PARTNERS
IN PARENTING

1617 Monument Avenue, Suite 202
Richmond, Virginia 23220
Phone: (804) 442-7192
www.piprva.com

Child & Adolescent Background Information

Thank you for taking the time to complete this form and returning it to us as soon possible. The information you provide will enable the child's therapist to have a better understanding of the childand will help in his or her evaluation and treatment.

Today's Date: _____

Child's Legal Name: _____ Preferred Name: _____
Last First Middle

Date of Birth: _____ Age: _____ Race/Ethnicity: _____

Sex: _____ Gender Identity: _____ Pronouns: _____

Home Address: _____

School Child Attends: _____ Grade: _____

School's Address: _____

School's Phone #: _____ Fax #: _____

Teacher's Name, phone number, and email address:

_____

Guidance Counselor's Name, phone number, and email address:

_____

Name of Child's Pediatrician/Family Doctor: _____

Referred by: _____ Phone: _____

Child Lives with: ☐Two biological parents ☐Shared custody ☐ Adoptive parent(s)

☐Foster parent(s) ☐One Parent ☐ Other _____

Parent One Name: _____ DOB: _____

Home Address: _____
If different from child

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Employer: _____

What is your preferred method of contact? _____

Parent Two Name:_____DOB: _____

Home Address: _____
If different from child

Primary Phone:_____Secondary Phone: _____

Email Address: _____

Employer: _____

What is your preferred method of contact? _____

If divorced/separated, child lives with: **Parent One**)_____% of time **Parent Two**)_____% of time

Who has legal custody? ☐Parent One ☐Parent Two ☐Shared custody

☐Other (Foster Home, Social Services, Relative, etc.) _____

Has non-custodial parent been informed of this treatment or evaluation? Yes ☐ No ☐

If shared legal custody, non-custodial parent must sign all release forms and consent totreatment forms.

REASON FOR REFERRAL: List the major concerns facing the family. If you are requesting a psychological evaluation, please let us know what questions you hope to have answered by thisevaluation.

_____

_____

_____

_____

_____

_____

_____

Please bring in copies of the child's most recent evaluations, IEPs, and report cards.

FAMILY MEMBERS in household (please include siblings, parents, grandparents, & other guardians):

Name:_____Age:_____Relationship:_____Lives In ☐ Out of Home ☐

Name:_____Age:_____Relationship:_____Lives In ☐ Out of Home ☐

Name:_____Age:_____Relationship:_____Lives In ☐ Out of Home ☐

Name:_____Age:_____Relationship:_____Lives In ☐ Out of Home ☐

Name:_____Age:_____Relationship:_____Lives In ☐ Out of Home ☐

Name:_____Age:_____Relationship:_____Lives In ☐ Out of Home ☐

Name:_____Age:_____Relationship:_____Lives In ☐ Out of Home ☐

Name:_____Age:_____Relationship:_____Lives In ☐ Out of Home ☐

_____

_____

_____

If any of the children were adopted, please note below.

Child (Name and Age at Adoption): _____

Child (Name and Age at Adoption): _____

Child (Name and Age at Adoption): _____

Does the child know he or she is adopted? Yes ☐ No ☐

Do you have a current adoption social worker or involvement with an adoption agency?

If so, please list their name and contact information:

_____

_____

Please note if there have been any recent significant changes in the family (for example marriage,divorce, separation, death).

_____

_____

_____

_____

_____

Please list medical or mental health professionals currently or previously consulted:

Name:_____ Date:_____ Phone:_____

Name:_____ Date:_____ Phone:_____

Name:_____ Date:_____ Phone:_____

If you have reports, treatment summaries, or other documents from these professionals, please bring copies with you.

Please note any previous psychological or psycho-educational evaluations of the child:

Date	Type of Evaluation	Examiner

Please bring copies of any previous psychological evaluations.

Please describe child's medication history:

Medication (include Dosage, Start/Stop Dates, Prescribed by Whom)

_____

_____

_____

_____

_____

Please list the child's strengths:

_____

_____

_____

_____

_____

Please tell us anything else you think might be important for us to know about the child or family at this time:

_____

_____

_____

_____

This form was completed by:_____ Date: _____

Permission for Email and/or Text Message Communication

Email and text messaging allow Partners in Parenting therapists to exchange information efficiently for the benefit of our clients. At the same time, we must recognize that email and text messaging are not acompletely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you give signed permission for us to send you email and/or text messages about appointments and scheduling, please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email and/or text messaging, we will continue to use U.S. Mail or telephone to communicate with you.

