1. CHILD & ADOLESCENT INTAKE PACKET

Today's date: / /

Who referred your child to therapy?

Child's Name: Date of Birth: / / Age:

Parent's Name (1): Parent's Name (2):

Step-Mother's Name: Step-Father's Name:

Legal Guardian's Name (*if applicable*):

Address: City: State: Zip:

Parent E-mail (s):

Child's Cell: Home:

Parent's Cell (1): Parent's Cell (2):

Parent's Work (1): Parent's Work (2):

Emergency Contact (outside immediate family):

Name: Relationship: Number:

Primary Care Physician: Phone:

Is your child in school or in daycare? (If applicable, please indicate which one)

School/Daycare Name: Grade (if applicable): School Daycare Address:

School/ Daycare Phone: How many hours per week?:

Has the # of hours dramatically changed in the past 6 months? Yes ☐ No ☐ If yes, explain:

Is there someone you would like us to contact at the child's school/daycare (e.g., teacher, administrator, counselor)?

Name:

Phone: E-Mail:

Does your child have an Individualized Education Plan (IEP)? Yes ☐ No ☐

If applicable, please specify classification, classroom type and accommodations:

If not applicable, does your child receive any special accommodations in school (e.g., 504)? Yes☐No☐

If yes, please specify:

Has it ever been recommended and/or has your child been held back a grade? Yes ☐ No ☐

If yes, please explain:

Has your child ever been suspended or expelled from school? Yes ☐ No ☐
If yes, please explain:

FAMILY INFORMATION

Please list all individuals who are currently living in child's **primary** residence:

Name	Relationship to Child	Age

If applicable, please list all individuals who are currently living in child's **secondary** residence:

Name	Relationship to Child	Age

Child's parents are: (*check one*) Single ☐ Married ☐ Cohabiting ☐ Separated ☐ Divorced ☐ Widowed ☐

Parent's Occupation (1) : Parent's Occupation (2):

Step-Parent's Occupation (1): Step-Parent's Occupation (2):

Have there ever been any deaths of or separations from parents, family members, nannies, babysitters, or friends with whom patient was close or had frequent contact? (*Check one*) Yes ☐ No ☐
If yes, please explain and include dates of separation/loss and relationship to child:

Have any family members had emotional or psychiatric problems? (Check *one*) Yes ☐ No ☐
If yes, please indicate who? What was the nature of their difficulties? Was treatment sought?

DEVELOPMENTAL HISTORY

Pregnancy/Delivery/Developmental History:
(If your child was adopted, please fill out the information as best you can and go to the next page.)

Please list any complications the child's mother had during pregnancy or delivery:

Child was born (Check *one*):

PRE-TERM By # days ☐ ON-TIME ☐ POST-TERM By # days ☐ Birth Weight lbs oz

Head Size

At what age did your child achieve these developmental milestones?

CRAWLING: WALKING: TALKING (single words):

TALKING (sentences): TOILET TRAINING: READING:

Did/do you have any concerns regarding your child's development from ages 0 to 5 years old?

EXCESSIVE CRYING: Yes ☐ No ☐ HYPERACTIVITY: Yes ☐ No ☐ SPEECH: Yes ☐ No ☐

FEEDING PROBLEMS: Yes ☐ No ☐ SLEEP: Yes ☐ No ☐ HEARING: Yes ☐ No ☐

MOVEMENT: Yes ☐ No ☐ SOCIAL RELATEDNESS: Yes ☐ No ☐ VISION: Yes ☐ No ☐

COMMUNICATION: Yes ☐ No ☐ SEPARATION FROM CAREGIVER: Yes ☐ No ☐ MUSCLE TONE: Yes ☐ No ☐

SENSORY ISSUE: Yes ☐ No ☐ (If yes, please indicate if they are overly sensitive or under-responsive to taste, touch, smell, vision, or sound)

If you answered yes to any of the items above, please describe and indicate if professional evaluation (e.g., Early Intervention, CPSE, CSE, neuropsychological) and/or intervention was pursued (e.g., Occupation Therapy, Physical Therapy, Speech Therapy):

Please provide any other important information about your child's development that you feel is important:

ADOPTION HISTORY *(Please skip section if not applicable.)*

At what age was your child placed for adoption? What country was your child born in?

