MacGregor Behavioral Health Services LLC Contact Information - Youth

Youth Name _____ Date of Birth _____ Male / Female

Mother Name: _____ Father Name: _____

Occupation: _____ Occupation: _____

Step-Father / Partner: _____ Step-Mother / Partner: _____

Occupation: _____ Occupation: _____

Mother Address: _____ Father Address: _____

City, State, Zip: _____ City, State, Zip: _____

Office use only

PHONE NUMBERS (ONLY PROVIDE NUMBERS THAT YOU ARE GIVING MBHS PERMISSION TO USE AND LEAVE A MESSAGE (provide as many as possible, and indicate preferences for use) – provide a description of each "dad cell", "mom home", etc:

_____

_____

TEXT MESSAGE (to use HIPAA-compliant secured text messages delivered to your phone/device, a cell phone number and the carrier is required – list the cell phone number(s) that you are giving MBHS permission to use for secured text messages)

Area code and cell number Carrier (e.g., Verizon) cell description ("mom's cell", "Johnny's cell")

_____

_____

_____

E-MAIL (to use HIPAA-compliant secured email messages, list the email address(es) that you are providing your permission for MBHS to use – provide a description of each email, "mom's", "dad's work", etc):

_____

_____

EMERGENCY CONTACTS – for children, the parents are always the first emergency contact. However, if we are not able to reach you, please list the name(s) and all available phone numbers for any other individual(s) you prefer contacted. Only give us the information that you are giving MBHS permission to use.

Name Relationship (e.g., "friend") Phone Numbers

_____

If your child takes any psychiatric (mental health) medications, list the PSYCHIATRIST OR OTHER PRESCRIBING DOCTOR, if not, list your child's PEDIATRICIAN/FAMILY DOCTOR:

Name of Practice: _____ Name of Doctor: _____

Address: _____

Phone: _____ Fax _____

Child Name: _____ Date of Birth: _____

What is the main problem/issue that you want to resolve and how long has it been going on (just a brief description, you will have plenty of time to discuss all of your concerns and provide additional details):

Parent marital status and child's custody/living situation(s):

Names and Ages of siblings:

List all of the individuals residing in your child's home(s):

Is there anything else about your child's family situation that is unusual or important?

Child's School: Current Grade:

What are your child's main academic/social/behavioral problems and strengths at school and describe typical grades?

List all supportive services that your child receives for school:

List all ALLERGIES, MEDICAL CONDITIONS, OR DISABILITIES:

List all of your child's CURRENT MEDICATIONS WITH DOSAGES:

If your child has ever taken psychiatric medications (for mental health), WHEN was the first time and WHAT was prescribed?

List all of your child's previous psychiatric (mental health) medications that have been discontinued:

List all previous counseling/therapy/behavioral support/psychiatric services, with approximate dates or your child's age when each service was received:

Child Name: _____ Date of Birth: _____

Has your child had any problems or symptoms of:

	CURRENT	IN THE PAST	NEVER	Prefer Not to Answer
Lack of support from family				
Few friends, socially isolated				
Rejected or bullied by peers				
Involvement in sports, clubs, community activities				
Developmental delays				
Academic / Learning problems				
Failed a grade				
Problems concentrating / Easily distracted				
Poor Impulse control				
Easily frustrated				
Disruptive behavior at school				
Detentions / suspensions				
Tantrums at home				
Rude, disrespectful verbal behavior				
Non-compliant, refusal behaviors				
Mood swings				
Anger problems				
Hit /kicked /hurt a teacher				
Hit /kicked /hurt a peer at school				
Hit /kicked /hurt an adult at home				
Hit /kicked /hurt a child at home or in the community				
Mean or cruel to younger children or animals				
Sadness / Crying				
Emotional outbursts or meltdowns				
Irritability / very grouchy				
Low energy / lethargic				
Loss of interest in doing things				
Poor motivation				
Low self-esteem				
Anxiety / worrying				
Clingy / Separation anxiety				
Anxiety attacks (panic attacks)				
Acting “too” happy / Silly / Giddy				
Dramatic / Attention-seeking behaviors				
Phobias or unrealistic fears				
Thoughts s/he can’t make stop or just keep repeating in his/her head				
Behaviors s/he can’t stop (compulsions)				
Problems with inappropriate sexual behaviors or sexual identity				
Sexual play with peers / siblings				
Excessive sleeping				
Can’t get to sleep or stay asleep				
Other sleeping problems				
Loss of appetite				
Emotional eating / over-eating				
Complains of being “fat” or talks about wanting to lose weight				
Eating disordered thoughts or behaviors				

