



## Doray Psychological Services, P.L.L.C.

212 N. McKinley St.  
Little Rock, AR 72205

Phone: (501) 404-2077  
Fax: (501) 228-8189

Email: [intakes@DorayPS.com](mailto:intakes@DorayPS.com)  
Web: [www.DorayPS.com](http://www.DorayPS.com)

### Child Court-Ordered Evaluation Packet

Welcome to our practice! The documents in this packet contain important information about our professional services and business practices. Please make sure to read through them before signing them, because it is important for you to be aware of and to understand this information.

For the purpose of these documents, “**you**” refers to the client, and “**legally authorized representative**” refers to someone who has the **legal authority to make health care decisions for the client** (for example, a parent or legal guardian of a child under 18, a DHS caseworker of a child under 18 in DHS custody, a family member who has legal guardianship or health care power of attorney for an adult 18 or older). Adults 18 and older generally have the legal authority to make health care decisions for themselves, while children and adolescents under 18 generally do not. No one can make such decisions for another person unless they have the legal authority to do so.

We are legally and ethically required to obtain your informed consent to services by the Ethics Code of the American Psychological Association (APA) and the Health Insurance Portability and Accountability Act (HIPAA), a federal law that gives clients certain rights related to the use and disclosure of their health information. This packet contains the following documents, each of which you or your legally authorized representative must review and sign:

- A general **service agreement**, which contains general information about our business policies and practices as well as clients’ rights and responsibilities.
- A specific **service contract**, which contains information about specific policies and practices related to the type of services you are seeking (for example, psychotherapy, psychological evaluation, court-ordered evaluation).
- A **HIPAA Privacy Documentation** form, which documents that we have provided you with the included **HIPAA Notice of Privacy Practices for Protected Health Information**.
- A **consent form**, which indicates that you agree to participate in services with us, are aware of the business practices described in these documents, and agree to adhere to our business policies.
- A **history form**, which asks about your reasons for seeking services and gathers general background information.

When you meet with your clinician, you will have an opportunity to discuss any questions or concerns that you have about the information in this packet. We appreciate you giving us the opportunity to be of help.



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# Service Agreement

## Fees and Payment for Services as of March 1, 2015

### Our fees are as follows:

Initial appointment:	\$250
45-minute therapy session:	\$175
60-minute therapy session:	\$200
30-minute therapy session:	\$110
45-minute family therapy session:	\$200
Psychological evaluation:	\$200 per hour
Court-related services:	\$200 per hour
Telephone/email contact:	Free for the first 15 minutes, then \$50 per 30 minutes

**Some insurance plans do not cover certain behavioral health services.** For example, some do not cover family therapy or group therapy services, services for diagnoses that they consider to be behavioral or developmental in nature, and/or psychological testing services. You should contact your insurance carrier to confirm coverage for specific behavioral health services.

**Many insurance plans require a separate pre-authorization for psychological testing.** This typically can be obtained only after the initial appointment has been completed and must be requested by the providing psychologist. Charges for psychological evaluation include fees for time spent reviewing records, administering and scoring tests, interpreting test results, and report writing as well as conducting face-to-face interviews and feedback sessions. Please see the ***Psychological Evaluation Contract*** for more information.

**Insurance plans do not pay for procedure codes associated with court-related evaluations and consultations.** If you currently are involved or become involved in legal proceedings that require your clinician's participation, you will be expected to pay for all of the clinician's professional time related to the court case, and will be charged an up-front retainer fee. If your attorney agrees to be responsible for the charges, payment will be required up front and in full. Charges will include the costs of preparation and transportation, even if your clinician is called to testify by another party. Please see the ***Court Evaluation/Consultation Contract*** for more information.

**Fees may be charged for professional services not listed above that are needed and/or are requested of us.** Examples of such services include consulting with other professionals (with your permission) and preparation of records or treatment summaries. We will discuss any such fees with you before the service is provided so that you will be aware of the costs. A portion of our hourly fees may be charged if your clinician works for periods of less than one hour.

