CHILD/ADOLESCENT INTAKE INFORMATION

CLIENT FULL NAME _____DATE OF BIRTH_____

ADDRESS _____

CITY_____ STATE_____ZIP_____

PHONE_____HOME PHONE_____WORK _____

E-MAIL_____

EMERGENCY CONTACT _____ CELL _____

MAY I LEAVE A VOICE MAIL OR TEXT MESSAGE ON YOUR PHONE? Yes No

IF YES, MAY I LEAVE A MESSAGE REGARDING? Appt Billing Clinical

WOULD YOU LIKE TO RECEIVE APPT. REMINDERS? Yes No

RESPONSIBLE PARTY INFORMATION

NAME_____DATE OF BIRTH_____

REL'SP TO CLIENT_____ Check if Address is Same as Client_____

ADDRESS_____

CITY_____STATE_____ZIP_____

I AM RESPONSIBLE FOR PAYMENT OF SERVICES BY DEBORAH KASS, MS, LCSW

SIGNATURE: _____ DATE: _____

Deborah Kass, MS, LCSW 503) 544- 4355

OFFICE POLICIES

WELCOME

Please take a few minutes to review my policies and procedures. This information introduces you to my practice and may help answer your questions. If you have further questions or concerns, please don't hesitate to talk with me at any time.

APPOINTMENTS

Every effort will be made to determine a consistent time for appointments. If you need to change an appointment, a 24 hour notification is required. In the event of a late cancellation, I will try to reschedule your appointment. If that is not possible, you will be charged in full for a missed appointment.

EMERGENCY CARE

Should you feel that you are in crises and need immediate assistance, please call the Multnomah County Crisis Hot Line at (503) 988 – 4888 or go to the nearest hospital emergency room. Please do not use e-mail or text message for emergencies.

COMMUNICATION

I carry a cell phone with voice mail. Please note that you may press (*star) to bypass the voice mail message. I encourage you to leave me a message; voice mail is checked regularly. If you text me regarding an appointment confirmation, lateness or cancellation, I will make an effort to respond via text or phone. While you may call at any hour, please note that if you call in the evening I may not receive the message until the morning. I return most phone calls on the same day and make every effort to return all calls within 24 hours.

E-MAIL

The Healthcare Insurance and Portability Act (HIPPA) requires that all e-mail communication between therapist and patient be encrypted. In compliance with this regulation your e-mail and phone number will be entered into my Secure Patient Portal. You will receive a "Welcome" e-mail from which you can register for this portal. From this personal profile, you may do the following:

- ***View upcoming appointments.***
- ***Select communication preferences.***
- ***Send emails through a secure, confidential connection.***
- ***Update contact information.***

As with any technology, the calendar and appointment reminder system of this Secure Patient Portal is occasionally inaccurate. Always note your appointment in your calendar and please don't hesitate to contact me to confirm your appointment time.

Communication of confidential or highly private information via unsecured e-mail, assumes that you have made an informed decision, and agreed to the risk that such communication may be intercepted.

FEES

My fee is $140 per 50 minute session or $180 per 80 minute session. Consultations with other professionals are billed at $45 per 15 minutes. Payment is expected each session until you are an established patient. At that time, I will invoice monthly with payment due within 10 days.

Checks and credit cards are accepted forms of payment. If a balance accrues due to failure of payment, I will request a payment plan and credit card authorization or seek payment through a collection agency.

By Signing Below I Agree to:

- **Authorize a Credit Card Billing Payment Plan in the Event of an Unpaid Balance.**
- **Payment of Services Rendered by Deborah Kass MS, LCSW**

_____ _____
Signature: Date:

RECEIPTS AND STATEMENTS

To ensure the best possible clinical service, I remain independent of insurance companies. Should you choose to pursue insurance reimbursement, I will provide you with an insurance ready receipt.

My signature below attests to my understanding of these office policies.

Name _____ Date_____

CONSENT TO TREATMENT

CREDENTIALS

In 1983 I completed a Bachelors Degree in Creative Arts Therapy from Northwestern University. Subsequently, in 1987 I earned a Masters Degree in Clinical Social Work from Columbia University and an additional Masters Degree in Special Education and Early Childhood from Bank Street College of Education. While in New York City, I trained at the Mount Sinai Adolescent Health Center as well as the Jewish Family Service. After moving to Portland, I worked on the Adult and Adolescent In-Patient Psychiatric Units at Portland Adventist Health Center. I have been in private practice for over 20 years and was a full-time parent for ten years.