Child Name: _____ Date of Birth: _____

Has your child had any problems or symptoms of:

	CURRENT	IN THE PAST	NEVER	Prefer Not to Answer
Emotionally abused / Verbally abused				
Witnessing harsh and hostile verbal arguments				
Physically abused				
Sexually abused				
Witnessing domestic violence or adult fights				
Other type of Trauma				
Bad dreams / Nightmares				
Avoiding things that give him/her strong memories of bad experiences				
Strong memories / Flashbacks				
Toileting problems / bedwetting				
Self-Injurious behavior (e.g., cutting, head-banging)				
Talking about not wanting to be here anymore				
Suicidal statements or comments				
Suicide attempt(s) or threatening suicidal behavior				
Seeing / Hearing things that are not there				
Very strange or very unusual behaviors				
Psychiatric hospitalization or crisis services				
Trying smoking / alcohol / drugs				
Lying				
Stealing				
Destroying things on purpose				
Set fires without adult approval				
Police involvement / legal problems				
Parent(s) that served in the military				
Parental / Family history (biological relatives) of depression/anxiety				
Parental / Family history of more serious mental health issues				
Parental / Family history of substance abuse				
Parental / Family history of suicidal behavior/attempts				
Parental / Family history of criminal / legal problems				

Are there any other problems or symptoms that your child is having that were not included? Is there anything else that would be important to know about your child's situation?

Thank you for your time and we look forward to meeting with you.

Client Name: _____ Date of Birth: _____

MacGregor Behavioral Health Services LLC (MBHS) offers a range of psychological services and the fee varies depending on the type of services received. Fees are charged based on the fee schedule in effect on the date the service was delivered. You may request a copy of the fee schedule at any time, and you will be notified of prices and price increases before any services are delivered. Fees are due at the time of service.

If MBHS is not able to verify "in-network" insurance coverage before services, then payment is required in full at the time of service. For "in network" insurance plans, MBHS will directly bill and make all reasonable attempts to receive reimbursement from the insurance company, however, (1) you are responsible for informing the psychologist of any changes in insurance coverage BEFORE the service is provided, and (2) you are responsible for outstanding fees that have not been paid by the insurance company for any reason after 60 days from date of service. All deductibles, copays, and coinsurances are due at time of service, and there is a $5 charge per invoice for any fees that are not paid at time of service.

For "out of network" insurance plans, you will need to provide full payment at the time of service and then submit the receipt to your insurance company to obtain reimbursement. MBHS will not accept the "allowable" rates designated by "out of network" insurance plans and fees will be charged according to the MBHS current fee schedule. If you request that the psychologist complete authorizations, treatment plans, phone calls, or other paperwork for insurance reimbursement, you will be charged for the psychologist's time at the rate of $25 per 15 minutes.

There is a $25 fee that will be charged to your account if the after-business-hours 888-235-8011 number is used to contact the MBHS on-call psychologist, and for calls lasting more than 15 minutes your account will be charged $25 per each additional 15-minute increment. Insurances DO NOT reimburse crisis phone call fees.

If you request any legally-related services (e.g., written documents or phone calls for attorneys or court), your account will be charged $125 per hour. If the identified client's receipt of services results in the psychologist's participation in legal proceedings (depositions, court testimony, etc.), you will be responsible for $1,000 per day ($1,500 per day for any county other than Adams County), even if the psychologist is ordered to participate by another party. This fee includes preparation for the testimony, travel expenses, and cancelling the day of routine business. **Health insurance will not pay for any portion of any legally-related service.**

CREDIT/DEBIT CARDS ARE NOT ACCEPTED and there is a $10 per month late fee / finance charge on any unpaid balance. If the account is past due for more than 90 days, a collection agency may be used to obtain payment. There is a $25 fee for a check returned for any reason, including any check that incurs a fee during processing (e.g., re-deposited check).

Your account will be charged for copies of clinical records, late cancellations / missed appointments, and additional services (refer to the current fee schedule for these amounts).

