI. MEDICAL HISTORY

***Major Medical History*:**

Please list any major medical conditions, serious illness or accidents, hospitalizations, medically necessary surgeries, or neurological events including loss-of-consciousness, seizures or convulsions.

Age	Illness/Diagnosis	Treatment(s) Received/ Medications Prescribed	Provider/Hospital	Outcome

Current Medical Provider:

Physician Name: _____

City: _____ Phone: _____

1. **What kinds of physical exercise does your child get?** _____

_____

2. **How much soda, tea, or other sources of caffeine does your child consume each day?**

_____

3. **Does your child try to restrict his/her eating in any way?** YES NO (Circle one)

If yes, describe how: _____

If yes, describe why: _____

4. **Does your child have any problems getting enough sleep?** YES NO (Circle one)

If yes, what problems (falling asleep, staying asleep)? _____

If yes, do you know what is causing the problem?_____

Average number of hours your child sleeps per night: _____

5. **Has your child ever used tobacco?** YES NO (Circle one)

If yes, please describe: _____

6. **Has your child ever used alcohol?** YES NO (Circle one)

If yes, please describe: _____

7. **Has your child ever used recreational drugs?** YES NO (Circle one)

If yes, please describe: _____

_____

Are there any other medical or physical problems you are concerned about? _____

_____

VII. MENTAL HEALTH HISTORY

Prior Mental Health Treatment

Please list any prior mental health treatment your child received and any corresponding diagnosis. Include visits to a therapist, counselor, psychiatrist, psychologist, social worker, or mental health clinic, as well as any psychiatric hospitalizations or admission to residential treatment facilities.

Age	Issue/Diagnosis	Treatment(s) Received/ Was it helpful?	Provider or Hospital	Reason for termination

Is your child currently seeing another mental health care provider (psychologist, psychiatrist, marriage & family therapist, counselor, or social worker)?

❑ No ❑ Yes *(If yes, please complete below)*

Provider's name & title: _____

Phone: _____ City: _____

How long has your child been under this provider's care? _____

Reason for care: _____

Do you plan to continue your child's care with the above provider? _____

Psychotropic Medications & Vitamins/Supplements

Please list any prescribed medications or herbal supplements that your child has taken to treat *mental health or behavioral symptoms*.

Medication	Approximate dates (or age)	Purpose	Prescribed/supervised by

Family Mental Health History

Please list any members of your child's immediate or extended family who have been either formally diagnosed or suspected to have a mental illness, *including* substance and alcohol use disorders (e.g., depression, anxiety, alcoholism, addiction).

Name & Relationship to Patient	Illness/Issue	Diagnosed (Yes/No)	Please indicate any treatment history or other notes about what you know of their illness

Safety Issues

To the best of your knowledge, has your child ever been abused? ❑ Yes ❑ Unsure ❑ No

If you answered *yes* or *unsure*, please indicate any instances below that apply:

- ❑ Emotional abuse (underline any that apply) - *Willfully causing mental suffering of a child or endangering a child's emotional well-being through: Belittling; ridiculing; humiliating; name-calling; excessive screaming, cursing, raging at child; demeaning jokes; excessive teasing about capabilities or physical appearance; refusing love, attention or touch; shunning child from family; unpredictable, unreasonable & extreme reactions; locking child out of the home to discipline or punish; threats or intimidating behaviors; unreasonable demands placed on child; excessive or unreasonable punishment for typical childhood behaviors; isolating a child from peers or prohibiting normal play/opportunities for stimulation; promoting or rewarding unhealthy or criminal behaviors; exposing child to violence in the home; exposing child to other inappropriate or traumatic events)*

- ❑ Neglect – *Failure of caregiver to provide adequate food, clothing, shelter, or supervision (may or may not result in any physical harm to child)*

- ❑ Physical abuse – *Bodily injury inflicted on a child by willful cruelty, unjustifiable punishment, or corporal punishment*

- ❑ Sexual abuse – *Victimization of a child by sexual activities including molestation, indecent exposure, fondling, rape, incest, and exposure of a child to sexually inappropriate content (verbally or visually).*

Have Child Protective Services (CPS) or law enforcement ever investigated or taken a report of suspected abuse of your child?