I am currently a candidate in the Adult Psychoanalytic Training program at the Oregon Psychoanalytic Institute (OPI). This training requires my participation in 4 years of post-graduate academic studies along with supervised psychoanalytic clinical cases. If you are interested in psychoanalysis, please don't hesitate to ask for more information.

As Director of PdxParenting and creator of the curriculum "Kids Who Feel Smart," I provide affordable research based education that promotes strong family relationships. Using a contemporary understanding of temperament and developmental psychology, workshop curriculum includes topics such as Building Self-Esteem, Sibling Rivalry and Teen Brain. More information about "Kids Who Feel Smart" can be found at my website under PdxParenting.

RISKS AND BENEFITS

My approach to psychotherapy is based upon research and clinical experience that have proven to be effective with most but not all clients. I cannot, therefore, guarantee positive results for all who seek treatment. External factors, such as life events, medical issues and irregular attendance to appointments can interfere with progress. If I believe you could be better served by or with additional services such as a psychological evaluation, medication management or alcohol and drug rehabilitation with another therapist or program, I will assist you with referrals. At times therapy can lead clients to feel more upset as they are working through difficult feelings. I encourage you to talk with me about any questions or concerns you might have about the treatment I provide.

LEGAL DISPUTES

In order to keep our relationship strictly therapeutic, I do not participate in any legal proceedings involving current or former clients. I will not, except as required by law, testify in cases of divorce, custody competency, or any other legal actions. Please note my involvement in legal proceedings is frequently detrimental to your child's therapy as it disrupts a child's sense of trust in his or her therapist. Should I be under subpoena to testify, I will state this professional opinion in court. I do not conduct custody evaluations or abuse investigations. To best serve your legal needs, I will refer you for support in the event of legal disputes to an outside independent professional.

CONFIDENTIALITY

The information you share with me remains confidential with limited exceptions. These exceptions are:

- **You have signed a release form of disclosure.**
- **You are a danger to yourself or others.**
- **The abuse of a child or elderly person is reasonably suspected.**
- **Court Order.**
- **You have committed a crime against me.**

Your signature below attests to your understanding and consent to these policies.

_____ _____

Signature **Date**

CHILD OR ADOLESCENT THERAPY

My policy is to obtain a consent for treatment from the custodial parent or guardian. Both parents are informed of and included in the treatment unless there are specific reasons not to do so. Research and clinical experience strongly suggests that parents' commitment to parental guidance and education improves the outcome of a child or adolescent's therapy experience.

For children and teenagers to use therapy productively, it is essential for them to have a sense of privacy about what they do or say in therapy. Simultaneously, both parents also need to have a sense of how therapy is proceeding. Therefore, it is understood that I will not share any specifics about a child's therapy unless in my clinical judgment withholding information poses the significant possibility of harm to the child. It is also understood that both parents will be updated about the general course of treatment, offered parental guidance and education along with my professional judgment about their child's welfare.

Please be aware that in most instances, both parents are allowed access to the child's treatment records. What is disclosed to me related to the treatment of your child may be entered into the child's treatment record. If conflict between parents or if a parent's needs are interfering with a child's mental health and development, I will make a referral for individual or couple's counseling. I do not provide individual or couples therapy to the parents of my patients.

It is understood that depending upon a child's age or reading level either a copy of this agreement will be provided to the child or a developmentally appropriate explanation of its content will be provided to the child by myself.

In the event that either or both parents become dissatisfied and decide to end their child's treatment, it is understood and agreed upon that it is in the best interests for the child to schedule a final "good-bye" session rather than for the child to experience being abruptly pulled out of therapy.

In Regards to the Child/Teen_____, my signature below attests:

- **That I understand and consent to the treatment conditions as stated above,**
- **To support the goal of treatment for the best interests of the child,**
- **That I am the custodial and legal parent/guardian of this child.**
- **That I have a legal right to procure mental health treatment for this child,**
- **That if the terms of this agreement are violated, my child's therapy may be damaged and require termination.**

Signature:_____Date:_____

Deborah Kass, MS, LCSW 503) 544- 4355

DIVORCE OR SEPARATION

For your child's benefit, it is essential that I maintain neutrality in any divorce or custody disputes. Whether individual or family focused, all sessions are conducted for the benefit of your child. If conflict between parents or if a parent's needs are interfering with a child's mental health and development, I will make a referral for individual or couple's counseling. I do not provide individual or couples therapy to the parents of my patients. Any unresolved feelings about your ex-spouse as well as your own adjustment to divorce or visitation issues, should be addressed with your own therapist. If you need assistance locating a therapist, I would be happy to help with referrals.

My policy is to include both parents in the treatment unless there are specific reasons not to do so. Please be aware that in most instances, both parents are allowed access to the child's treatment records. What is disclosed to me related to the treatment of your child may be entered into the child's treatment record.

