NAOMI C. BABCOCK, MSSA, LCSW **Child Therapist**

CLIENT INFORMATION:

Patient Name: ______________________ ______________
Last First Date of Birth

Parent Name: ______________________
(Guardian) Last First

Address: ____

Contact Info: ____
(Guardian) Home Work Cellular E-Mail

Grade Level: ____________ School: ____________

FINANCIAL RESPONSIBILITY:

Name of Insured: ______________________ ______________
Last First Date of Birth

Insurance Co.: ____________ Phone: ____________

Member ID: ____________ Policy/Group#: ____________

Employer: ____________ SSN: ____________

The client or responsible party is responsible for payment of professional services. Signature below certifies claim information and authorizes payment of benefits to the therapist rendering services, unless the client has paid in full at the time of services.

Signature: ______________________ **Date:** ______________________

1425 West Elliot, Suite 201 • Gilbert, AZ 85233 • 480.208.5029

PERSONAL INFORMATION:

Reason for Counseling: ______________________________

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Previous Counseling: ______________________________

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Referred By: ______________________________

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Current Medication: ______________________________

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Medical Issues: ______________________________

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PARENT CONCERNS (please circle all that apply)

Academic Problems	Assaultive	Attention Seeking
Communication Issues	Defiant Behavior	Delusions
Depressed	Destructive to Property	Developmental Delay
Disruptive in School	Hyperactive/Impulsive	Poor Concentration
Learning Problems	Lying	Sleep Disorder
Over-anxious	Poor Peer Relations	Poor Self Esteem
Self Mutilation	Sensory Issues	Abuse (Physical/Sexual)
Social Withdrawal	Suicidal Thoughts	Temper Tantrums
Truancy	Unrealistic Fears	Separation Anxiety

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NOTICE OF PRIVACY:

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

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, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. 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.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

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. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

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

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about

either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $85 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Signature: ______________________________ **Date:** ______________________________

SERVICES PROVIDED:

Individual Services:

Therapy Session: Managed Care

- Initial Phone Consult (15 minutes) Free
- Intake Session (60-90 minutes) Insurance Copay (varies by coverage)
- Ongoing Session (45-50 minutes) Insurance Copay (varies by coverage)
- Onsite Visit (45-50 minutes) Insurance Copay (varies by coverage)

Therapy Session: Out of Pocket

- Initial Phone Consult (15 minutes) Free
- Intake Session (60-90 minutes) $115-185
- Ongoing Session (45-50 minutes) $115
- Onsite Visit (45-50 minutes) $115

Income Based: Sliding Scale*

	Family Members				
Annual Income	**1**	**2**	**3**	**4**	**5**
$30,000 or less	$55	$55	$45	$40	$40
$30,000 to $44,999	$65	$65	$55	$45	$40
$45,000 to $59,999	$75	$75	$65	$55	$50
$60,000 or greater	$115	$115	$115	$115	$115

- E-Mail Consultation Varies

Consulting Services:

- Day Care Faculty Training $85 per hour

* As referenced by the higher of total household AGI from prior year's 1040 or annualized current year income.

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