❑ No ❑ Yes (If *yes*, please describe the circumstances and outcome of the investigation/report):

_____

_____

_____

Has your child ever been in legal trouble with the law? ❑ No ❑ Yes (please describe):

_____

_____

Since age 8, has your child ever been in a physical fight with a peer or displayed physical violence toward an adult? ❑ No ❑ Yes (please describe): _____

_____

Has your child ever reported having thoughts of suicide/wanting to take their own life?

❑ **No** ❑ **Yes (*if yes, please compete below*)**

At what age did your child first report having these thoughts?	_____
When was the last time your child reported having these thoughts?	_____
How frequently does your child report having these thoughts (e.g., every day, every week, several times per month, once per month, once every couple of months)?	_____
Please provide examples of what your child reports to you (or others).	_____ _____
What is usually happening in your child's life when they report these thoughts?	_____ _____

Has your child ever *attempted* suicide?

❑ **No** ❑ **Yes (*if yes, please complete below)***

Age	Description of Attempt	How the Attempt was Intervened	Aftermath

Has a family member attempted or committed suicide (parent, aunt/uncle, grandparent, sibling, child)?

❑ **No** ❑ **Yes (please describe):** _____

Have your child ever engaged in any self-harming behavior (e.g., cutting)?

❑ **No** ❑ **Yes (please describe):** _____

VIII. Coping & Strengths

Briefly list any major crises that have occurred in your child's life, and how your child handled them:

_____

_____

_____

_____

What are your child's major strengths?

_____

_____

_____

When is your child happy, relaxed, or enjoying themself?

_____

_____

_____

What people and activities support or comfort your child when they are struggling?

_____

_____

IX. Goals for Therapy

In your own words, please describe what brings you and your child here today: _____

_____

_____

_____

When did this issue begin? _____

***Please check any characteristics that describe your child*:**

- ☐ **Affectionate**
- ☐ **Argues, "talks back," smart-alecky, defiant**
- ☐ **Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes**
- ☐ **Cheats**
- ☐ **Cruel to animals**
- ☐ **Concern for others**
- ☐ **Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends**
- ☐ **Complains**
- ☐ **Cries easily, feelings are easily hurt**
- ☐ **Dawdles, procrastinates, wastes time**
- ☐ **Difficulties with parent's paramour/new marriage/new family**
- ☐ **Dependent, immature**
- ☐ **Developmental delays**
- ☐ **Disrupts family activities**
- ☐ **Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules**
- ☐ **Distractible, inattentive, poor concentration, daydreams, slow to respond**
- ☐ **Dropping out of school**
- ☐ **Drug or alcohol use**
- ☐ **Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats**
- ☐ **Exercise problems**
- ☐ **Extracurricular activities interfere with academics**
- ☐ **Failure in school**
- ☐ **Fearful**
- ☐ **Fighting, hitting, violent, aggressive, hostile, threatens, destructive**
- ☐ **Fire setting**
- ☐ **Friendly, outgoing, social**
- ☐ **Hypochondriac, always complains of feeling sick**
- ☐ **Immature, "clowns around," has only younger playmates**
- ☐ **Imaginary playmates, fantasy**
- ☐ **Independent**
- ☐ **Interrupts, talks out, yells**
- ☐ **Lacks organization, unprepared**
- ☐ **Lacks respect for authority, insults, dares, provokes, manipulates**
- ☐ **Learning disability**
- ☐ **Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales**
- ☐ **Likes to be alone, withdraws, isolates**
- ☐ **Lying**
- ☐ **Low frustration tolerance, irritability**
- ☐ **Mental retardation**
- ☐ **Moody**
- ☐ **Mute, refuses to speak**
- ☐ **Nail biting**
- ☐ **Nervous**

