CM COUNSEL
Practice Information Notice

523 Plymouth Road, Suite 215, Plymouth Meeting, PA 19462 – 610-825-9400
740 Springdale Drive, Suite 102, Exton, PA 19341 – 610-524-0780
210 Mall Boulevard, Suite 204, King of Prussia, PA 19406 – 484-808-5340

Welcome to CM Counsel. We are pleased that you have chosen us for treatment. We are committed to providing you with quality mental health services. . This packet contains important information about CM Counsel professional services and business policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and rights with regard to the use and disclosure of your Protected Health Information (PHI). The Notice of Privacy Practices is included in this packet. The law requires that we obtain your signature acknowledging that we have provided you with this information.

Fees:
Payment is expected at the time of appointment. We accept cash, checks, credit cards and debit cards for payment. Checks should be made payable to CM Counsel. Payment schedules for other professional services will be agreed to when they are requested.

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. The practice will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled.

However, you, not your insurance company, are responsible for full payment of the practice fees. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, please call your plan administrator.

Please bring your insurance card to your first appointment. If you are covered by more than one insurance carrier, please notify our administrative staff ASAP. If there is any change in your insurance status or carrier, please tell us immediately. You may discuss any questions you have regarding fees and payments with your clinician. **Any check returned due to insufficient funds will result in a $25 service charge.**

Emergencies:
If there is a life-threatening emergency, please go to the nearest hospital emergency room and/or call 911.

Contacting CM Counsel:
You may contact CM Counsel by phone during regular office hours, 9am – 5pm. In Plymouth Meeting, call 610-825-9400. In Exton, call 610-524-0780. In King of Prussia, call 484-808-5340.

After hours: For administrative and other matters, please call one of the office phone numbers and leave a message. If you are calling about an urgent clinical matter that requires attention outside of regular office house, please call the on-call therapist at 610-256-2195.

Confidentiality:
No records of your treatment will be released outside of CM Counsel without specific written permission from you. There are some unusual circumstances under which we may release information without your authorization. Additional information regarding confidentiality is included in this packet. Please discuss any questions or concerns you may have with your therapist.

Suggestions & Complaints:
All of us at CM Counsel are committed to providing quality care. We are dedicated to excellence in customer service and would like the opportunity to address any concerns or complaints you have. If you have a recommendation or concern, please contact Catherine Frank, Ph.D. or Michael Frank, Ph.D. at 610-825-9400.

Clients Rights & Responsibilities:
A copy of CM Counsel's "Statement of Patient's Rights & Responsibilities" is included in this packet. Please feel free to discuss these and any other issues you may have with your clinician. We ask for your signature on the form to assure that this information has been communicated and a copy given to you.

****ALERT** FOR EXTON CLIENTS ONLY**: Exton clients with evening and weekend appointments must use the following code to enter the building: ***CMCM (**2626). If the code fails, push the "List" button and dial CM Counsel.

CM Counsel's NO SHOW and LATE CANCELLATION Policy

Welcome and thank you for choosing CM Counsel. We know you have numerous choices. We hope our clinicians and administrative staff go above and beyond meeting your needs and expectations

We at CM Counsel are devoted to providing services to those who come to us requesting assistance. As such, we prepare well in advance for the appointment mutually agreed upon. We consider this time important in terms of providing professional services uniquely designed. In other words, this is time dedicated specifically to you.

Given our commitment to providing optimal services, we ask that our clients make a commitment as well. We ask that you make every effort to keep your appointment. While we understand there are occasional unforeseen circumstances and emergencies that might present an obstacle to attending your appointment, our policy requires you to notify us at least 24 hours in advance of any cancellation.

Neglecting to do so has two major consequences: First insurance will not pay for any missed session. Thus no one, including your clinician, receives any payment. Given that this is our livelihood, we are at a loss when a late cancel or a no show occurs. Secondly and equally important, if a cancellation is not made in a timely fashion, it is often impossible to offer other clients waiting for an appointment the newly opened hour.

It is for the reasons described that the following out-of-pocket fees are incurred for late cancellations and no shows:

Psychotherapists: $75
PhD Psychologists: $100
Psychiatric Evaluation: $150
Psychiatric Follow-Up: $85

We are sure that you can understand why these fees exist and are collected prior to or at the time your next appointment is made. If you have any concerns regarding this policy, please discuss them when you meet your clinician.