**Payment for services is expected at the time services are rendered.** An initial appointment will not be scheduled unless you have been made aware of our fees and agree to assume responsibility for payment of services even if you are covered by insurance or another third party payer. Managed care agencies (HMO, PPO, etc.) often require a referral from the primary care physician and/or pre-authorization for services from the insurance company. If you have insurance coverage, you are responsible for any co-payment/coinsurance amount and any unsatisfied deductible required by your insurance plan. In general, any outstanding balance must be paid prior to or at the time of the next appointment. At your clinician's discretion, you may be required to pay your outstanding balance before scheduling the appointment. Reports, test results, and medical records are not released prior to payment for services. Payments may be made with cash, check, Visa, MasterCard, American Express, or Discover Card at the time of the service. Other payment options can be discussed with your clinician, and in the event that alternative arrangements are made, a separate fee schedule will be signed. Accounts 90 days or more past due may be referred to a collection agency.

**A diagnosis will be necessary if you are going to use insurance benefits.** Diagnoses are currently derived from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Upon request, your clinician will be glad to share the diagnosis or diagnoses with you and to provide you with the relevant DSM-IV description(s).

### **Late Arrivals, Cancellations, and Missed Appointments**

**An appointment is a commitment.** Appointment times are reserved specifically for you and/or others participating in your evaluation or treatment. The clinician will do his or her best to start appointments on time. If you arrive late for an appointment, your clinician probably will not be able to meet for the full scheduled time, and your appointment may be cancelled and rescheduled for another time at the discretion of the clinician. Clinicians are rarely able to fill cancelled appointment slots on short notice. If you need to cancel an appointment, please do so as far in advance as possible. If your clinician can find another time during the week to meet, they will do so.

**If you do not keep a scheduled appointment, you may be charged for the clinician's time, and you may not be given the opportunity to reschedule it.** If you miss an appointment or do not cancel it at least 24 hours in advance, a cancellation/no-show fee of 50% of the charges for the scheduled session will be charged, and you will be asked to pay the fee at or before your next visit. If you arrive for an appointment late enough that it must be cancelled and rescheduled, you will be charged the cancellation/no-show fee. If the client is a child or adolescent under 18 and is not accompanied to an appointment by a parent or legal guardian, this may be treated as a no-show, depending on the circumstances. Similarly, if the client is an adult 18 or older and another adult has legal guardianship or power of attorney but does not accompany the client to an appointment, this may be treated as a no-show. In such cases, the appointment may be cancelled and rescheduled at the discretion of the clinician.

**Exceptions to these policies may be made in cases where you and the clinician both agree that you were unable to attend an appointment due to circumstances beyond your control.** Examples of such cases include unforeseeable, incapacitating illness or bad weather in which motorists are being asked to stay off the roads and/or schools and businesses are closing. Please note that the client or the person financially responsible for the client is responsible for paying cancellation/no-show fees, which insurance plans do not cover.

## **Communications With Clinicians and Staff**

**Because clinicians do not answer the telephone when in session with clients, you generally will not be able to reach them directly.** You may leave messages with front office staff during business hours. You may leave voicemail messages at any time. When you leave a voicemail, please make sure to clearly state your name, telephone number, and a **brief** message indicating the purpose of your call. If you are difficult to reach by phone, please include in your message some times that you will be available. Clinicians make every effort to return phone calls within 24 to 48 hours, with the exception of weekends and holidays. If you choose to communicate with a clinician by text message, the privacy of your communication cannot be guaranteed. Any emails that you send to a clinician will be responded to within the same time frame as phone calls. In the event that your clinician will be unavailable for an extended period of time, you will be provided with the name of a colleague to contact, if necessary. **If you are in an emergency situation, please call 911 or go to the nearest emergency room or mental health facility.**

**We are sensitive to our clients' privacy and confidentiality in public settings.** With this in mind, if you happen to encounter a clinician or office staff member around town, he or she will not acknowledge your relationship or initiate a conversation unless you do so first. In essence, though they are pleased to chat briefly with you outside of the office, it is up to you whether to initiate conversations with them in public settings.