Where did your child live before he/she came to live with you (e.g., orphanage, biological parents, biological family members, foster care)? What were the conditions like in the child's previous home(s)?

What does your child know about his/her biological parents?

What information about his/her biological parents or the circumstances of his/her adoption have you kept from your child out of concern for its impact on his/her well-being?

Does your child have other biological full or half-siblings? (*Check One)* Yes ☐ No ☐
If yes, do you or your child know their whereabouts?

Was your child the victim of suspected or confirmed neglect, physical or sexual abuse? (*Check One)* Yes ☐ No ☐
If yes, please describe:

Please discuss the circumstances surrounding your (and your spouse/partner's) decision to adopt a child:

Does your adopted child evidence any of the following behaviors? (*Please circle):*

RUNNING AWAY ☐	EXCESSIVE CLINGING ☐	SEXUALIZED BEHAVIORS ☐	AGGRESSIVE BEHAVIORS ☐
DIFFICULTY WITH SLEEP OR BEDTIME ☐	DIFFICULTY RELATING TO PEERS ☐	PHYSICAL DEVELOPMENTAL DELAYS ☐	LYING OR STEALING ☐

MEDICAL HISTORY

Please list your child's medical problems (*from infancy to present time*):

Hospitalizations / Surgeries:

Dates	Reason for Hospitalization/Surgery

Current Medications for Medical Issues:

Rx Name: Dosage: mg Start Date: / /

Rx Name: Dosage: mg Start Date: / /

PSYCHOSOCIAL HISTORY

Was your child the victim of suspected or confirmed neglect, physical or sexual abuse? (*Check One)* Yes ☐ No ☐
If yes, please describe:

TREATMENT HISTORY

Has your child ever had psychological / psychiatric treatment of any kind? (*Check One)* Yes ☐ No ☐ *If yes, please detail below:*

Mode of Treatment	Dates	Reason for treatment
OUTPATIENT		
Individual		
Family		
Group		
Other		
INPATIENT		
Hospitalization		

Has your child *ever* taken medication for a psychiatric problem? Yes ☐ No ☐

If yes, please list the names, dosage, &start date and end date, if applicable:

Rx Name: Dosage: mg Start Date: / / End Date: / /

Rx Name: Dosage: mg Start Date: / / End Date: / /

Rx Name: Dosage: mg Start Date: / / End Date: / /

Rx Name: Dosage: mg Start Date: / / End Date: / /

Rx Name: Dosage: mg Start Date: / / End Date: / /

Rx Name: Dosage: mg Start Date: / / End Date: / /

If currently prescribed medication, please list the name, address, and telephone number of his/her prescribing psychiatrist:

Name:

Address:

City: State: Zip:

Office#: Email:

REASON FOR REFERRAL

Please check the issues or symptoms you are currently concerned about with respect to your child (check all that apply):

SAD/DEPRESSED MOOD ☐	SLEEP DISTURBANCES ☐	HEARING VOICES ☐
WORRIES/ANXIETY ☐	NIGHTMARES ☐	SEEING THINGS OTHERS DON'T SEE ☐
WITHDRAWN ☐	POOR ATTENTION/ CONCENTRATION ☐	INNAPROPRIATE SEXUAL BEHAVIOR ☐
IRRITABLE ☐	HYPERACTIVITY ☐	SHYNESS ☐
PHYSICAL AGRESSION/ FIGHTING ☐	ACADEMIC PERFORMANCE ☐	SOCIAL SKILLS ☐
DECREASED/INCREASED APPETITE ☐	SCHOOL ATTENDANCE ☐	BULLYING OR BULLIED ☐
RESTRICTIVE EATING/ BINGING OR PURGING ☐	OPPOSITIONAL/ DEFIANT TOWARDS ADULTS ☐	CONFLICTS IN FAMILY RELATIONSHIPS ☐
BEREAVEMENT ☐	STEALING/LYING ☐	ALCOHOL/DRUG USE ☐
TRAUMA ☐	SELF-INJURIOUS BEHAVIOR (e.g. Cutting) ☐	WETTING/SOILING BED OR PANTS ☐
PARENTAL DIVORCE/ SEPARATION ☐	SUICIDAL THOUGHTS ☐	REPETITIVE BEHAVIORS (e.g., Hand Washing) ☐
TANTRUMS ☐	LOW SELF-ESTEEM ☐	PHYSICAL DEVELOPMENTAL DELAYS ☐
RUNNING AWAY ☐	EXCESSIVE CLINGING ☐	OTHER: (Specify)