It is understood that both parents give permission for me to release information obtained during the course of therapy to the other parent if I believe it is in the best interest of your child. However, it is also understood that for me to be the most helpful to your child with their feelings related to separation and/or divorce and its aftereffects, each parent needs to feel they can be honest about difficulties they are having with parenting in their household. Therefore, I will discuss with each parent only issues regarding their child occurring in their own household. I will not serve as a "go-between" to share information about one household with the other or to "fix" or change one parent at the request of the other. If conflicts between separated parents are interfering with a child's mental health or treatment, I refer parents to mediation or a parenting coordinator.

By Signing Below I Understand and Agree:

- **To the treatment conditions as stated above,**
- **To support the goal of treatment for the best interests of the child,**
- **That if the terms of this agreement are violated, my child's therapy may be damaged and require termination.**

Signature:_____ Date:_____

CHILD AND ADOLESCENT QUESTIONNAIRE
DEVELOPMENTAL HISTORY

Form Completed by: _____Date:_____

Child/Adolescent Name: _____Date of Birth: _____

Is your child adopted? Yes No If yes: Place and age of Adoption _____

Additional Significant Circumstances of Adoption _____

_____

Any significant family changes: _____

Pregnancy: _____

Specific Stressors: _____

Medical Factors:

☐ High Blood Pressure ☐ Sugar or protein in urine ☐ Excessive Weight Gain

☐ Infections ☐ Abnormal bleeding ☐ Medications

☐ Smoking ☐ Substance Use ☐ Other

Explain: _____

_____

Labor and Delivery: _____

Infancy: Early Problems: _____

Feeding/Sleeping Problems: _____

Milestone: *Achieved on time or delayed:*

Toilet training: _____Talking _____Walking_____ Dressing _____

Toddler/Preschool: _____

Any Concerns: _____

Educational History: _____

Academic Performance: Elementary _____ Middle _____High School_____

Grade Repeated:_____ Special Classes:_____

Interpersonal History: Peers _____Family_____

Authority figures _____

Present Medications:_____

Prior Medications:_____

Prescribed By: _____

Medication Allergies: _____

Psychiatric History: _____

Psychiatrist: _____**Therapist:**_____

Hospitalization or Drug Rehabilitation: _____

When: _____**Where:**_____

Results of Past Treatment: _____

Explain: _____

Any Placement History: _____

Legal Involvement: _____

Family History: ***Circle M for Maternal and P for Paternal. If on both sides circle both the M and P.***

M or P **Depression** ***M or P*** **Psychosis or schizophrenia** ***M or P*** **Anxiety**

M or P **Mental Retardation** ***M or P*** **Autism** ***M or P*** **Obsessive Compulsive Disorder**

M or P **SubstanceAbuse**_____

Any other significant history: _____

Let us know what your concerns are:

Please circle all that apply:

- Worries/Anxiety
- Separation anxiety
- Excessive fears
- Excessive crying
- Sleeps with or near parent
- Fears disasters
- Difficulty falling asleep
- Depressed/sad
- Makes irrational sounds
- Feels like a failure
- Declining grades
- Change in activity level
- Poor attention to details
- Avoids focused mental effort
- Hyperactive
- Difficulty playing quietly
- Squirmy/restless
- Trouble remaining seated
- Trouble relating to others
- Unable to pretend
- Talks in strange ways
- Repeats what others say
- Communication problems
- Hears voices
- Skips School
- Starts fires
- Physically cruel to animals
- Physically cruel to people
- Physically fights with others
- Refuses to do what is expected
- Edgy and restless
- Obsessive habits
- Compulsive rituals
- Isolates
- Nightmares
- Early morning awakening
- Loss of pleasure
- Change in appetite
- Social anxiety

- Difficulty paying attention
- Poor organization
- Easily distracted
- Blurts out answers
- Poor listening skills
- Interrupts others
- Peer conflicts
- Preoccupations
- Repetitive movements
- Frustrated with changes
- Illogical thoughts
- Does odd things
- Breaks curfew
- Destroys property
- Trespasses
- Runs away from home
- Angry
- Blames others for mistakes
- Provocative
- Irritable/tense
- Worries about parents
- Distressing thoughts
- Bed wetting
- School avoidance
- Physical complaints
- Feels worthless
- Lacks confidence
- Low energy level
- Suicidal thoughts
- Loses important objects
- Talks excessively
- Difficulty taking turns
- Forgets daily activities
- Steals
- Has strange ideas
- Bullies/threats
- Trouble with the law
- Avoids responsibility
- Carries a weapon