- ☐ Nightmares
- ☐ Need for high degree of supervision at home over play/chores/schedule
- ☐ Obedient
- ☐ Obesity
- ☐ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- ☐ Oppositional, resists, refuses, does not comply, negativism
- ☐ Prejudiced, bigoted, insulting, name calling, intolerant
- ☐ Pouts
- ☐ Recent move, new school, loss of friends
- ☐ Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- ☐ Responsible qRocking or other repetitive movements
- ☐ Runs away
- ☐ Sad, unhappy
- ☐ Self-harming behaviors—biting or hitting self, head banging, scratching self
- ☐ Speech difficulties
- ☐ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ☐ Shy, timid
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing, blasphemes, bathroom language, foul language
- ☐ Temper tantrums, rages
- ☐ Thumb sucking, finger sucking, hair chewing
- ☐ Tics—involuntary rapid movements, noises, or word productions
- ☐ Teased, picked on, victimized, bullied
- ☐ Truant, school avoiding
- ☐ Underactive, slow-moving or slow-responding, lethargic
- ☐ Uncoordinated, accident-prone
- ☐ Wetting or soiling the bed or clothes

Please look back over the concerns you have checked off. Which one do you *most* want help with?

_____

What changes are you hoping therapy might lead to? _____

_____

_____

_____

_____

Thank you for taking the time to answer these questions. We look forward to helping you and your family!

PARENT CONTRACT FOR CHILD THERAPY

Prior to beginning treatment, it is important for you to understand our approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. Under HIPAA and the APA Ethics Code, we are legally and ethically responsible to provide you with informed consent. As we go forward, we will try to remind you of important issues as they arise.

Resolving Disagreements

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, we will strive to listen carefully so that we can understand your perspectives and fully explain our perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. If either custodial parent decides that therapy should end, we will honor that decision. However, we ask that you allow us the option of having a closing session to appropriately end the treatment relationship with your child.

Confidentiality of Your Child's Treatment

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. While one goal of therapy is to strengthen the child's relationship with parents or primary care givers, children experience the most therapeutic benefit when there is a "zone of privacy" whereby they are free to discuss personal matters in session. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

Information We Will Share with You Over the Course of Therapy

Note that while we will not share what your child has disclosed to us without their consent, *we will* provide you with general information about treatment status, and we will raise issues that may impact your child either inside or outside the home. We will also inform you if your child does not attend sessions, or if it is necessary to refer your child to another mental health professional with more specialized skills. If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. If we ever believe that your child is at serious risk of harming him/herself or another, we will inform you.

Limits of Our Role as Your Child's Therapist

Although our responsibility to your child may require our involvement in conflicts between the parents, we need your agreement that our involvement will be strictly limited to that which will benefit your child in the context of therapy. This means, among other things, that you will treat anything that is said in session with us as confidential, and that neither parent will attempt to gain advantage between one another or in any legal proceeding from our involvement with your children. In particular, we need your agreement that in any such legal proceedings, neither of you will ask us to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena us or to refer in any court filing to anything we have said or done.

Note that such agreement may not prevent a judge from requiring our testimony, even though we will work to prevent such an event. If we are required to testify, we are ethically bound not to give our opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, we will provide information as needed (if appropriate releases are signed or a court order is provided), but we will not make any recommendation about the final decision. Furthermore, if we are required to appear as a witness, the party responsible for our participation agrees to reimburse us at the rate of $250 per hour to include time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Please initial below to indicate your agreement to each policy:

_____If you decide to terminate treatment, we have the option of having at least one closing session with your child to properly end the treatment relationship.

_____You are waiving your right to access to your child's treatment records.

_____We will disclose information without your child's consent if necessary to protect the life of your child or another person.

_____You agree that our role is limited to providing treatment and that you will not involve us in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).

_____You also agree to instruct your attorneys not to subpoena us or to refer in any court filing to anything we have said or done in the context of treating your child.

_____If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, we will provide general information to the evaluator. This information *will not* include recommendations concerning custody or custody arrangements.

_____If, for any reason, we are required to appear as a witness, the party responsible for our participation agrees to reimburse us at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

My signature below indicates that I have read, understand, and agree to the Parent Contract for Child Therapy:

_____	_____	_____	_____
Parent Signature	Date	Parent Signature	Date
_____	_____	_____	_____
Printed Name	Relationship to Child	Printed Name	Relationship to Child

_____

CURRY
PSYCHOLOGY GROUP

POLICIES AND PROCEDURES

I. THE INITIAL INTAKE APPOINTMENT / ASSESSMENT PHASE

The first appointment is a face-to-face "intake assessment." All intake paperwork must be completed prior to the initial session. This session is an opportunity for both the client and the therapist to assess mutual compatibility for an ongoing therapy relationship. The therapist will ask questions to obtain a comprehensive history of the presenting problem and assess the best course of treatment based on your goals for therapy. Depending on the complexity of the case, a second intake appointment may be required to complete the assessment. When enough information has been gathered, the therapist will provide you with recommendations for treatment.