Please elaborate on the reasons circled above and describe why you are seeking treatment for your child:

When did these difficulties begin? Did any specific event occur prior to them beginning?

PARENTING CHALLENGES

Please checkthe issues you are currently concerned about in relation to your role as a parent:

HELPING CHILD TRANSITION ☐	MAKING A ROUTINE ☐	HAVING TIME TO MYSELF ☐
ENFORCING RULES OR LIMITS ☐	COORDINATING WITH THE OTHER PARENT/CAREGIVER(S) ☐	TALKING TO MY CHILD ABOUT DIFFICULT TOPICS ☐
ASSISTING MY CHILD ACADEMICALLY ☐	SOOTHING MY CHILD ☐	MANAGING TANTRUMS ☐
FIGURING OUT WHAT MY CHILD IS FEELINGAND THINKING ☐	DOUBTING MY ABILITIES AS A PARENT ☐	FEELING UNAPPRECIATED BY MY CHILD ☐
TIRED AND FRUSTRATED A LOT ☐	FEELING LIKE I LOSE CONTROL IN FRONT OF MY CHILD ☐	AFRAID OF WHAT MY CHILD WILL DO OR SAY ☐
NO TIME TO PLAY OR ENJOY TIME WITH MY CHILD ☐	PROFESSIONAL OR PERSONAL ISSUES INTERFERRING ☐	MY MOOD/ANXIETY INTERFERRING ☐
PREOCCUPATION WITH MY OWN EXPERIENCES AS A CHILD ☐	MANAGING MY CHILD AND HIS/HER SIBLING(S) ☐	HELPING CHILD ADJUST TO DIVORCE, SEPARATIONS, LOSSES ☐
PREOCCUPIED WITH PAST TRAUMA ☐	UNSURE HOW TO APPROACH TOPIC OF ADOPTION ☐	FEELINGS OF RESENTMENT TOWARD MY CHILD ☐

Please elaborate on the reasons circled above and/ or identify and elaborate on additional issues not mentioned:

When did these difficulties begin? Did any specific event occur prior to them beginning?

Please describe any other issues, questions, or concerns you have about your child.

Informed Consent and Treatment Agreement

STARTING THERAPY FOR/WITH MY CHILD

Prior to beginning treatment, it is important for you to understand Rennicke & Associates approach to treatment with you and/or your child and to agree to some guidelines about fees, cancellation policies, and confidentiality. It is important to all of the therapists at Rennicke & Associates that our clients and their families are empowered with information so that their treatment can be successful.

WHO KNOWS WHAT & HOW

"Will I find out what is happening in my child's therapy sessions?"

At Rennicke & Associates, we believe parents are the experts on their children and that your active participation in treatment is essential to your child's long-term health and development. We believe so strongly in parents' role in treatment that we frequently work in a family model of treatment, where parents are included in the therapy sessions. In these instances, you will be participating and aware of what issues your child is talking about in treatment.

Depending on the age of your child and the issue that they are struggling with, your child's therapist might decide to meet individually with your child. When your child is meeting one-on-one with their therapist, it is often necessary for them to develop a "zone of privacy" whereby they feel more open to discuss personal matters with greater ease and safety. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. In these instances, we ask parents to allow their child to have a private space to discuss matters that are troubling them.

Even when meeting individually with your child, it is Rennicke & Associates policy to provide you with general information about your child's treatment status and attendance through regular parent meetings and correspondence. In addition, your child's therapist will let you know if it is necessary to refer your child to another mental health professional with certain 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. You and your child's therapist must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If your therapist ever believes that your child is at serious risk of harming him/herself or another, they will inform you.

"Will other therapists at Rennicke & Associates know about my child's sessions?"