## **Use of Third Party Software, Applications, and Electronic Communication**

We use a number of software, web-based, and electronic applications created and administered by third party providers. These include but are not limited to LuxSci (Lux Scientiae), Psyquel, Google Drive, Google Gmail, and various cell phone providers. Additionally, third party applications may be implemented by our practice without any additional disclosure to you at any point in the future. While these vendors were chosen based on their professionalism and reputation, we cannot guarantee their compliance with HIPAA and other regulations, with the exception of LuxSci and Psyquel, with which Doray Psychological Services, PLLC has HIPAA Business Associate Agreements. By signing this agreement and receiving services from this practice, you exempt Doray Psychological Services, PLLC from liability or blame for any privacy violations that occur due to one of these vendors.

## **Questions and Concerns**

If at any time you have questions about a clinician's qualifications or practices, please discuss your concerns with the clinician in question. Similarly, if you have any questions or concerns about the process or progress of an evaluation or therapy, please discuss them with the clinician. Any concerns about clinical issues that remain unresolved may be directed to Dawn P. Doray, Psy.D., President and Clinical Director of Doray Psychological Services, or to Terri L. Miller, Ph.D., Clinical Psychologist at Doray Psychological Services. Dr. Doray can be reached by phone at (501) 404-2077 extension 2, or by email at [drdawn@dorayps.com](mailto:drdawn@dorayps.com). Dr. Miller can be reached by phone at (501) 404-2077 extension 3, or by email at [terrimillerphd@dorayps.com](mailto:terrimillerphd@dorayps.com).

If at any time you have questions or concerns about our business practices, policies, or processes (for example, billing and payment, security and maintenance, staff training and supervision), please discuss them with the front office staff. Any concerns about administrative issues that remain unresolved may be directed to Eric Doray, Vice President of Doray Psychological Services. Mr. Doray can be reached by phone at (501) 404-2077 extension 4, or by email at [eric@dorayps.com](mailto:eric@dorayps.com).

I understand and agree to follow the policies and procedures described above.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Client's Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client's Legally Authorized Representative

\_\_\_\_\_  
Relationship of Legally Authorized Representative to Client



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# Court Evaluation/Consultation Contract

## Fees And Payment For Services

**Fees for court evaluations and consultations are billed at an hourly rate of \$200.** Please note that insurance companies **DO NOT** pay for procedure codes associated with a court evaluation or consultation. The client or the person financially responsible for the client is responsible for paying all related costs. All work related to a court case is billable. This includes but is not limited to diagnostic evaluations; administration, scoring and interpretation of psychological tests; consultations with attorneys and/or other individuals who have information relevant to a case (for example, teachers in child custody evaluations); review of records, discovery, or other evaluations; preparation and record review prior to a deposition or court testimony; depositions and court testimony; and travel to offsite locations such as court, attorneys' offices, schools, or clients' homes. Payment of our fees is for the professional services that we provide. There are times when the results of our evaluation or consultation may not be helpful to a client. In such cases, and the client and his or her attorney will need to decide whether and how to use the findings.

**An initial retainer is required before beginning a court evaluation or consultation, and the balance must be paid in full prior to release of the report.** Our retainer fee generally is **\$2000** for each evaluation or consultation (that is, 2 adults = \$4000; 2 adults and 2 children = \$8000). A **separate, nonrefundable retainer** is required for attendance at any court hearing or deposition in order to clear the clinician's schedule (\$1000 for half a day and \$1600 for a full day). We make some exceptions to this policy on a case by case basis, depending on who is responsible for payment. For example, if a state agency is responsible for payment, then the evaluation may proceed with written approval for the estimated cost of the evaluation. For the convenience of clients who need or wish to make payments over a period of time, the retainer and/or all other fees can be paid by credit card (Visa, MasterCard, American Express, or Discover Card). As mental health professionals, we do not work on a contingency basis.

## Appointment Procedures

The process for making an initial appointment for evaluation or consultation varies according to the nature of the case.

- If a court order authorizes the evaluation (such as in child custody cases), then a copy of the order must be forwarded to us. The purpose or goal of the evaluation should be stated in the order. It is helpful if the order specifies any time frames requested by the court for completion of the report. The order also should require the cooperation of the parties to be evaluated. When a court order is issued for a psychological evaluation, the client and/or his or her attorney should contact us immediately to confirm that we have received the order and to schedule an appointment.

