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
Web: www.DorayPS.com

Child Psychotherapy 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. Dr. Miller can be reached by phone at (501) 404-2077 extension 3, or by email at 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.

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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Psychotherapy Contract

General Information About Psychotherapy

The purpose of psychotherapy is for a person to get help with problems that are bothering him or her, or that are keeping them from being satisfied or successful in important areas of life such as school, work, and relationships. People enter therapy for different reasons. For example, you may be entering therapy because you want to talk with someone about your problems, or because someone in your life such as a family member, teacher, or doctor has concerns about you. Or you may be seeking therapy for your child or another person in your care because you are concerned about his or her well-being.

Therapy is a process that varies depending on the personality of the participants and the problems that the client is experiencing. We view it as a partnership between client and therapist, with the support of collateral participants (family members, friends, and other concerned parties who participate in treatment in order to help the client). It involves regularly scheduled meetings between the therapist and participants to work toward identified goals. The therapist suggests a general plan and specific strategies for working toward those goals. Effective therapy requires active engagement, commitment, communication, and trust on the part of everyone involved. The client's active participation both inside and outside of sessions is required in order to change the thoughts, feelings, behaviors, relationships, and/or situations that interfering with his or her functioning.

Therapy has both benefits and risks. Because it often involves discussing unpleasant aspects of life, people participating in therapy may at times experience uncomfortable levels of sadness, anxiety, guilt, frustration, anger, loneliness, or helplessness. They may recall unpleasant memories that bother them at school, at work, or at home. Personal or family secrets may need to be told or discussed. Therapy may lead a person to make changes in his or her life that are unsettling, unpopular, or difficult. It is possible that problems may initially get worse, or that therapy may not seem to work. Most of these issues are to be expected when people start to make important changes in their lives, and most will be temporary. In the long run, therapy often leads to a significant reduction in distressing feelings; higher achievement and productivity in school and at work; greater satisfaction in family and social relationships; healthier skills for coping with life stress; a clearer sense of values, purpose, and goals; and better overall functioning.

One potential risk of therapy with a child or adolescent involves disagreement between parents and/or disagreement between parent(s) and therapist about the best interests of the child. If any such disagreements occur during the course of a child's treatment, the therapist will strive to understand everyone's perspectives and to fully explain his or her own. This discussion may lead to a resolution of the disagreement or to an agreement to disagree, so long as this enables the child's progress in therapy. In the end, the child's parent(s) will decide whether therapy will continue. If the parent(s) decide that

therapy should end, the therapist will honor that decision. However, we ask that the therapist be allowed the option of having a few closing sessions with the child to appropriately end the treatment relationship.

Preparation For Therapy

If the client has ever had any mental health or educational evaluations, psychotherapy or counseling, medication management, or other services, please arrange to have records of those services sent to us before the initial appointment. Examples of such records include reports of psychiatric, psychological, or psychoeducational evaluations; reports of testing for special educational services; reports of disability evaluations; psychotherapy or medication notes; and hospital discharge summaries. Copies of school records containing information about academic performance, school behavior, and services received (for example, current and previous report cards, standardized achievement test scores, disciplinary reports, individualized education plans [IEPs]) often are very helpful, and should be sent before the initial appointment if they are available. We prefer to receive either photocopies by USPS mail or electronic copies by email, as faxed copies can often be difficult or impossible to read. If you provide us with original documents, our fee for copying or scanning records is 25 cents per page plus a $20 per hour administrative fee, with a minimum charge of one hour.

It is important that the client be in good physical health during therapy sessions. If he or she is physically ill—especially if the illness is contagious and/or the client has a fever—please call us to cancel and reschedule for another day.

We ask that only the client and others directly participating in therapy sessions (for example, parents, spouses) attend appointments. Children who are not the person(s) receiving or participating in therapy 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.

What to Expect in Therapy

The first one to three sessions of therapy involve assessment and treatment planning. The therapist will gather background information about the client's history and current functioning, and will, if necessary, develop a formal diagnosis. The therapist, client, and supporting participants will develop an understanding of what is and is not going well for the client, as well as a mutually agreed-upon set of goals to work toward. They will evaluate whether they feel comfortable working with each other and whether the therapist is the best person to provide the services needed to meet the identified goals. If either the client or therapist does not feel comfortable with the other, if there are services needed that the therapist cannot provide, or if the client's needs would be better met by a professional with more specialized knowledge or skills, the therapist will recommend that the client see someone else and will provide referrals as necessary.