Once again, thank you for choosing to work with us. We look forward to ongoing and positive relationships with you.

Most sincerely,
CM Counsel

CM Counsel

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your Protected Health Information (PHI). This notice explains our legal duties and privacy practices with regard to your PHI. We are required by law to provide you with a copy of this notice and abide by the terms of this Notice. Accordingly, we will ask you to sign a statement acknowledging that we have provided you with a copy of this notice. We reserve the right to change the terms of this notice at any time. The change may by retroactive and cover PHI that we received or created prior to the revision. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If CM Counsel revises our policies and procedures, we will post the revised notice prominently in the office. You may also request a written copy of the revised notice.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

CM Counsel may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when CM Counsel provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when CM Counsel obtains reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of CM Counsel. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

CM Counsel may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes made by your practitioner about conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) CM Counsel has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. CM Counsel will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this notice.

III. Uses and Disclosures with Neither Consent nor Authorization

CM Counsel may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause, on the basis of professional judgment, to suspect abuse of children with whom we come into contact in our professional capacity, we am required by law to report this to the Pennsylvania Department of Public Welfare.
- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services CM Counsel has provided to you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and we determine that you are likely to carry out the threat, CM Counsel must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.
- **Worker's Compensation:** If you file a worker's compensation claim, CM Counsel will be required to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.
- **Section 164.512 of the Privacy Rule:** When the use and disclosure without your consent or authorization is allowed under other parts 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 purposed 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 CM Counsel is required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Patient's Rights

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, CM Counsel is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being treated at CM Counsel. Upon your request, we will send your bills to another address.) The request must be in writing, but we will not ask for an explanation from you. We will accommodate reasonable requests, but we may condition the accommodation on information as to how payment, if any, will be handles and specification of an alternative address or other method of contact.
- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. If you want to exercise this right, please submit a request to access medical records in writing. This right does not extend to psychotherapy notes, information compiled in reasonable anticipation of legal action and confidential information relating to certain lab tests. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend*: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. If you want to exercise this right, please make your request for amendment of medical records in writing. You will need to provide a reason for the requested amendment. CM Counsel may deny your request if we determine that we did not create your record, is not maintained by use, would not be available for access or is accurate and complete. Your records will not be changed or deleted as a result of our granting your request, but the amendment will be attached to your record and

its existence noted in your record as necessary. Use of this procedure is not necessary for routine changed to your demographic information, such as address, phone number, etc. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting*: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). If you want to exercise this right, please provide your request in writing. The accounting does not have to list disclosures made to carry out treatment, payment and healthcare operations; to you; pursuant to an authorization; for national security or intelligence purposes; to correctional institutions or law enforcement personnel; or that occurred prior to April 14, 2003. Compliance with this right is time consuming and do we reserve the right to charge you a fee if you request more that one accounting in a 12-month period. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy:* You have the right to obtain a paper copy of this notice from CM Counsel upon request, even if you have agreed to receive the notice electronically.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket:* You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for CM Counsel services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI:* You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your 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 your PHI has been compromised.

V. Organizational Policies

To facilitate the smooth and efficient operation of our practice, we engage in certain practices and policies that you should understand. You can avoid any of the following practices by discussing your concerns with us and working out an alternative arrangement as is possible.

- We contact our patients by telephone, which might include leaving a message on an answering machine or voice mail to provide appointment reminders or other pertinent administrative information.
- Our staff will conduct routine discussions at our front desk with patients as needed.
- We may us sign-in sheets and call out names in our waiting room to manage patient flow.
- We may share PHI with third party business associates that perform various functions for the practice (for example, billing services and transcription services), and we have written contracts with those entities containing terms that require the protection of your PHI.
- We may share PHI with their-party "business associates" that perform various functions fur us (for example, billing, transcription), but we have written contracts with those entities containing terms that require the protection of your PHI.
- We may disclose your PHI to your personal representative(s), if any, unless we determine in the exercise of our professional judgment that such disclosures should not be made.