- In family court cases where two opposing attorneys or clients have agreed to an evaluation without a court order, then either a consent agreement signed by the parties or a letter from each attorney indicating agreement to cooperate with the evaluation is recommended. Once an agreement is reached, the parties or their attorneys should contact us to schedule their appointments.
- If the person to be evaluated is a child under age 18, a parent or legal guardian must accompany him or her to our office to sign a release. In any event, a signed release from the child's parent/legal guardian or a letter from his or her attorney empowering us to complete the evaluation must precede the release of the report.
- In other cases, when an attorney is requesting an evaluation of a client, the client can simply call us for an appointment. However, it is usually helpful if the attorney communicates with us by phone, letter, or email first to clarify the purpose of the evaluation, as clients sometimes are unclear regarding the reasons for the evaluation. This can lead to the need for additional appointments, which is a financial burden to the client.
- The initial appointment will be scheduled once all required documents (for example, court orders, consent agreements) and the initial retainer are received.
- If the appointment is not kept by the client or is cancelled less than 24 hours prior to the scheduled time, there is a facility and professional time-loss fee of \$200 for each hour missed or cancelled.
- **We ask that only the person(s) being evaluated and others directly participating in the evaluation (for example, parents, spouses) attend appointments.** Children who are not the person(s) being evaluated are not allowed to attend sessions, and we cannot provide supervision for them while their family members are in session, so we respectfully ask that you make other arrangements for their care.

I understand and agree to follow the policies and procedures described above.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Client's Legally Authorized Representative

\_\_\_\_\_  
Date

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Printed Name of Client's Legally Authorized Representative

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# HIPAA Notice of Privacy Practices For Protected Health Information

*This notice describes how clients' health care information may be used and disclosed and how they can get access to this information.*

Doray Psychological Services, P.L.L.C. (DPS) is permitted by federal privacy laws to make uses and disclosures of a client's health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to the client. Such information may include documentation of the client's symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing-related documents for those services.

## I. Uses and Disclosures of Protected Health Information

**Protected health information (PHI)** is information that can be used to identify the client (for example, name, social security number, telephone number), and relates to past, present or future health conditions, treatment, and related health care services. A client's protected health information may be used by DPS and disclosed to others in order to provide treatment to the client, obtain payment for the services provided to the client, carry out the health care operations necessary to support our practice, and fulfill any other purpose permitted or required by law.

**Treatment** refers to the use and disclosure of PHI to provide, coordinate, and manage a client's health care and related services. Examples of treatment include but are not limited to meeting with DPS clinicians for the purpose of evaluation, testing, and/or therapy. In order to coordinate the client's care, we may talk to other health care providers, such as the client's primary care physician or psychiatrist. If we refer the client to another health care provider, we may give the other provider information about the client so that they can be more effectively evaluated and/or treated. If we believe that the client is at risk of harming himself or herself, we may disclose information about him or her to family members, partners, friends, other health care providers, or legal authorities to the extent needed to ensure his or her safety. When the client's clinician is away from the office for an extended period of time, a colleague may cover their practice and take emergency calls. The client's clinician will provide their colleague with any information about the client that they believe will be necessary to assist during their absence.

**Payment** refers to the use and disclosure of the client's PHI to obtain payment for the health care services provided to him or her. Examples of payment activities include but are not limited to calling the client's health insurer to verify coverage/benefits, sending treatment plans to the health insurer in order to get pre-authorization for treatment, submitting health insurance claims to the health insurer, and collection activities.

**Health Care Operations** refers to the use and disclosure of the client's PHI to carry out the business activities of DPS practice. Examples of health care operations include but are not limited to quality assessment and improvement activities; performance evaluation, enhancement, and/or training activities; health care fraud and abuse detection/compliance; and arranging for legal services to enforce/defend DPS legal rights.

- **Use** applies only to activities within the DPS office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies the client.
- **Disclosure** applies to activities outside of the DPS office, such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses And Disclosures Requiring Authorization

DPS may use or disclose PHI for purposes outside of treatment, payment, or health care operations when appropriate authorization is obtained. An **authorization** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when DPS is asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from the client or the client's legally authorized representative before releasing this information. We also will obtain an authorization before releasing psychotherapy notes. **Psychotherapy notes** are notes the clinician has made about their conversation with the client during a private, group, joint, or family counseling session, which they have kept separate from the rest of the health care record. These notes are provided a greater degree of protection than PHI.