Therapy typically begins with a 45- or 60-minute session once per week and lasts for up to 6-12 weeks. The frequency of sessions may be gradually reduced to every other week or once per month as the client is feeling better and functioning better. Clients have the right to end therapy at any time. However, it is our hope that the ending will be mutually agreed upon and planned so that the final sessions can be used to review the progress that has been made, to discuss any future work that needs to be done, and to say goodbye.

Role of Collateral Participants in Therapy

Collateral participants are not considered to be clients. The role of a collateral participant varies depending on the client's needs and preferences, and may involve attending treatment sessions (either alone or with the client) or providing information by phone, email, or other means. Clients and collateral participants in therapy often experience intense and/or distressing emotions, and may experience tension in their relationships with each other. Collateral participation in therapy may result in better understanding of the client or an improved relationship with the client, or may help in the collateral participant's own personal growth. Participation of collaterals in therapy is often important, and is sometimes necessary for success, especially in treatment of children and adolescents. The collateral participant is not responsible for payment for services unless he or she is financially responsible for the client.

The therapist's primary legal and ethical responsibilities are to the client, and this includes protection of the client's privacy. Except in cases where in the therapist's professional judgment it is necessary in order to protect the client from serious and immediate harm to self or others, the therapist will not share with collateral participants the specifics of what the client has disclosed in one-on-one sessions. Although no charts are kept on collateral participants, information about them may be entered into the client's records. The confidentiality of information in the client's records is protected by law and by the APA Ethics Code, and this information cannot be disclosed without the consent of the client or the client's legally authorized representative except under the circumstances noted in the ***HIPAA Notice of Privacy Practices*** and as discussed below. Collateral participants have no right to access the records without the client's consent, except in cases where the collateral is the client's legally authorized representative (for example, the parent or guardian of a child or adolescent under 18). The collateral participant is expected to maintain the confidentiality of the client.

Confidentiality and Communication With Third Parties

We communicate with other service providers, school personnel, family members, and other interested parties when necessary or appropriate. We do this in order to obtain relevant historical and current information about the client's functioning in different contexts, to coordinate recommended interventions, and to assist in advocating for the client's needs. We do this only with the knowledge and permission of the client and/or the client's legally authorized representative, and we obtain necessary releases of information as required by law. Examples of situations in which the therapist might communicate with a third party include talking to a client's teacher or counselor to find out how things are going in school or to provide suggestions for school-based interventions, or talking to the health care provider prescribing a client's medication to give feedback about whether the medication is helpful.

There are some situations in which the therapist either cannot or may not maintain a client's confidentiality because he or she is required by law and/or by professional ethical guidelines to disclose information that was shared in confidence. Examples of such situations include the following:

- The therapist has reason to believe that the client has plans to cause serious harm or death to themselves or to someone else who can be identified, and that he or she has the intent and ability to act on that plan within the very near future. In such cases, the therapist will inform family members and other parties as needed to protect the client and others from harm.

- The client is engaged in behaviors that could cause serious harm to self or others, even if no harm is intended. In such cases, the therapist will use his or her professional judgment to decide whether anyone should be informed.

- The therapist has reason to believe that the client is being neglected or abused physically, sexually, or emotionally, or has been neglected or abused in the past. In such cases involving either a child or an impaired adult, the therapist is required by law to make a report to the Arkansas Department of Human Services (DHS) Child Abuse Hotline or Adult Abuse Hotline, depending on the client's age. If this information has already been reported, the therapist will report only new information to DHS.

- The client is involved in a court case and a request is made for information about therapy. In such cases, the therapist will not disclose information without the written consent of the client or the client's legally authorized representative unless he or she is required by the court to do so. The therapist will do everything he or she can within the law to protect the client's confidentiality, and will inform the client if he or she is required to disclose information to the court.