Questions and Complaints

If you have questions about this notice, disagree with a decision CM Counsel has made about access to your records, or have other concerns about your privacy rights, you may contact Michael Frank, Ph.D., Privacy and Security Officer, CM Counsel, 523 Plymouth Road, Suite 215, Plymouth Meeting, PA 19462, 610-825-9400. If you believe that your privacy rights have been violated and wish to file a complaint with CM Counsel, you may send your written complaint to Michael Frank, Ph.D., Privacy and Security Officer, CM Counsel, 523 Plymouth Road, Suite 215, Plymouth Meeting, PA 19462. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. CM Counsel will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

The effective date for this notice is August 2016. CM Counsel reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting the revised notice prominently in our office. You may also request a written copy of the revised notice.

CM Counsel
Electronic Communication Policy

In order to maintain clarity regarding the use of electronic modes of communication during your treatment, CM Counsel has prepared the following policy. Many of the commonly used modes of electronic communication now regularly used in our society put your privacy at risk and can be inconsistent with the law and the professional standards of the practitioners at CM Counsel. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment to the extent possible and insure that it is consistent with ethics and the law. If you have any questions about this policy, please feel free to discuss them with your practitioner or the Clinical Director of the practice, Cathy Frank, Ph.D.

Email Communication:
CM Counsel will use email communication with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges with your practitioner or the office should be limited to things like setting and changing appointments, billing matters and other administrative matters. Please do not email your practitioner or the office about clinical matters because email is not a secure way to communicate with your practitioner. If you need to discuss a clinical matter with your practitioner, please call the office to speak with your practitioner by phone or wait to discuss the matter in session. The telephone or face-to-face communication is a much more secure method of talking about clinical matters.

Text Messaging:
Because text messaging is a very unsecure and impersonal mode of communication, CM Counsel practitioners or office staff do not send text messages or respond to text messages from anyone in treatment at CM Counsel. So, please do not send text messages to your practitioner or the office unless we have made other arrangements in advance.

Social Media:
The practitioners and office staff do not communicate with or contact clients through social media platforms like Twitter, Facebook, Snap Chat, etc. This is because communication on these types of social media platforms can create significant security risks for you. Your practitioner may participate on various social networks, but cannot communicate professionally with patients. Please do not try to communicate with your practitioner via social media platforms. Please feel free to discuss this policy with your practitioner if you have questions.

Websites:
CM Counsel has a website that you are free to access. The website provides information about the practice. If you have any questions about the website, please discuss with your practitioner during your session.

CM COUNSEL
Statement of Limits to Patient Confidentiality
Patient Copy

CM Counsel believes the protection of client information is of primary importance and thus maintains strict confidentiality standards. We employ only those persons who maintain professional standards of confidentiality, including confidentiality of personal information and your client record.

CM Counsel staff is subject to standards that contain strict obligations of confidentiality. Client records are maintained in CM Counsel clinical treatment facilities only, in secured files with controlled access.

No records of treatment will be released outside of CM Counsel without specific written permission from you, the client or guardian. **There are some unusual circumstances under which CM Counsel may release treatment information without your authorization. These situations are:**

1. An emergency involving imminent danger of harm to yourself or to others (suicidal or homicidal).
2. An audit of program evaluation by qualified personnel representing the insurance carrier.
3. Court order.
4. Physical and/or sexual abuse of a minor.
5. Abuse, neglect, exploitation or abandonment of an older adult.
6. Use, creation or dissemination of child pornography.
7. If a crime is threatened or committed at the CM Counsel or against CM Counsel staff.
8. If a client is employed by a company that has additional exceptions to confidentiality, i.e. safety sensitive positions and reporting of substance abuse.
9. In the case where a client is referred by a primary care physician and is receiving medication from CM Counsel, medication reports ay be sent without your consent.
10. If a government agency is requiring the information for health oversight activities
11. If you or your legal representative files a complaint or lawsuit against CM Counsel, we may disclose relevant information about you in order to defend the practice and practitioners.
12. Worker's compensation claims.

Duty to warn and protect:

The duty to warn and protect overrides the usual right to confidentiality. If a therapist believes that a client represents a threat to himself or others, the therapist shall attempt to warn the client's family member of potential self-harm and attempt to warn the potential victim in a timely manner. In such a case, the police may be contacted. In any life-threating situation, any relevant information obtained during the initial evaluation or from ongoing treatment can be released.

New PA Child Protective Service Law Reporting Requirements as of Dec. 31, 2014:

If there is reason to suspect, in the judgment of a CM Counsel practitioner, that a child under 18 years of age is or has been abused, the practitioner is mandated by law to report those suspicions to the authority or government agency vested to conduct child abuse investigations. The CM Counsel practitioner is required to make such reports even if he or she does not see the child in a professional capacity.