The client or client's legally authorized representative may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. They may not revoke an authorization to the extent that (1) DPS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

DPS will also obtain an authorization from the client or client's legally authorized representative before using or disclosing:

- PHI in a way that is not described in this **Notice**.

## III. Uses And Disclosures With Neither Consent Nor Authorization

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

- **Child Abuse.** If we have reasonable cause to suspect that a child has been subjected to child maltreatment or has died as a result of child maltreatment, or we have observed a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, we must immediately notify the child abuse hotline.
- **Adult and Domestic Abuse.** If we have reasonable cause to suspect that an endangered or impaired adult has been subject to conditions or circumstances that would reasonably result in abuse, sexual abuse, neglect or exploitation, we must immediately report this to an appropriate authority.
- **Health Oversight Activities.** If we receive a subpoena from the Arkansas Psychology Board, we may be required to disclose PHI to comply with that subpoena.
- **Judicial and Administrative Proceedings.** If the client is involved in a court proceeding and a request is made for information about his or her diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without a court order or the written authorization of the client or the client's legally appointed representative. The privilege does not apply when the client is being evaluated for a third party or where the evaluation is court-ordered. The client or client's legally authorized representative will be informed in advance if this is the case.
- **Serious Threat to Health or Safety.** If the client communicates to DPS a threat of physical violence against a reasonably identifiable third person, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that the client will inflict serious physical harm on himself or herself, we may disclose information in order to protect him or her.

- **Worker's Compensation.** We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- When use and disclosure without the consent or authorization of the client or client's legally authorized representative is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

There may be additional disclosures of PHI that we are required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

#### IV. Client Rights

- The client or client's legally authorized representative has the **right to request restrictions** on certain uses and disclosures of protected health information about the client. We may but are not required to agree to any restrictions requested.
- The client or client's legally authorized representative has the **right to receive confidential communications of PHI by alternative means and at alternative locations.**
- The client or client's legally authorized representative has the **right to inspect and/or obtain a copy of the client's PHI** for as long as the PHI is maintained. The request must be made in writing and we will charge a fee for the costs associated with inspecting/copying the information. Under certain circumstances, we may deny the request. At the request of the client or client's legally authorized representative, we will discuss with them the details of the request and denial process.
- The client or client's legally authorized representative has the **right to request an amendment of the client's PHI.** The request must be made in writing and must provide a reason to support the requested amendment. We may deny the request. At the request of the client or client's legally authorized representative, we will discuss with them the details of the amendment process.
- The client or client's legally authorized representative generally has the **right to receive an accounting of disclosures** of the client's PHI for which neither consent nor authorization has been provided. At the request of the client or client's legally authorized representative, we will discuss with them the details of and exceptions to the accounting process. The first accounting provided within a 12 month period is free. A fee will be charged for each subsequent request within a 12-month period.
- The client or client's legally authorized representative has the **right to obtain a paper copy** of the notice from DPS upon request, even if they have agreed to receive the notice electronically.
- The client or client's legally authorized representative has the **right to restrict disclosures** when they have paid for the client's care out of pocket. The client or client's legally authorized representative has the right to restrict certain disclosures of PHI to a health plan when they pay out-of pocket in full for our services.
- The client or client's legally authorized representative has the **right to be notified if there is a breach of the client's unsecured PHI.** They have a right to be notified if: (a) there is a breach (a use or disclosure of PHI in violation of the HIPAA Privacy Rule) involving the client's PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that the client's PHI has been compromised. See breach **Addendum** below.

## V. Our Duties

- We are required by law to maintain the privacy of PHI and to provide the client or client's legally authorized representative with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify the client or client's legally authorized representative of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our privacy policies and procedures, we will provide all current clients with a written copy of the revised Notice. Former clients will be notified of revisions only upon request.