Confidentiality for Kids in Therapy

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining that trust. One goal of therapy with children and adolescents is to promote stronger and better relationships between them and their parents. However, it often is necessary for kids to develop a "zone of privacy" in which they feel free to discuss personal matters—which may involve issues either inside or outside of the home—that they may not feel comfortable sharing with their parents. This is particularly true for adolescents, who naturally are developing a greater sense of independence and autonomy. Consequently, it is our policy for therapists to provide parents with only general information about their child's treatment. Such information would include, for example, whether the child attends his or her sessions, what issues are being discussed, what progress has been made, and in what areas further intervention may be helpful.

As a general rule, the therapist will not share with parents the specific details of what a child has disclosed in one-on-one therapy sessions unless he or she has the child's permission to do so. It is important to note that if the child is an adolescent, these disclosures may involve sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors that his or her parent(s) would not approve of or would be upset by. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may warrant intervention. The therapist will discuss with the parent(s) their feelings and opinions regarding acceptable behavior, and will use his or her professional judgment to decide whether and how to intervene.

As a general rule, if the therapist has reason to believe that a child's behavior is placing him or her in serious and immediate danger of harm to self or others, the parent(s) will be informed and a plan will be implemented to address the behavior. Examples of situations in which the therapist generally **would not disclose** information shared in confidence include a teenager reporting that he or she has tried alcohol at a few parties, or is having protected sex with a boyfriend or girlfriend. Examples of situations in which the therapist generally **would disclose** information shared in confidence include a teenager reporting that he or she has a drug or alcohol problem, is driving while under the influence of drugs or

alcohol, is a passenger in a car with a driver who is under the influence of drugs or alcohol, or is having unprotected sex with people he or she does not know or in unsafe situations. If a child has questions about the types of information that would be disclosed to his or her parent(s), they may ask the therapist in the form of hypothetical situations (for example, "If someone told you that they were doing _____, would you tell their parents?").

In cases where the therapist feels that it is not necessary to disclose information to the parent(s) but feels that it is important for parent(s) to know what is going on, he or she will encourage the child to tell the parent(s) and help the child find the best way to do so. The therapist may also talk to the parent(s) about what is going on in general terms, without going into specifics, in order to help the parent(s) understand how to be supportive to the child. It should be noted that under Arkansas law, a child's parent/guardian has the right to access the child's therapy records, although this only rarely occurs.

Court Involvement and Kids in Therapy

The therapist's responsibility to a child or adolescent under 18 receiving therapy may require his or her involvement in conflicts between parents. However, we ask that parents agree that any such involvement will be strictly limited to that which will benefit the child. This means, among other things, that parents will treat anything that is said in session with the therapist as confidential. **They will not attempt to gain advantage in any legal proceeding from the therapist's involvement with the child.** The therapist may be required to testify in cases where therapy is court-ordered, where the therapist is court-appointed to provide treatment services, or where abuse or maltreatment issues have been disclosed during therapy. There may be other circumstances in which it is appropriate for the therapist to testify if arrangements are made prior to beginning services.

If the therapist is required to testify, he or she is ethically bound not to give an opinion about either parent's suitability for custody or visitation unless agreed to prior to beginning treatment or as required by law or contract with DHS. If the court appoints a custody evaluator, attorney ad litem, or caseworker, the therapist will provide information as needed (if appropriate releases are signed or a court order is provided), but will not make any recommendation about the final decision. Furthermore, if the therapist is required to appear as a witness, the party responsible for his or her participation agrees to reimburse at the rate of **$200 per hour** for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs. A separate retainer fee for court appearance is also required in order to clear the therapist's schedule. Please see the ***Court Evaluation/Consultation Information Sheet*** for more information.

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

_____ _____
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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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.

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
Web: www.DorayPS.com

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

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

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Little Rock, AR 72205

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Web: www.DorayPS.com

Consent for Psychological Evaluation and/or Psychotherapy

I consent to mental health evaluation and/or treatment 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. I authorize the insurance provider to pay Doray Psychological Services, P.L.L.C. for services rendered.

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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Child History Form

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: _____

Referral Information

Who were you referred by? _____

What are your reasons for seeking evaluation or therapy for the child 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, resentfulness, 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?