Furthermore, the CM Counsel practitioner is mandated to report suspected child abuse if anyone age 14 or older tells the practitioner that he or she has committed child abuse, even if the victim is no longer in danger.

All CM Counsel practitioners are also mandated to report suspected child abuse if anyone tells the practitioner that he or she knows of any child who is currently being abuse even if the practitioner does not see the child in a professional capacity.

All CM Counsel practitioners are mandated to report use, creation or dissemination of child pornography.

If you have any questions about limits to confidentiality and mandated reporting laws, please discuss with your practitioner.

My signature below indicates that I understand confidentiality standards and limits to my confidentiality and my questions/concerns were addressed.

Signature of Patient or Guardian of Patient Date

CM COUNSEL
Statement of Limits to Patient Confidentiality
File Copy

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- An audit of program evaluation by qualified personnel representing the insurance carrier.
- Court order.
- Physical and/or sexual abuse of a minor.
- Abuse, neglect, exploitation or abandonment of an older adult.
- Use, creation or dissemination of child pornography.
- If a crime is threatened or committed at the CM Counsel or against CM Counsel staff.
- If a client is employed by a company that has additional exceptions to confidentiality, i.e. safety sensitive positions and reporting of substance abuse.
- In the case where a client is referred by a primary care physician and is receiving medication from CM Counsel, medication reports ay be sent without your consent.
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Signature of Patient or Guardian of Patient Date

Child/Adolescent Intake Information **Date: _____**

_____

Patient's Name (Last, First, MI) **Gender** **Date of Birth**

_____

Address **City** **State** **Zip**

Mother	**Father**
Home Phone:	Home Phone:
Cell:	Cell:
Work:	Work:

Please check:
Biological Parents are: ☐Married ☐Legally Separated ☐Divorced ☐Living together, not married
Is there is a court ordered custody agreement: □Yes □No □Not Applicable If yes, please provide a copy.

Address of mother:
_____

Address of father:
_____

Referred by:
_____

Pediatrician: _____ Phone: _____
Pediatrician address:
_____

Reason for Visit:

Does the child agree there is a problem? **□Yes** **□No**
Were there precipitating events that led to these problems?

Has the child received individual therapy? **☐ Yes** **☐ No**
If yes, indicate reason and name of therapist:

Has the child ever had a psychiatric hospitalization ☐ **Yes** ☐ **No**
If yes, please indicate dates and reasons:

_____

Has the child ever had difficulty with the police? ☐ **Yes** ☐ **No**
If yes, please explain

_____

Has the child ever appeared in Juvenile Court? ☐ **Yes** ☐ **No**
If yes, please explain

_____

Has the child ever been adjudicated delinquent? ☐ **Yes** ☐ **No**
If yes, please explain

_____

Has the child ever been in placement? ☐**Yes** ☐ **No**
If yes, please indicate dates and places:

_____

Previous Evaluations (Including dates and results)

PSYCHOLOGICAL:

_____

NEUROLOGICAL:

_____

SPEECH:

_____

PSYCHIATRIC:

_____

OTHER:

_____

Has the child ever taken or is he/she currently taking any prescribed medication for emotional or behavioral problems? ☐ **Yes** ☐ **No**

Age_____Medication_____Reason_____Name of Doctor_____

_____

_____

_____

How does the child get along with authority figures? _____

_____

_____

How does the child get along with peers?_____

_____

LIFE SKILLS, EDUCATION, VOCATIONAL

EDUCATION HISTORY – Please name school and describe child's experience at school

Preschool:

_____

Elementary:

_____

Junior High:

_____

High School:

_____

In general, the child's school progress has been: ☐Excellent ☐Average ☐Poor

Type of classes: ☐Regular ☐Special Education
If child is in special education class(es), please describe the type of class and dates of placement:

_____

Did the child skip a grade? ☐Yes ☐No
If yes, which grade? _____

Did the child repeat a grade? ☐Yes ☐No
If yes, which grade? _____

Has the child ever had specific learning difficulties? ☐ Yes ☐ No
If yes, please specify:
_____

Does the child attend school on a regular basis? ☐ Yes ☐ No
If no, please explain:
_____

Does the child appear motivated to attend school? ☐ Yes ☐ No
If no, please explain:
_____