## VI. Complaints

If you believe that we have violated the client's privacy rights or you disagree with a decision we have made about access to the client's PHI, please notify DPS in person, by phone at (501) 404-2207, or by mail at 212 N. McKinley St., Little Rock, AR 72205. You also may file a complaint with the Regional Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202; Telephone: (214) 767-4056 or (800) 368-1019; Fax: (214) 767-0432; TDD: (214) 767-8940.

## VII. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on May 15, 2014. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. Current clients will be provided with a copy of the revised Notice. Former clients will be given a copy of the revised notice upon request.

### **Breach Notification Addendum to Policies & Procedures**

- When DPS becomes aware of or suspects a breach as defined below, DPS will conduct a risk assessment. The risk assessment considers the following four factors to determine whether PHI has been compromised: ***the nature and extent of PHI involved; to whom the PHI may have been disclosed; whether the PHI was actually acquired or viewed; and the extent to which the risk to the PHI has been mitigated.*** DPS will keep a written record of that risk assessment. The HITECH Act added a requirement to HIPAA that psychologists (and other covered entities) must give notice to patients and to HHS if they discover that ***unsecured*** Protected Health Information (PHI) has been breached. A ***breach*** is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule. Examples of a breach include but are not limited to stolen or improperly accessed PHI, PHI inadvertently sent to the wrong provider, and unauthorized viewing of PHI by an employee in the practice. PHI is "unsecured" if it is not encrypted to government standards.
- Unless DPS determines that there is a low probability that PHI has been compromised, DPS will give notice of the breach. If notice is required, DPS must notify any client affected by a breach without unreasonable delay and within 60 days after discovery. A breach is ***discovered*** on the first day that DPS knows (or reasonably should have known) of the breach.
- The risk assessment can be conducted by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, DPS will provide any required notice to clients and to HHS.
- After any breach, particularly one that requires notice, DPS will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.



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### HIPAA Privacy Documentation *Acknowledgment of Receipt of Notice of Privacy Practices*

- The **Notice of Privacy Practices** tells me how Doray Psychological Services, P.L.L.C. will use the client's health information for the purposes of treatment, payment for treatment, and health care operations.
- The **Notice of Privacy Practices** also explains in more detail how Doray Psychological Services, P.L.L.C. may use and share the client's health information for other than treatment, payment, and health care operations.
- Doray Psychological Services, P.L.L.C. also will use and share the client's health information as required or permitted by law.
- I acknowledge that I have received a copy of the Provider's **Notice of Privacy Practices** with the effective date of 5/15/2014.

I understand and agree to the statements above.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Client's Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client's Legally Authorized Representative

\_\_\_\_\_  
Relationship of Legally Authorized Representative to Client



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### Consent for Court-Ordered Evaluation

I consent to psychological evaluation for myself or for the client for whom I am the legally authorized representative, and agree to adhere to the business policies of Doray Psychological Services, P.L.L.C.

I understand that Doray Psychological Services, P.L.L.C. will share the client's health information according to federal and state law for the purposes of treatment, payment, and health care operations.

I understand that as the client or other legally authorized representative, I am responsible for all charges incurred, regardless of the client's insurance status.

I agree to pay for services as charges are incurred. **Please note that court-ordered evaluations cannot be billed to insurance companies.**

I understand and agree to the statements above.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Client's Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client's Legally Authorized Representative

\_\_\_\_\_  
Relationship of Legally Authorized Representative to Client



## Doray Psychological Services, P.L.L.C.

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# Child History Form for Court-Ordered Evaluation

Please feel free to use additional pages to provide information where needed.

### Demographic and Contact Information

Child's full legal name: \_\_\_\_\_

Name child prefers to be called: \_\_\_\_\_

Child's DOB: \_\_\_\_\_ Child's SSN: \_\_\_\_\_

Child's age: \_\_\_\_\_ Child's gender:  Male  Female  Other

Name of Parent(s)/Guardian(s): \_\_\_\_\_

Mailing address: \_\_\_\_\_

Please indicate which forms of communication are acceptable and provide the relevant contact information:

Home phone  No  Yes \_\_\_\_\_

Cell phone  No  Yes \_\_\_\_\_

Work phone  No  Yes \_\_\_\_\_

Email  No  Yes \_\_\_\_\_

Please provide an emergency contact other than the parent(s)/guardian(s) listed above:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