On some occasions, the therapist may determine that a client's needs are outside the scope of the services offered in the individual therapy setting, or that the client is unlikely to benefit from the services offered without additional supports. In such cases, the therapist will provide information and guidance regarding next steps and will assist the client in arranging any recommended appointments with outside providers or facilities to ensure that an effective plan of care is in place.

II. PAYMENT

Credit card information will be obtained at your first appointment with the Curry Psychology Group. You or your payer will be charged at the time of each appointment according to the fees outlined in the Financial Policies (see attached form). If you have an accepted insurance plan, the office will charge you the appropriate copayment as derived from your insurance company's eligibility database. If after charging for the copayment, the office comes to know through your insurance's Explanation of Benefits that the amount due is greater or less than the amount originally charged to you, the office will appropriately bill you for the difference and/or refund the excess to your patient account as applicable. The Curry Psychology Group is not liable for any copay, coinsurance, or other obligations reported to our office by your insurance company. Should you have questions regarding your coverages, please contact your insurance carrier for details. If you seek reimbursement from an insurer, our office will submit claims on your behalf at your request.

III. CANCELLATIONS

Since scheduling of an appointment involves the reservation of time specifically for you, we request notice of changes to an appointment **by noon at least one business day prior**. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Insurance companies do not reimburse for missed sessions. (For Monday appointments, cancellations must be made by noon on the previous Friday. For appointments occurring the day after a holiday, cancellations must occur by noon on the prior business day.)

IV. Routine Phone Calls & Email

Contact regarding administrative matters. Administrative and scheduling questions may be left on your provider's confidential voicemail or sent to your provider via email. On weekdays, we will typically return administrative calls and emails within 24 hours.

Contact regarding clinical matters. To ensure that we can fully attend to our clients' needs, we ask that all clinical matters be discussed in-person, over the phone, or via our secure online therapy platform to ensure that there is direct and clear communication. **Please do not contact your therapist by text message**, as this is neither a reliable nor secure mode of communication.

V. Emergency Procedures

In the event of a clinical emergency, such as acute thoughts of harming oneself or others or experiencing a traumatic life event, you may leave a message on your provider's confidential voicemail indicating the nature of the emergency, and your provider will return your call as soon as possible. Please understand that your provider may not be available, especially after-hours or on weekends. **Therefore, if you feel you are in imminent danger to yourself or others or if you feel that your health is at risk, please visit your nearest emergency room; dial 9-1-1; or call the National Crisis Lifeline day or night for free immediate support at 1-800-273-8255.**

Frequency of between-session emergency contact. Please note that requests for emergency contact between scheduled sessions is to be limited to true clinical emergencies only. In cases when a client requires more than two standard duration appointments per week, continued treatment with the provider will be contingent on the client's acceptance of a higher level of care (intensive outpatient, partial hospital, or inpatient treatment), involvement of family members in monitoring safety and compliance (if appropriate), psychiatric support with medication compliance, and/or other modifications of treatment to enhance the client's stability.

VI. The Roles of Therapist versus Evaluator

Litigation Limitation. The ethics and rules of our profession preclude us from serving in a dual-role of therapist and evaluator. As your therapist, we will not be conducting a formal evaluation and therefore do not have a valid and reliable basis from which to provide an expert opinion to any third party. Furthermore, due to the private nature of the therapeutic process, it is agreed that this process should be protected and should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on our clinicians to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Letters & Other Statements of Opinion. Similarly, we do not provide statements of opinion or recommendations in written letter, report, or client forms, unless explicitly retained for the purposes

of a psychological evaluation. If an established therapy client requires evaluative services, we will provide appropriate referrals.