Has the child ever been suspended? ☐ Yes ☐ No
If yes, please list reasons: _____

_____

Describe any other school problems: _____

_____

<u>Academic Performance:</u>
Highest grade in last school report: _____

Lowest grade in last school report: _____

Favorite subject: _____

Least favorite subject: _____

What is the child's current: Reading grade-level? _____

Math grade-level? _____

What are the child's educational goals?_____
☐ Quit School ☐ Graduate High School ☐ Go to College

FAMILY BACKGROUND & DYNAMICS

Child currently lives with: _____

_____

History of child's living situations (with whom and dates): _____

_____

Child's parents are: ☐ **Married, living together** ☐ **Never married, live together** ☐ **Separated** ☐ **Divorced**
☐ **Other:**_____

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Name:	_____	_____
Birthdate:	_____	_____
Age at birth of child:	_____	_____
Occupation:	_____	_____
Employer:	_____	_____
How long employed:	_____	_____
Highest school level:	_____	_____
Present marital status:	_____	_____
Date of present marriage:	_____	_____
Any previous marriages:	_____	_____
General health:	_____	_____

Brothers/Sisters (indicate if stepbrother or stepsister)

Name	Age	School	Grade/Occupation	Living With?

Has the child accepted new siblings?_____

List others living in the home:

Name	Age	Relationship

Has any of the child's family members had problems with:
☐ **Reading** ☐ **Spelling** ☐ **Math** ☐ **Speech** ☐ **Writing**
If yes, please explain: _____

_____

Is there any history in the child's family of: ☐Mental Retardation ☐Epilepsy ☐Birth Defects ☐ Psychiatric Illness ☐Drug Abuse ☐Alcohol Abuse ☐Addiction Problems
If yes, please explain:_____

How does the child get along with: Mother_____ **Father:**_____

Sisters: _____ **Brothers:**_____ **Other:**_____

Who usually handles discipline? _____

What discipline methods are used (i.e. scolding, spanking, grounding, etc.)?_____

_____

How does the child usually respond to discipline?_____

_____

What are the traumas or losses that the child has experienced? _____

_____

What are the family expectations for treatment? _____

_____

IF THE CHILD IS ADOPTED:
Adoption source: _____

Reason and circumstances: _____

Age when child was first in home: _____

Date of adoption: _____

What has the child been told? _____

DEVELOPMENTAL HISTORY: PRENATAL AND BIRTH:

Was the child planned for? ☐Yes ☐No
Were there any complications during pregnancy (physical or emotional)? ☐Yes ☐No
If yes, please explain: _____

_____

Was the delivery full term? ☐Yes ☐No
If premature, how early? _____ **If post mature, how late?**_____

Birth weight: _____**lbs.** _____**oz.**
Type of delivery: ☐Spontaneous ☐Caesarean ☐With instruments ☐Head first ☐Breach
Did the baby require oxygen? □Yes □No
Did the baby require blood transfusion? □Yes □No
During infancy, indicate the history of any of the following:

			How Long?
Irritability	☐Yes	☐No	_____
Difficulty breathing	☐Yes	☐No	_____
Difficulty sleeping	☐Yes	☐No	_____
Colic	☐Yes	☐No	_____
Normal weight gain	☐Yes	☐No	_____

Was the child breast-fed? _____ Bottle-fed? _____ Was the feeding done on schedule? _____ Demand? __
Were there feeding problems? ☐Yes ☐No
At what age did toilet training begin? _____
Bladder control achieved at age _____ Bowel control achieved at age _____

Sitting without support achieved at age _____ Crawling at age _____ Walking without support at age ____
Speaking words at age _____ Speaking sentences at age _____

Was there any difficulty with:
Gross motor skills (i.e., bicycling, sports, etc.)? ☐Yes ☐No

If yes, please explain: _____

Fine motor skills (i.e., using scissors, tying shoes, etc.)? ☐Yes ☐No

If yes, please explain: _____

Language skills (i.e., stuttering, lisp, word finding, etc.)? ☐Yes ☐No

If yes, please explain: _____

Describe the child's speech and language at present:
☐Below average ☐Average ☐Above average

Describe the child's coordination at present:
☐Below average ☐Average ☐Above average

MEDICAL/HEALTH:

Describe the child's general health: _____

_____

Name of the pediatrician, family physician or clinic: _____

Describe any physical handicaps or limitations: _____

_____

Check the child's eating patterns: ☐Healthy, balanced diet ☐Junk food ☐Overeats ☐Undereats
Describe any serious injuries, accidents, traumas and hospitalizations: _____

_____

Describe any chronic medical conditions:_____

_____

Does the child take medication for any medical conditions? _____

_____

List any medication allergies? _____

_____

Has the child ever been seen by a medical specialist? ☐Yes ☐No
If yes, please explain:
NAME OF PHYSICIAN REASON

_

Note all health problems past or present:

	Age		Age
Blood Pressure	_____	**Sugar problems**	_____
High fevers	_____	**Allergies**	_____
Convulsions	_____	**Heart conditions**	_____
Weight problems	_____	**Unconsciousness**	_____
Concussion	_____	**Headaches**	_____
Fainting	_____	**Stomach problems**	_____
Dizziness	_____	**Accident-prone**	_____
Vision problems	_____	**Frequent colds**	_____
Hearing problems	_____	**Frequent tiredness**	_____
Poor appetite	_____	**Serious injury**	_____
Prolonged illness	_____	**Hospitalization**	_____

RECREACTION/LEISURE:

Does the child have friends? ☐ **Many friends** ☐ **Few friends** ☐ **No friends**

Are these friends ☐ **About the same age?** ☐ **Older?** ☐ **Younger?**

☐ **Same sex?** ☐ **Opposite sex?** ☐ **Both boys & girls?**

Is the child more of a leader or a follower? _____

How does the child spend leisure time after school? _____

_____

List the child's primary interests and hobbies: _____

_____

List any group activities in which the child participates (i.e., Boy Scouts, sports, church group, etc.): _____

_____

Signature of Person Completing Form: _____ **Date:** _____

Print name of Person Completing Form: _____

Financial Responsibility and Assignment of Release:

I hereby authorize that my insurance benefits be paid directly to CM Counsel and I accept financial responsibility for all non-covered services and copays. I also authorize CM Counsel to release any information regarding treatment to my insurance company(s) as required for payment of services rendered.

Parent/Guardian Signature: _____ **Date:** _____

Please Print Parent/Guardian Name: _____

Reviewing Therapist's Signature: _____ **Date:** _____

SYMPTOM/PROBLEM CHECKLIST

Name of Patient: _____ **Date:**_____
Person completing form: ☐ **Parent** ☐ **Child**

YES	NO	
☐	☐	Difficulty concentrating
☐	☐	Often fails to finish things
☐	☐	Trouble listening
☐	☐	Easily distracted
☐	☐	Difficulty sticking to an activity
☐	☐	Often acts before thinking
☐	☐	Difficulty organizing work
☐	☐	Frequently calls out in class
☐	☐	Difficulty sitting still
☐	☐	Acts as if driven by a motor
☐	☐	Disruptive in classroom
☐	☐	Physical violence toward others
☐	☐	Destruction of property
☐	☐	Steals from family
☐	☐	Steals from people outside the home
☐	☐	Does not have any close friends of same age for more than 6 months
☐	☐	Chronic violation of rules (in school, home, law)
☐	☐	Running away from home
☐	☐	Persistently lies
☐	☐	Truant from school
☐	☐	Sets fires
☐	☐	Unrealistic worry about harm to family members
☐	☐	Unrealistic worry about separation from family
☐	☐	Refusal or fear of going to school
☐	☐	Fear of falling asleep
☐	☐	Repeated nightmares
☐	☐	Physical symptoms/complaints during school days
☐	☐	Unusual shyness of strangers
☐	☐	Unrealistic worry about future events
☐	☐	Preoccupation with appropriateness of past behaviors
☐	☐	Over concern about competence