It is the policy of MBHS for ONE individual to accept financial responsibility for services rendered to the client. In shared custody of a child situations, MacGregor BHS will not accept responsibility for determining who is responsible for which percentage of fees or collecting/invoicing percentages to multiple individuals.

Accepting financial responsibility and/or providing payment for services rendered to an adult or adolescent 14 years or older DOES NOT entitle you to access that individual's confidential treatment information. Individuals 14 years or older must be willing to provide their authorization for anyone (including their own parents or spouse) to access their clinical records.

The MBHS fee schedule is available on request, and you are agreeing to accept the rates in effect at the time of service. These fees are subject to change WITH notification prior to service delivery. Your signature below indicates that you are accepting all of the terms and conditions of this contract, and that you are accepting financial responsibility for all of the fees for services provided by MacGregor Behavioral Health Services LLC (MBHS) to the client named above that are not reimbursed by health insurance(s) for any reason:

****** You must be 18 years or older to sign this agreement and accept financial responsibility ******

_____	_____	_____
Printed Name	Signature	Date

MacGregor Behavioral Health Services LLC

Consent for Psychological Services Agreement – Child (under 14 years)

Child Client Name _____ Date of Birth _____

Welcome to MacGregor Behavioral Health Services LLC (MBHS). We appreciate your trust, and welcome the opportunity to provide quality professional services. This document contains information regarding professional therapeutic services, policies, and your legal rights regarding the confidentiality of your child's protected health information (Health Insurance Portability and Accountability Act - HIPAA). HIPAA is a federal law that provides increased protection and client rights with regard to the use and disclosure of your child's Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Notice of Privacy Practices (Notice) details the use and disclosure of your child's protected health information and your access to this information.

You must be a legal guardian of the child client named above, and when you sign this "Consent for Psychological Services Agreement" (Agreement), it will represent an agreement between you and MBHS. You may revoke this Agreement in writing at any time. That revocation will be binding unless MBHS has taken action in reliance on it; if there are obligations imposed on MBHS by your child's health insurer in order to process or substantiate claims made under your policy; or if there are outstanding financial obligations on the client account.

Office Policies

The psychologists' work schedules vary and your child's psychologist is often not immediately available by phone and does not accept calls while in session. You may leave a message with the office manager, or leave a voice mail message at the office phone number, and your child's psychologist will return your call as soon as possible. In life-threatening situations, immediately call **911** or go to the local hospital emergency room. If a non-life-threatening crisis occurs during non-business hours, an on-call psychologist is available to you by calling 888-235-8011. The on-call psychologist **may not be your child's** treating psychologist, as the on-call responsibility rotates among the practice psychologists. Your account will be charged for the use of this after-hours service according to the fee schedule in effect on the date of the call.

A "no show / late cancel" is defined as less than 24 hours notice to the MBHS office for a missed appointment. New clients who no show / late cancel for their initial appointment will be placed back at the end of the existing waiting list. Clients already working with an MBHS psychologist are provided one excused no show / late cancel per 6 month period of time. When a no show / late cancel occurs, you will receive notification of the missed appointment with no fee charged. The second and third no show / late cancel is charged according to the fee schedule in effect at the time of the missed appointment, and after the 3rd no show / late cancel appointment within a 6 month period of time, each no show / late cancel is charged at the full cost of the service.

MBHS makes every effort to respect your preferences and requests regarding electronic communications. MBHS will not contact you at any phone number or email address unless you have specifically provided that contact information to MBHS for use. There are security risks associated with all forms of electronic storage and transmission, however, MBHS offers secure, HIPAA-compliant messaging and encrypted email. If you choose to use text messages, standard email, and other non-encrypted forms of electronic communications, you are being informed that these electronic communications are not HIPAA-compliant for the purposes of sending PHI. Your use of any electronic communications indicates that you are choosing to accept all of the associated risks with these communications. If you send a non-HIPAA-compliant communication (e.g., email) to the MBHS office or staff, then you are providing your implicit permission for the MBHS staff to respond using that same form of electronic communication (e.g., reply to your email). If any MBHS staff initiates an electronic communication, then the MBHS staff will either use a HIPAA-compliant communication, or will make every effort to restrict the content of the electronic communication to administrative information that does not include PHI. You must notify the MBHS office immediately if you receive an electronic communication that contains information that you consider PHI and that you object to similar types of information being sent through non-HIPAA-compliant electronic communications. After you notify the MBHS office, electronic communications will be ceased immediately. Some forms of HIPAA-compliant encrypted storage and transmission of your child's PHI is required for normal treatment, payment, and health care operations. All of your child's PHI, clinical information, and treatment documentation is stored and transmitted in accordance with HIPAA regulations and compliance standards.