Rennicke & Associates is a *continuous learning environment*, which means that all of our therapists are engaged in ongoing professional development and training. You should know about the following:

- SUPERVISION/CONSULTATION: Some of our staff are trainees (e.g. postdoctoral fellows, psychology externs), which means that they have not received their professional license to practice psychotherapy independently and require a supervisor to provide treatment. In addition, all of our licensed staff meets with the clinic director, Courtney Rennicke, Ph.D., to discuss administrative and clinical issues. If your therapist has a supervisor other than Dr. Rennicke, they will provide you with the name and contact information of the staff member(s) supervising their cases.

- CASE CONFERENCE: Our staff meets together once a week to discuss new psychotherapy research and techniques, to talk with other experts in the field, and often to talk with each other about our cases so that our clients get the benefit of many minds thinking together to provide you with the best possible level of care. If you decide to pursue treatment at Rennicke & Associates, your child's case might be discussed in this setting. All of the staff present at Rennicke & Associates case conference meetings abide by HIPAA rules about confidentiality.

"What happens if my partner/spouse and I become separated or are involved in divorce proceedings?"

If you are co-parenting, your child's therapist at Rennicke & Associates will only get involved in situations that they decide will benefit your child and are relevant to the agreed upon treatment goals. This means, among other things, that if you are married and begin a process of legal separation or divorce, or are divorced already, you will treat anything that is said in session with your child's therapist as ***confidential***. Neither you nor

your former partner will attempt to gain advantage in any legal proceeding between the two of you from the clinician's involvement with your child.

It is not our role nor is it ethical for your child's therapist at Rennicke & Associates to provide testimony or a forensic evaluation for custody agreements. In particular, Rennicke & Associates needs your understanding that in any such separation, divorce or child custody proceedings, ***neither you nor your former spouse will ask your clinician to testify in court***, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena the clinician or to refer in any court filing to anything your therapist has said or done. If such a subpoena occurs, you will be charged your child's hourly rate for all of the clinician's preparation time for testifying, as well as all their time in court.

ONCE YOUR CHILD STARTS THERAPY

We want to prevent misunderstandings regarding your child's attendance and payment for sessions, as well as give you information about what to expect in their therapy session. We think it is important to know about:

- ATTENDANCE: Once your child starts treatment, s/he will reserve a specific time to meet with their therapist, typically once a week for 50 or 60 minutes. We all run a little late from time to time, so it is important to know that if your child comes **late to session**, it unfortunately means that they will lose time from that session.

- TOUCH: Touch is a normal part of your interactions with your child outside of the therapy room. When you are present in session, it is also important to harness the positive impact of touch with your child, which can relieve their stress, decrease anxiety and depression, and increase their comfort. Depending on the type of therapy your child is starting, your therapist might also use touch to help organize your child or to model nurturing and connecting activities for you and your child to do together. At all times our goal is to maintain safety and meet the developmental needs of your child, therefore touch will only be initiated with you and your child's expressed permission.

- VIDEOTAPING: Videotaping of sessions is standard practice at Rennicke & Associates, and by signing a separate video consent form with your therapist, you can agree to let you and/or your child be recorded as part of their treatment. Videotaping might be required for certain types of treatment at Rennicke & Associates, which your child's therapist will discuss with you. Reviewing video of sessions is an invaluable resource to our clinicians to improve their skills and enhance their conceptualization of your child's case, as well as provide potential learning tools for you as parents.

FEE

I understand that my child's therapist and I will agree on a starting fee for treatment. I also understand that my child's therapist has the right to increase my child's session fee at any time by giving me verbal and/or written notice at least **4 weeks** in advance of the fee increase.

PAYMENT

I understand that payment is due in full at the end of each session. If I fail to pay for two or more consecutive sessions, my child's therapist has the right to stop treatment with my child and refer him/her to another appropriate treatment provider. I will pay by cash, check or credit card (Discover, MasterCard, or Visa). If I choose to pay by cash or check, I agree to leave a debit or credit card on file in the event that I delay payment for my child's sessions by 10 or more days from the date of service. In the event that my check is returned for insufficient funds, I understand that a $20 fee will be incurred.