YES	NO	
☐	☐	Excessive need for reassurance
☐	☐	Physical problems with no detectable cause
☐	☐	Marked self-consciousness
☐	☐	No interest in making friends
☐	☐	No pleasure in peer relations
☐	☐	Conscious refusal to talk in most social situations, including school
☐	☐	Temper tantrums
☐	☐	Frequently fights with peers
☐	☐	Stays out late at night
☐	☐	Stubborn
☐	☐	Severe confusion/distress about identity issues(goals, values, future)
☐	☐	Loss of weight
☐	☐	Refusal to eat to maintain normal body weight
☐	☐	Recurrent episodes of binge eating with self-induced vomiting
☐	☐	Rapid, involuntary movements
☐	☐	Stuttering
☐	☐	Wets bed at night
☐	☐	Soils clothes or bed with feces
☐	☐	Sleepwalking
☐	☐	Night terrors
☐	☐	Reading problems
☐	☐	Arithmetic problems
☐	☐	Language problems
☐	☐	Articulation problems
☐	☐	Comprehension problems
☐	☐	Memory impairment
☐	☐	Alcohol use
☐	☐	Marijuana use
☐	☐	Other drug use, specifically _____
☐	☐	Unusual, unrealistic fears, suspicious about people
☐	☐	Hearing voices or seeing visions
☐	☐	Intense preoccupation with self

Yes	No	
☐	☐	More talkative with pressured speech
☐	☐	Decreased need for sleep
☐	☐	Persistently sad or depressed
☐	☐	Marked increase or decrease in appetite
☐	☐	Loss of interest or pleasure in usual activities
☐	☐	Loss of energy and fatigue
☐	☐	Feelings of worthlessness or excessive guilt
☐	☐	Recurrent thoughts of death or suicide
☐	☐	Mood swings
☐	☐	Feelings of inadequacy or low self-esteem
☐	☐	Decreased effectiveness in school or at work
☐	☐	Irritability or excessive anger
☐	☐	Pessimistic attitude towards future
☐	☐	Frequently feels empty or bored
☐	☐	Tearfulness or crying frequently
☐	☐	Marked fear of certain places
☐	☐	Panic attacks with shortness of breath, palpitations, dizziness
☐	☐	Perfectionistic
☐	☐	Very indecisive
☐	☐	Easily led by others
☐	☐	Problems with mother
☐	☐	Problems with father
☐	☐	Problems with siblings
☐	☐	Problems with other authority figures

CONSENT TO TREAT MINORS

I, _____, give my consent for _____ to receive treatment, which may include medication, from CM Counsel.

I certify that I am able to give consent because:

____ I am the child's natural or adoptive parent with legal custody to consent to treatment (if applicable, please provide a copy of any interim or final custody agreement relating to the child.)

____ I am the child's legal guardian, foster parent or I have been given power of attorney to make health care decisions on behalf of the child (provide a copy of the relevant documents, i.e., guardianship papers, foster care documentation, power of attorney, etc.).

Signature_____ Date_____

Print name:_____

Witness_____ Date_____

If custody agreement requires the consent of both parents/guardians for treatment of their minor child, please fill out this second Consent to Treat a Minor for signature.

CONSENT TO TREAT MINORS

I, _____, give my consent for _____ to receive treatment, which may include medication, from CM Counsel.

I certify that I am able to give consent because:

____ I am the child's natural or adoptive parent with legal custody to consent to treatment (if applicable, please provide a copy of any interim or final custody agreement relating to the child.)

____ I am the child's legal guardian, foster parent or I have been given power of attorney to make health care decisions on behalf of the child (provide a copy of the relevant documents, i.e., guardianship papers, foster care documentation, power of attorney, etc.).

Signature_____ Date_____

Print name:_____

Witness_____ Date_____

Patients have a right to:

- Be treated with dignity and respect.
- Fair treatment regardless of race, religion, gender, ethnicity, age, disability or source of payment.
- Have their treatment and other patient information kept private. Only where permitted by law, may records be released without patient permission.
- Know about treatment choices, regardless of cost or coverage by the patient's benefit plan.
- Share in developing their plan of care.
- Information in language they can understand.
- A clear explanation of their condition and treatment options.
- To be told the consequences of refusing treatment or not complying with prescribed treatment.
- To file a grievance should a dispute arise over treatment or claims.
- Information about clinical guidelines used in providing and managing their care.
- Ask the provider about their work history and training.
- Request certain preferences in a provider.
- To have sufficient information to be able to give informed consent to treatment except in emergencies.

Patients have a responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers true and accurate information they need so they can deliver the best possible care.
- Follow the treatment plan and/or take medication.
- Tell their provider and primary care physician about medication changes including medication changes given by others.
- Arrive for appointments on time or call to cancel the appointment at least 24 hours prior to the scheduled appointment.
- Avoid actions or threats that endanger the lives, health or social well being of the Practice Group employees, providers or other patients.
- Pay all necessary fees at the time of the appointment unless they have made alternative arrangements with the Practice Group.
- Address any concerns regarding services or quality of care to the Practice Clinical Director, Catherine Frank, Ph.D.
- Report abuse or fraud.