You are responsible for your own safety, and for the safety of any other adults or children who accompany you or your child to appointments. You are responsible for insuring that children on our premises have adult supervision at all times, and any toys available in the waiting area are used at the discretion and supervision of the parent /caretaker. You are responsible for being aware of and insuring safety around natural physical dangers, including, but not limited to, stairs, windows, potholes and ice on pavement. Please be notified

that children are not allowed to remain in the waiting room unsupervised, and they must be accompanied by an adult to the restroom. There will be no one available to supervise children who are not involved in the session, and every effort should be made to bring only the individuals involved in the session (or bring an adult to supervise children). We deem our office premises to be reasonably safe, however, you should present for appointments only at your sole discretion. You may cancel any appointment without penalty or fees in any situation in which you deem the office premises unsafe. While every attempt is made to maintain safe premises, your signature on this Agreement indicates that you are accepting sole responsibility for the safety of yourself, your child, and any other individuals accompanying you to appointments while in, on, or around our office premises, and you understand and agree that MBHS is not responsible and cannot be held liable for any negative consequences or damages related to the MBHS premises.

Psychological Services

Participation in psychological services can have both risks and benefits. Psychological evaluation and therapeutic services often involve discussing unpleasant aspects of your life, and you and your child may risk experiencing uncomfortable feelings (e.g., anger, sadness, guilt), emotional distress, and/or increased behavior problems. However, psychological evaluation and treatment services can yield many benefits, including improved emotional functioning, social relationships, and alleviation of emotional and psychiatric disorders. However, there are no guarantees with regard to the effectiveness of psychological services, or for your child's particular experience of risks or benefits. MBHS provides all psychological services within the guidelines of the professional, ethical, and legal standards established these services. If you have any concerns regarding any aspect of your child's evaluation or treatment services, your child's psychologist is available to respond to your concerns or questions. You have a choice in providers and are under no obligation to receive services from MBHS. Your signature on this Agreement provides your consent for your child to receive all of the psychological assessment and treatment procedures deemed necessary and appropriate by the treating psychologist. Your signature on this Agreement also indicates that you understand there is the possibility, as with all types of treatment services, that your child's participation in psychological services could possibly have unfavorable effects on yours and your child's personal, family, legal, or financial situation.

Parental Consent, Professional Records, and Limits on Confidentiality

According to PA state law, the consent of BOTH parents (and/or all legal guardians) is required for youths under the age of 14 years to receive routine psychological services. For children with separated or divorced parents, if one parent objects to the child's participation in psychological services, a court order must be obtained to authorize MBHS to provide services without the other parent's consent.

The laws and standards require that the treating psychologist maintain a clinical record of your child's services. Your child's clinical record may contain the reasons for seeking services, symptoms, diagnosis, treatment plan, session information and progress, medical, social, and family history, records received from other providers, billing information, phone calls and other communications, information provided by other individuals participating in the child's services (e.g., a parent reporting their own history of suicidal behaviors), the treating psychologist's observations and opinions regarding the child client and any individuals participating in the child's treatment, and all other information related to your child's clinical services. HIPAA mandates that for children under the age of 14 years, both parents have a legal right of access to their child's treatment records, even if that parent did not initiate or participate in the services. Except in unusual circumstances in which the treating psychologist believes that parental access to your child's record is reasonably likely to cause substantial harm, any parent/legal guardian may examine and/or receive a copy of your child's clinical record (additional fees will apply). If a request to access your child's records is denied, there is a right of review which will be discussed with the requestor.

For children under the age of 14 years, your child's confidentiality is protected and no clinical information will be released to anyone other than a parent/legal guardian without your authorization WITH THE FOLLOWING EXCEPTIONS:

> Neither your consent or authorization is required for the release of your child's PHI if (1) the information is court-ordered to be released, (2) a government agency requests the information for health oversight activities, (3) you file a worker's compensation claim, and/or (4) you, or anyone on your child's behalf, file a complaint or lawsuit against MBHS or any MBHS employee (your child's entire clinical file can be used within the legal defense). The treating psychologist is obligated by law to disclose your child's PHI in order to protect others from harm if the treating psychologist believes that (1) a child receiving services is being abused, (2) an elderly/vulnerable person is in need of protection, and/or (3) your child presents a specific and immediate threat of serious bodily injury to him/herself or another individual (suicidal or homicidal). These situations are very unusual and the laws regarding confidentiality are complex. You should consult an attorney for specific advice if you have concerns.