CANCELLATION POLICY

I understand that a **full fee is charged for cancellation for any reason**, which includes, but is not exclusive to: illnesses, medical emergencies, child care conflicts, travel delays, and school demands. If my child has to miss a session, I or he/she will notify their therapist at least **24 hours in advance** via e-mail at **info@rennickeassociates.com** in order to avoid incurring the charge of my session fee. ***If I do not give 24 hours advanced notice, I understand that I will be charged for a full session.***

PHONE/VIDEO SESSIONS AND CONSULTATIONS

I understand that phone or video therapy sessions will be **conducted only in emergency situations** or under special circumstances that have been negotiated and agreed upon between Rennicke & Associates, myself and my child. In the event of a phone session, I will incur all long distance charges.

I understand that phone or video sessions conducted with my child, or for consultations conducted at my expressed request with other professionals (e.g., my child's teacher or school psychologist), which I have provided my child's therapist a written release of information to contact, are **prorated and billed** on the basis of my child's full session rate. I understand billing for these consultation sessions begins **only after the first 15 minutes** of the phone conversation or consultation and will paid in full at the completion of the consultation.

I have read and reviewed RENNICKE & ASSOCIATES' confidentiality, cancellation and fee policies and agree to abide by them:

Please **initial** the points below and include your signature at the bottom to indicate your agreement with Rennicke & Associates' child therapy policies:

LEGAL GUARDIAN:

☐I am the legal guardian/personal representative of my child and am legally empowered to make medical decisions on their behalf.

OR

☐I share custody of my child and have provided written documents that detail my legal authority to decide to start psychotherapy for my child in agreement with my child's other parent.

PRIVACY:

☐ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

WHEN THERAPIST WILL BREAK CONFIDENTIALITY:

☐I understand that I will be informed about situations that could seriously endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment.

FEES & CANCELATION POLICY

☐I understand that I will be charged my full regular rate if I or my child cancels less than 24 hours in advance for any reason.

☐I understand that for consultation phone calls lasting longer than 15 minutes, for intake reports, for letters written on my child's behalf that I will be charged on a prorated rate based on my child's therapist's hourly rate.

Parent Signature _____ Date___/____/_____

Parent Printed Name_____

DEBIT/CREDIT CARD AUTHORIZATION FORM

Please indicate how you would like to use your debit/credit card:

☐ I would like to put my card on file to pay **regularly** (e.g. weekly, bimonthly) for my child's sessions.

☐ I am planning to pay by cash or check and would like to put my card on file to be used only in the event that **I delay payment** by 10 or more days from the date of service or for use on an **emergency basis** with my expressed verbal consent.

Client Name:

Card Holder's Name (*If different from above)*:

Billing Address:

City: **State:** **Zip:**

Billing Phone:

Debit/Credit Card Type (*Please check one)*:

☐Discover ☐MasterCard ☐Visa

Debit/Credit Card Number:

Exp. Date: /

Security Code: (*This is a 3 to 4 digit number on the back of your debit/credit card*).

I authorize RENNICKE & ASSOCIATES to charge the debit or credit card listed above in accordance with the terms of the cancellation and fee policies agreement.

AGREEMENT: By typing my name is the space provided below, I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.
By printing my name below, I accept the conditions.

Card Holder's Signature: *First name* *Last name*

HIPAA NEW YORK NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

HIPAA PROVIDES INDIVIDUALS WITH CERTAIN RIGHTS RELATED TO THEIR PROTECTED HEALTH INFORMATION (PHI), INCLUDING THE RIGHT TO REQUEST THEIR PHI BE KEPT CONFIDENTIAL. ALTHOUGH MINORS DO NOT GENERALLY HAVE THE AUTHORITY TO EXERCISE RIGHTS ON THEIR OWN BEHALF, STATE LAW AND HIPAA PROVIDE MINORS WITH THE AUTHORITY TO EXERCISE CONTROL OVER CERTAIN CATEGORIES OF THEIR OWN PHI, INCLUDING OUTPATIENT MENTAL HEALTH TREATMENT FOR CHILDREN OVER THE AGE OF 12.