Is anyone else encouraging, pressuring, or forcing you to seek help for the child at this time? ☐ No ☐ Yes

Please provide any other information about the reasons for seeking evaluation or therapy for the child at this time that you think might be helpful or important:

_____

_____

_____

_____

_____

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

Please list all mental health and 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? _____

_____

_____

_____

_____

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)

Has the child ever repeated a grade in school? ☐ No ☐ Yes If yes, which grade(s)? _____

Do you have concerns about the child's academic performance? ☐ No ☐ Yes

If yes, please explain: _____

_____

Do you have concerns about the child's behavior in school? ☐ No ☐ Yes

If yes, please explain: _____

_____

Please indicate any special services the child is currently receiving or has received in the past:

☐ Special education/IEP services (for example, resource services, self-contained classes, inclusion services)

☐ Section 504 services/accommodations

☐ Speech-language therapy

☐ Other services: _____

☐ Occupational therapy

☐ Tutoring

☐ Gifted & Talented programming

☐ Testing for eligibility for special services

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: _____

_____

_____

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?
		☐ Male ☐ Female ☐ Other	☐ No ☐ Yes
		☐ Male ☐ Female ☐ Other	☐ No ☐ Yes
		☐ Male ☐ Female ☐ Other	☐ No ☐ Yes
		☐ Male ☐ Female ☐ Other	☐ No ☐ Yes
		☐ Male ☐ Female ☐ Other	☐ No ☐ Yes
		☐ Male ☐ Female ☐ Other	☐ No ☐ Yes

Is the child's family unusual in any way? ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

_____

Please provide any other information about the child's family that you think might be helpful or important, including mental health or substance abuse issues in close family members:

_____

_____

_____

_____

Child's Social History

Does the child have any close friends other than family members? ☐ No ☐ Yes

If yes, how many? _____

How often does the child spend time with friends outside of school in a typical month? _____

Does the child have any trouble making or keeping friends? ☐ No ☐ Yes

If yes, please explain: _____

_____

Does the child generally have any trouble getting along with others his or her age? ☐ No ☐ Yes

If yes, please explain: _____

_____

Does the child participate in any organized activities (for example, sports, dance, scouting)? ☐ No ☐ Yes

If yes, what and how often? _____

_____

Does the child have any hobbies or interests that he or she pursues on a regular basis? ☐ No ☐ Yes

If yes, what and how often? _____

_____

Does the child engage in any exercise or physical activity on a regular basis? ☐ No ☐ Yes

If yes, what and how often? _____

_____

Child's Medical and Developmental History

Contact information for the child's pediatrician or family doctor:

Name: _____ City and State: _____ Phone #: _____

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:

_____

_____

_____

_____

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

- ☐ Sleep problems
- ☐ Fatigue or low energy
- ☐ Problems with appetite or eating behavior
- ☐ Weight problems
- ☐ Trouble breathing or shortness of breath
- ☐ Heart racing or pounding, or irregular heartbeat
- ☐ Chest pain or discomfort
- ☐ Stomach pain
- ☐ Nausea, vomiting, or diarrhea
- ☐ Headaches
- ☐ Dizziness, lightheadedness, or fainting
- ☐ Trembling or shaking
- ☐ Numbness or tingling of body parts
- ☐ Chills, hot flushes, or sweating
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Problems with sexual functioning or behavior
- ☐ 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

Other Information

What are the child's strengths? _____

_____

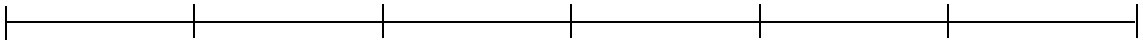
_____

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:

_____

_____

_____

_____

_____

_____

Insurance Information

If you have provided this information elsewhere or by other means, please feel free to skip this section.

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Phone Number: _____	Phone Number: _____
Policy Holder: _____	Policy Holder: _____
Policy Holder's DOB: _____	Policy Holder's DOB: _____
Policy Holder's SSN: _____	Policy Holder's SSN: _____
Policy ID Number: _____	Policy ID Number: _____
Group Number: _____	Group Number: _____

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