VII. Termination of Treatment by the Provider

The Curry Psychology Group reserves the right to terminate treatment under certain conditions which compromise the therapist's ability to provide effective services, the client's ability to benefit from services, or when it is legally and/or ethically appropriate to do so. Such circumstances include, but are not limited to:

- Three missed appointments or late-cancellations within a six-month period
- Non-adherence to the treatment plan
- Non-compliance with practice policies & procedures
- Refusal to accept a higher level of care or supplemental care when clinically indicated
- Behaviors that are disrespectful, devaluing, threatening, or otherwise inappropriate toward the provider, staff, other clients, or any persons present in the building
- Misrepresentation or omission of pertinent clinical information
- Non-payment of fees

VIII. Privacy

The Curry Psychology Group will not disclose details of your treatment nor your medical record to third parties without your written approval. Our providers operate in accordance with the HIPAA laws. By signing our policies document, you acknowledge that you understand your rights under the HIPAA laws and can freely discuss these rights with your provider. You understand that if you are not the payer for services provided, matters related to billing may be discussed with the payer. You also acknowledge that you have received notice of the privacy policies.

IX. Limits of Confidentiality

Information collected by providers in evaluation and treatment of patients is considered confidential. However, there are certain instances where such healthcare providers are required or allowed by law to make exceptions to this confidentiality. Examples of these situations include the following:

1. The patient authorizes a signed release of information to a designated recipient.
2. The therapist is provided with information leading her to believe that a patient is at risk for harming self or others, or is unable to meet his/her basic needs.
3. Information presented to the therapist that indicates that child or elder abuse/neglect is occurring.
4. A court has ordered release of records.
5. Other reporting requirements mandate release of client information (i.e., a client with dementia whose ability to operate a motor vehicle is potentially compromised).
6. A third-party payer (i.e., an insurance company) is involved in payment. Insurance companies usually require information on dates or service, diagnoses, and types of office visit, but other information may be required before payment is authorized.

X. Consent to Treatment

I acknowledge that I have received and have read (or have had read to me) the introductory forms provided to me about the therapy I am considering. I have had all my questions answered fully.

I understand that developing a treatment plan with my provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided.

I am aware that I may stop my treatment with this provider at any time. The only thing I will still be responsible for is paying for the services I have already received.

By signing below, I acknowledge that I have read the above policies/procedures and am undertaking treatment with the Curry Psychology Group with full awareness and acceptance of the policies and procedures governing this practice:

_____ _____

Signature of Client or Guardian **Date**

_____

Printed Name

CURRY
PSYCHOLOGY GROUP

NOTICE OF PRIVACY PRACTICES:
CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION TO ARRANGE TREATMENT

This form is an agreement between you, and your provider/"us"/"we." When we use the words "you" and "your" below, this can mean you, your child, or some other person who will be receiving care and to whom you are an authorized representative/guardian.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the sole purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you.

In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling our office. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our office/your provider. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____
Signature of Client (or Guardian/Representative) Date

_____
Printed Name of Client

_____ _____
Printed Name of Guardian/Representative Relationship to Client

AGREEMENT TO PAY FOR PSYCHOLOGICAL SERVICES

CANCELATION POLICY (ALL CLIENTS):

Please contact the office at 949-258-9777 to cancel any upcoming appointment. Cancellation of an appointment must be made by noon on the business day prior to the appointment. Since alternative bookings are unlikely after that time, our policy includes a charge of the full session fee for "no show" or late cancellations occurring with insufficient notice. This represents the amount of time reserved for your service. Note that this fee is not eligible for payment or reimbursement by insurance.

If cancelling an appointment that is scheduled on a Monday, notice must be received by our office on the Friday prior to the appointment. Cancellations received during the weekend will be considered late and the fee will apply. Similarly, if an appointment is scheduled the day after a holiday, notice of intent to cancel must be received by the last business day prior to the holiday.

PAYMENT POLICY:

You or your payer will be charged at the time of each appointment according to the fees outlined in the attached fee schedule. We are in-network with Tricare West military insurance. We also bill out-of-network insurance plans with a deposit for the full service fee. Credit card information will be obtained at your first appointment with the Curry Psychology Group and automatic payments can be arranged for future sessions. Acceptable payment methods include credit card and cash.