THIS POLICY DESCRIBES WHEN, AND UNDER WHAT CIRCUMSTANCES, THE MINOR'S HEALTH CARE PROVIDER MUST MAINTAIN THE CONFIDENTIALITY OF A MINOR'S PHI WHEN IT IS REQUESTED BY THE MINOR'S PERSONAL REPRESENTATIVE. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your child's *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "***Minor***" refers to an individual who is under 18 years of age, and who is neither married nor the parent of a child.

- ***"Minor's personal representative"*** is the minor's parent, legal guardian, or another with documentation proving he/she has legal custody of the minor (e.g., a stepparent who presents valid custody papers).

- "***PHI***" refers to protected health information, which is demographic and health information that could identify your child.

- ***"Treatment, Payment and Health Care Operations"***
  - *Treatment* is when I provide, coordinate or manage your child's health care and other services related to your child's health care. An example of treatment would be when I consult with another health care provider, such as your child's physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your child's PHI to your health insurer to obtain reimbursement for your child's health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "***Use***" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies your child.

- "***Disclosure***" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about your child to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization, or release of information, from you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- ***Child Abuse***: If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment, or the local child protective services agency.

  Further, if I reasonably believe a minor has been or is subject to domestic violence, abuse, and/or neglect by the minor's personal representative and that keeping the minor's PHI related to the abuse confidential is in the best interests of the minor, I may refuse to release or provide access to the minor's abuse-related PHI to the minor's personal representative.

- ***Health Oversight***: If there is an inquiry or complaint about my professional conduct to the New York State Board for Psychology, I must furnish to the New York Commissioner of Education, your child's confidential mental health records relevant to this inquiry.

- ***Judicial or Administrative Proceedings***: If your child is involved in a court proceeding and a request is made for information about the professional services that I have provided him/her and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when your child is being evaluated by a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

- ***Serious Threat to Health or Safety***: I may disclose your confidential information to protect your child or others from a serious threat of harm by your child.

- ***Worker's Compensation***: If your child file a worker's compensation claim, and I am treating your child for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- ***Minor's Right to Consent to Treatment***. A minor who is over the age of twelve (12) may seek and receive mental health outpatient services independently from his/her personal representative. (Parental consent is not required.) The minor's personal representative does not have the right to the minor's PHI if the minor alone consented to the treatment, unless the minor authorizes the release.

- ***Right to Request Restrictions:*** As your child's personal representative, you have the right to request restrictions on certain uses and disclosures of protected health information about your child. However, I am not required to agree to a restriction you request for your child.

- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative

locations. (For example, you may not want a family member to know that your child is seeing me. Upon your request, I will send his/her bills to another address.)

- ***Right to Inspect and Copy:*** You have the right to inspect or obtain a copy (or both) of PHI in your child's mental health and billing records used to make decisions about your child for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- ***Right to Amend***: You have the right to request an amendment of your child's PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- ***Right to an Accounting***: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- ***Right to a Paper Copy:*** You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with an updated copy if your child is still in therapy with me. If we have ended therapy, you may request an updated copy to be sent to you by mail.

V. Questions and Complaints

If you are concerned that I have violated your child's privacy rights, or you disagree with a decision I made about access to your child's records, please contact Dr. Courtney Rennicke at (212) 337-3565 or info@rennickeassociates.com about your concerns. If you do not feel comfortable doing this, you may call The New York State Psychology Licensing Board at 1-800-442-8106 or send an email to conduct@mail.nysed.gov with your questions or a complaint. You may also address your complaints to the Secretary of the U.S. Department of Health and Human Services by obtaining their contact information on their website at www.hhs.gov/ocr/hipaa.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 9, 2009.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by providing you with a paper copy at our next session from the date of revision. If your child is no longer in therapy, I will provide a revised notice only at your written request.

VII. Consent for Treatment

I have read and understood this policy statement. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to have my child participate in this intake evaluation and/or treatment. I understand that I may withdraw my child from treatment at any time.

Typed Name of Patient:

Typed Name of Personal Representative: **Date:**

AGREEMENT: By typing my name is the space provided above, I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.

By typing my name above, I accept the conditions.

Clinician's Digital Signature: **Date:**