### Court Information

Your attorney's name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Other party's attorney: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Attorney ad Litem: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

What is the reason for the evaluation? \_\_\_\_\_

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### Referral Information

Who were you referred by? \_\_\_\_\_

What problems is the child experiencing at this time? Please indicate all that apply:

- Cognitive or learning problems** (for example, trouble with learning, comprehension, thinking, or memory; mental confusion; trouble with reading, writing, or math; failing in school)
- Attention problems** (for example, trouble paying attention or concentrating; not listening even when spoken to directly; easily distracted; trouble organizing or finishing tasks or activities)
- Hyperactivity** (for example, restless or fidgety; unable to sit still or stay seated; always moving; talking too much; engaging in non-stop activity)
- Impulse control problems** (for example, not thinking before acting; doing things that are risky, reckless, or irresponsible; talking out of turn; interrupting or intruding on others; trouble waiting)
- Mood problems** (for example, sadness or tearfulness; not interested in doing things or talking to people; low self-esteem; feeling worthless; feeling hopeless; talking or thinking about death or suicide, attempting suicide; irritability, anger, resentment, or hostility; easily annoyed; losing temper frequently or easily; extreme or abnormal cheerfulness)
- Anxiety** (for example, excessive or unrealistic worries; feeling tense, nervous, "on edge," or panicky; easily startled; extreme or unusual fears of specific objects or situations; extremely self-conscious; clingy or afraid to be away from parents or other family members; concerns about doing things perfectly; having to do things a certain number of times or the exact same way each time)
- Behavior problems** (for example, breaking rules; arguing with others; annoying others on purpose; lying, cheating, or stealing; running away from home; skipping school; destructive toward property; aggressive toward people or animals; threatening or intimidating toward others)
- Social/peer problems** (for example, few or no friends; not interested in having close relationships; trouble forming or maintaining close relationships; trouble getting along with others; loneliness; withdrawn, abnormally shy or excessively friendly; poor social skills; not caring about other people's feelings; bullying)
- Family problems** (for example, trouble communicating; frequent arguments; emotionally distant; trouble adjusting to separation or divorce; trouble adjusting to blended family; trouble managing child's behavior; need help with parenting strategies)
- Trauma/maltreatment** (for example, death of a loved one; abandonment by parent/caregiver; traumatic accident or injury; exposure to violence; exposure to natural or man-made disasters; physical, sexual, verbal, or emotional abuse or neglect)
- Odd behaviors or experiences** (for example, seeing things or hearing voices that aren't there; strange, illogical, or nonsensical beliefs or ideas; thoughts are disorganized or run together; making poor eye contact; showing no emotion; laughing or crying inappropriately; having unpredictable outbursts; getting very upset over small changes in routine or surroundings; making strange movements; talking in a strange way; showing interest in very few topics or things; strange interests in or preoccupation with certain subjects or objects)
- Other problems** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have these problems been going on? \_\_\_\_\_

Did anything in particular seem to set off these problems?  No  Yes

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do these problems seem to be  staying the same  getting worse  getting better?

Please provide any other information about problems the child is experiencing at this time that you think might be helpful or important:

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### Child's Mental Health and Substance Abuse Evaluation and Treatment History

Please list all mental health or substance abuse services that the child has received or is currently receiving (including psychological evaluations, educational evaluations, psychotherapy or counseling, medication management, residential treatment, and inpatient hospitalizations):

Name of Provider or Facility	Date(s) of Service	Type(s) of Service	Reason(s) for Service

If the child has had therapy or counseling, was it  not at all helpful  somewhat helpful  very helpful?