In most situations, MBHS can only release information regarding your child's psychological services if you sign an authorization form that meets the legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides your consent for the following:

Client Name (print) _____

Occasionally the treating psychologist may need to consult with other professionals regarding your child's treatment. Every effort is made to avoid revealing your child's identity, and the other professionals are also legally bound to keep the information confidential. Typically these consultations are not discussed directly with you and function to provide your child with the highest quality of care.

MBHS employs psychologists and administrative staff. Your child's PHI may be shared with other MBHS staff for clinical and administrative purposes. All MBHS staff are trained to protect to PHI and will not release any information outside of MBHS.

If the treating psychologist deems your child's functioning to be a crisis or danger concern (at the sole discretion of the treating psychologist), you are authorizing your child's psychologist to contact any individuals necessary to assist with stabilizing your child's functioning to safe levels and to attempt to insure safety (this can often avoid a psychologist's mandate to call the police).

Health Insurance

In order to obtain reimbursement for services from your child's insurance company, some of your child's clinical information is required to be released to the insurance company. Although all insurance companies are required by law to keep your child's information confidential, MBHS has no control over how they secure and utilize your child's information after it has been provided to them. You should call your child's insurance company if you have questions about how they use and secure your child's information.

Your signature below authorizes (1) the use of your child's PHI for treatment, payment, and health care operations, (2) the disclosure of all information necessary, including mental health and substance abuse information, to obtain pre-authorizations/certifications/approvals from your child's insurance company, to submit and process claims for payment, and to provide quality assurance/utilization information to your child's insurance company, and (3) the payment of insurance benefits to MacGregor Behavioral Health Services LLC for services rendered. Your signature on this agreement provides your permission for MBHS to transmit and store your claims/billing through HIPAA-compliant secured servers, claims processing centers, and your health insurance's claims processing department.

Your signature below indicates that you are providing your informed consent for your child to participate in psychological services, and agree to hold harmless and release from all liability JoAnn MacGregor, Ph.D., James B. MacGregor, Ph.D., Amy Taylor, Psy.D., MacGregor Behavioral Health Services LLC, and all MBHS staff and employees for any negative effects or damages that may result from your and/or your child's participation in psychological services, release of information, and/or the claims/fee collection process. You are agreeing that if you, or anyone on your or your child's behalf, file a lawsuit, licensure, or ethics complaint, or take any other legal action against MBHS and/or any employee(s) of MBHS concerning any aspect of your child's psychological services, and there is a favorable ruling for MBHS and/or any MBHS employee(s), then you are agreeing that you will be financially responsible for all direct and indirect costs incurred by MBHS and/or any MBHS employee(s), including legal, professional, office and court costs for the complaint or suit filed by you or anyone on your child's behalf. These costs are due 30 days from the determination in favor of MBHS and/or MBHS employee(s).

Your signature indicates that you have read, understand, and agree to the terms of this Agreement. When you sign this Agreement, any previously signed Agreements are void and are no longer in effect. This Agreement remains binding and in effect, even if the child client ages to 14 years or older during treatment, until a new Agreement is signed. You may discuss any concerns with the treating psychologist, or with your attorney, before signing. You may keep a copy of this Agreement.

_____ _____

Mother/Legal Guardian Signature Date

_____ _____

Father/Legal Guardian Signature Date

Your signature below indicates that you have received, reviewed, understand and agree to the Notice of Privacy Practices for MacGregor Behavioral Health Services LLC, which describes the policies and procedures regarding the use and disclosure of any PHI, created, received, or maintained by MacGregor Behavioral Health Services LLC. Copies of the Notice are available at www.MacGregorBHS.com, in our office wait room, directly from the treating psychologist, or you can call 717-337-3005 to have it mailed to you.

_____ _____

Mother/Legal Guardian Signature Date

_____ _____

Father/Legal Guardian Signature Date

Revised: 09/01/2014

Client Name (print) _____