My signature below indicates that I have been informed of my rights and responsibilities and that I understand this information.

_____

Patient Signature Date

CM Counsel
523 Plymouth Road * Suite 215 * Plymouth Meeting, PA 19462 * Phone: 610-825-9400 * Fax: 610-825-7130
740 Springdale Drive * Suite 102 * Exton, PA 19341 * Phone: 610-524-0780 * Fax: 610-524-0787
210 Mall Boulevard • Suite 204 • King of Prussia, PA 19406 • Phone: 484-808-5340 • Fax: 484-231-8276

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s)and your primary care physician (PCP) is important to make sure that all care is complete, comprehensive and well coordinated. This form allows your behavioral health provider to share information with your PCP. The purpose of the disclosure is to release behavioral health and/or treatment information to ensure quality and coordination of care. No information will be released without your signed consent.

Patient Information

Last Name | First Name | Middle | Date of birth (MMDDYYYY)

Insurance Company | Subscriber ID # from Card | Home Phone Number

The following behavioral Health Provider May Disclose Information:

Name (person or organization) | Phone Number

The Information will be disclosed to the following Primary Care Physician:

Name (person or organization) | Phone Number

Street Address | City, State & Zip

Information to be Released:

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, medication(s) and prognosis.

Your Rights and Other Information:

• This authorization shall expire _____unless revoked in writing.
• You can revoke this authorization at any time in writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information already disclosed.
• You do not need to sign this authorization in order to obtain treatment or other services.
•This authorization is completely voluntary and you do not have to agree to authorize any use or disclosure.
•You have a right to receive a copy of this authorization once you have signed it.

Please check one of the following:

_____ I **consent** to and authorize release of my protected health information to my primary care physician.

_____ I **refuse** to authorize release of my protected health informaiton to my primary care physician.

Patient Signature | Date (required)

Signature of patient representative (if applicable) | Date (required)

Relationship to Patient (required)

CM COUNSEL

Acknowledgment of Receipt of

Notice of Privacy Practices, Practice Information Notice, Insurance Information & Confidentiality Statement

- I hereby acknowledge that I have received a copy and understand the information provided in the CM Counsel Notice of Privacy Practices.

- I hereby acknowledge that I have received a copy and understand the information provided in the CM Counsel Practice Information Notice, including policies regarding telephone calls, emergency procedures, cancellations, no show charges, fees, confidentiality and my rights and responsibilities as a patient.

- I hereby acknowledge I have read and understand the information provided to me by CM Counsel regarding my insurance benefits, copayment obligation and cancellation policy. I accept the terms as stipulated.

- I hereby acknowledge I have read, received a copy of and understand the information provided to my by CM Counsel regarding the confidentiality of my records and the limits of confidentiality.

I understand that, if at any time, I need another copy of the above-mentioned information, I may contact the office to request it. If further questions arise, I can consult with the staff of CM Counsel to have them answered.

_____

Patient or Representative Signature Date

Patient Name (please print):_____

Name of Representative (please print):_____

Note: If a copy of the Notice was provided by mail, please return this signed document to the CM Counsel office at your earliest convenience.

CM COUNSEL

Authorization to Disclose Information to Magellan Behavioral Health Eastern Pennsylvania Service Center

I understand that my records are protected under the applicable state law governing health care information that relates to Mental Health Services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CRF Part 2) and cannot be disclosed without my written consent unless otherwise provided for in state and federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, _____ hereby authorize _____
(Please Print Patient's Name) (Please Print Treating Clinician's Name)
to disclose to Magellan Behavioral Health, Eastern Pennsylvania Regional Service Center:

Report of initial intake evaluation, periodic reports as required, verbal or written information as needed and pertinent psychiatric information. To obtain approval for continued treatment sessions that are medically necessary are covered benefits of Personal Choice insurance.

_____ Date:_____
(Signature of Patient or Parent/Legal Guardian if patient is a minor)

_____
(Please print name signed above.)

_____ Date:_____
(Signature of Witness)

Prohibition of redisclosure:
Alcohol and Drug Abuse information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such legislation. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

COPY OF RELEASE OFFERED TO PATIENT: ACCEPTED____ REJECTED ____