In what ways was the therapy or counseling helpful or not helpful? \_\_\_\_\_

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### Child's School History

What school is the child currently attending? \_\_\_\_\_

What grade is the child currently in? \_\_\_\_\_ (last grade completed if currently between school years)

Please indicate any special services the child is currently receiving:

- |  |   |
|--|---|
| <input type="checkbox"/> Special education/IEP services (for example, resource services, self-contained classes, inclusion services) | <input type="checkbox"/> Occupational therapy                         |
| <input type="checkbox"/> Section 504 services/accommodations   | <input type="checkbox"/> Tutoring                                     |
| <input type="checkbox"/> Speech-language therapy   | <input type="checkbox"/> Gifted & Talented programming                |
| <input type="checkbox"/> Other services: _____   | <input type="checkbox"/> Testing for eligibility for special services |

## Child's Medical and Developmental History

Please list any major physical illnesses, injuries, surgeries, and developmental problems (for example, delays in speech, language, or motor skills; problems with toilet training; problems learning self-care skills) the child currently has or has had in the past:

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Does the child often experience any of the following? Please indicate all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Sleep problems                                   | <input type="checkbox"/> Headaches                                    |
| <input type="checkbox"/> Fatigue or low energy                            | <input type="checkbox"/> Dizziness, lightheadedness, or fainting      |
| <input type="checkbox"/> Problems with appetite or eating behavior        | <input type="checkbox"/> Trembling or shaking                         |
| <input type="checkbox"/> Weight problems                                  | <input type="checkbox"/> Numbness or tingling of body parts           |
| <input type="checkbox"/> Trouble breathing or shortness of breath         | <input type="checkbox"/> Chills, hot flushes, or sweating             |
| <input type="checkbox"/> Heart racing or pounding, or irregular heartbeat | <input type="checkbox"/> Vision problems                              |
| <input type="checkbox"/> Chest pain or discomfort                         | <input type="checkbox"/> Hearing problems                             |
| <input type="checkbox"/> Stomach pain                                     | <input type="checkbox"/> Problems with sexual functioning or behavior |
| <input type="checkbox"/> Nausea, vomiting, or diarrhea                    | <input type="checkbox"/> Alcohol or drug use                          |

When was the child's most recent physical exam? \_\_\_\_\_

Were there any findings that concerned you or the child's doctor?  No  Yes

If yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_

Is the child currently taking any prescription or over-the-counter medication(s)?  No  Yes

If yes, please provide details:

Name of Medication	Dose	Purpose of Medication

## Child's Family History

Mother's name: \_\_\_\_\_

Father's name: \_\_\_\_\_

Mother's age: \_\_\_\_ If deceased, when? \_\_\_\_\_

Father's age: \_\_\_\_ If deceased, when? \_\_\_\_\_

Mother's education:

- Eighth grade or less
- Some high school
- High school graduate or GED
- Some college or post-high school education
- College graduate
- Advanced graduate or professional degree

Father's education:

- Eighth grade or less
- Some high school
- High school graduate or GED
- Some college or post-high school education
- College graduate
- Advanced graduate or professional degree

Mother's employment status:

- Working, full-time or part-time
- Unemployed, looking for work
- Unemployed, not looking for work
- Disabled
- Retired
- Other: \_\_\_\_\_

Father's employment status:

- Working, full-time or part-time
- Unemployed, looking for work
- Unemployed, not looking for work
- Disabled
- Retired
- Other: \_\_\_\_\_

Mother's occupation, if working: \_\_\_\_\_

Father's occupation, if working: \_\_\_\_\_

Are the parents separated?  No  Yes Divorced?  No  Yes

If divorced, has either remarried? Mother:  No  Yes Father:  No  Yes

Has the child been adopted or raised by adults other than his or her biological parents?  No  Yes

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the child ever been in foster care?  No  Yes

If yes, please give reasons for placement: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the child's current living and visitation arrangement? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the child have any siblings?  No  Yes

If yes, please list them and indicate whether they live in the same household as the child:

Name	Age	Gender	Same Household?
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes

### Other Information

What are the child's strengths? \_\_\_\_\_

\_\_\_\_\_

What are the child's weaknesses? \_\_\_\_\_

\_\_\_\_\_

What is the child's level of general happiness and well-being? Please draw an "X" on the line:

\_\_\_\_\_

Very poor Okay Very good

Please provide any other information that you think might be helpful or important:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Thank you for your time and consideration in completing this form!

How much time did it take you to fill out? \_\_\_\_\_

The information provided above and on any accompanying pages is accurate to the best of my knowledge.

\_\_\_\_\_  
Signature of Child's Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Child's Legally Authorized Representative

\_\_\_\_\_  
Relationship of Legally Authorized Representative to Child