To check your out-of-network insurance benefits, we recommend that clients contact their insurer at the number listed on the back of their insurance card to ask the following questions:

1. Does my plan include out-of-network benefits for mental health/behavioral healthcare?
2. What is the maximum allowed amount if I receive individual psychotherapy, service code 90837, at an office, with a psychologist?
3. What percentage of the allowed amount does my plan pay?
4. Do I have an insurance deductible that I would have to pay before my out-of-network benefits are provided?

TRICARE WEST/MILITARY BENEFICIARIES:

Clients with Tricare West will be charged the appropriate copayment or deductible fee (as shown to our office from Tricare West's eligibility database) at the time of each appointment.

If, after charging for the copayment or deductible fee, the office comes to know through your insurance's Explanation of Benefits that the client's amount due is greater or less than the amount originally charged to the client, the office will bill the client for the balance *or* refund the excess to your patient account as applicable. The client accepts financial responsibility for all eligible services that are not paid by their insurance plan within 30 days of the date of service.

FEE SCHEDULE BY PROVIDER

SERVICES OFFERED	DR. SHANNON CURRY	DR. NICOLLE BUGESCU	KARI FISHER, MSW, ACSW	DR. CAREY INCLEDON	DR. FRANCESCA PARKER
Therapy Services					
INITIAL INTAKE APPOINTMENT	300. (55 min)	175. (50 min)	150. (50 min)	150. (50 min)	150. (50 min)
INDIVIDUAL THERAPY (ADULT OR CHILD)	250. (55 min)	175. (50 min)	150. (50 min)	150. (50 min)	150. (50 min)
FAMILY THERAPY	275. (55 min)	200. (50 min)	175. (50 min)	175. (50 min)	175. (50 min)
GOTTMAN COUPLES THERAPY 90-MIN APPOINTMENT Initial Assessment Final Assessment Extended Sessions	450. (90 min)	NA	NA	270. (90 min)	NA
GOTTMAN COUPLES THERAPY STANDARD APPOINTMENT	275. (55 min)	NA	NA	150. (50 min)	NA
Supplemental Services					
BETWEEN-SESSION PHONE CONTACT Per 15 min	75.	60.	50.	50.	50.
LETTERS AND FORM COMPLETION Per 30 min	150.	120.	90.	90.	90.
Testing & Educational Support Services					
PSYCHOEDUCATIONAL & DIAGNOSTIC ASSESSMENT (Includes Interview, Collateral Data Collection, Testing, Score Interpretation & Report Writing)	NA	200./hour with retainer	NA	180./hour with retainer	NA
SCHOOL VISITS/IEP MEETINGS Up to first 90 min (includes drive time)	NA	360. (≤90 min)	270. (≤90 min)	270. (≤90 min)	NA
Other Assessment Services					
FORENSIC PSYCHOLOGICAL ASSESSMENT	Contact for fees	NA	NA	NA	NA

By signing below the Client or Guardian indicates their understanding and agreement to the Curry Psychology Group's payment policies and fees as outlined in this document.

_____ _____

Signature of Client (or Guardian) **Date**

_____

Printed Name

CURRY PSYCHOLOGY GROUP
200 NEWPORT CENTER DR., SUITE 204, NEWPORT BEACH, CA 92660 | T. 949.258.9777 | F. 949.258.9749 | CONTACTUS@CURRYGROUP.ORG

Electronic Payment Authorization

Please enter the card information you wish to keep on file for automatic deduction of your session fee, copayment, or insurance deductible (if applicable). Only fees which have been previously disclosed and agreed to by you per the "Agreement to Pay for Psychological Services" will be charged.

The following credit and debit cards are accepted: Visa, MasterCard, Discover and AMEX.

Client Name: _____

Cardholder Information (*Please indicate the name and address associated with the credit or debit card you wish to use*):

Cardholder Name: _____

Address: _____ City_____ State: _____ Zip: _____

Main Phone Number: _____ Email: _____

Credit/Debit Card Information:

Card Type (check one): ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Card Number: _____

Expiration Date: _____ Security Code (3-digit code on back of card): _____

I, the cardholder, authorize fees for services rendered by this practice to be deducted from the credit or debit card listed above.

_____ _____
Cardholder Signature Date