Parent One Name:_____ Parent One Signature: _____

☐Yes, Cell Phone ☐Yes, Email ☐ No, Decline All

Parent Two Name:_____ Parent Two Signature: _____

☐Yes, Cell Phone ☐Yes, Email ☐ No, Decline All

PERMISSION TO TREAT:

I am legally authorized as the parent/guardian of_____ to enroll him/her in psychological services. I hereby authorize therapists with Partners in Parenting, PC to provide psychological treatment and/or evaluation for_____.

Client Name:_____ Signature (if over 14 years old): _____

Minor Guardian/Parent's Name:_____ DOB: _____

Minor Guardian/Parent's Signature:_____ Date: _____

If Applicable, Guardian/Parent Two's Name:_____ DOB: _____

If Applicable, Guardian/Parent Two's Signature :_____ Date: _____

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Notice of Privacy Policies

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS, DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. “Limits of Confidentiality”

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

· Health Oversight: Virginia law requires that licensed psychologists [social workers; counselors] report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In Virginia civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

· Serious Threat to Health or Safety: Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

· Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· Records of Minors: Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors. [For adolescents in psychotherapy, also see Sample Adolescent Consent Form, to be signed by minor and parent]

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· 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 you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – 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 written request, I will discuss with you the details of the accounting process.

· Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me or the office staff to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to Partners in Parenting, PC. You may also send a written complaint to the Virginia or U.S. Departments of Health and Human Services (contact information below):

Virginia Secretary of Health & Human Services
202 North 9th Street, Suite 622
Richmond, Virginia 23219
804-786-7765

Secretary of Health & Human Services
Hubert Humphrey Building
2000 Independence Avenue, S.W.
Washington, D.C. 20201
202-690-7000

EFFECTIVE DATE: 11-1-15

Signatures: Patient's Acknowledgement of Receipt of Notice of Privacy Practices

By signing, I acknowledge that I have been provided a copy of Partners in Parenting's Notice of Privacy Practices. We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

_____	_____	_____
Client Name	Client Signature (if over 14 years old)	Date
_____	_____	_____
Guardian Name	Guardian Signature	Date
_____	_____	_____
Guardian Two Name	Guardian Two Signature	Date

I further understand that my therapist may need to contact me. I agree to the following forms of communication knowing that the therapist or Partners in Parenting may leave his/her name and information about my appointments.

Please choose whether we have permission to:
Text to phone: ☐ Yes ☐ No Leave voice mail on phone: ☐ Yes ☐ No
Email a reminder: ☐ Yes ☐ No

Please provide contact information for all to which you agree to the above permissions.

Primary Phone: _____ Secondary Phone: _____

Email: _____ Email 2: _____

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TELETHERAPY CONSENT FORM

Definition of Services:

I/We, _____ (guardian/s), hereby give consent for _____(child) to engage in teletherapy with _____ (therapist). Teletherapy is a form of mental health service provided via internet technology using interactive video communications. I also understand that teletherapy involves the communication of the child's mental health information, both orally and/or visually. Teletherapy has the same purpose or intention as psychotherapy sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face therapy sessions. I understand that the child and I, as guardian, have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. The client must be a resident of Virginia. (This is a legal requirement for licensed mental health professionals practicing in this state under a VA license.)

2. The client has the right to withhold or withdraw consent at any time without affecting the right to future treatment.

3. The laws that protect the confidentiality of medical information also apply to teletherapy. As such, I understand that the information disclosed during therapy is generally confidential. However, there are mandatory exceptions to confidentiality, discussed with the therapist when starting treatment.

4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of the therapist, that: the transmission of client information could be disrupted or distorted by technical failures, or the transmission of client information could be interrupted by unauthorized persons.

5. The client agrees to not record the session by any means without express written consent of all parties.

6. I understand that there is a risk that services could be disrupted or distorted by unforeseen technical problems.

7. I accept that teletherapy does not provide emergency services. If the client experiences an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for immediate assistance.

8. I understand that there is a risk of being overheard by anyone near the client when not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment, and internet access for the teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for the teletherapy session. It is the responsibility of the provider to do the same.

9. I understand that I am responsible for payment for the teletherapy sessions if my insurance does not cover these.

Agreement: I have read, understand, and agree to the information provided above regarding telehealth.

Name of Client (Print)	**Client Signature (if over 14)**	
Name of Responsible Party/Legal Guardian	**Responsible Party/Legal Guardian (Signature)**	**Date**
Name of Responsible Party/Legal Guardian Two	**Responsible Party/Legal Guardian Two (Signature)**	**Date**

Therapist Signature: _____ **Date**: _____