Adoption & Attachment Therapy Partners, LLC

Arleta James, LPCC
1201 Canyon View Road
Sagamore Hills, OH 44067

Phone: 330-813-2525
Email: arletajames@gmail.com
Web: adoptattachtherapy.com

Helping adoptive parents forge strong connections among all family members via adoption-attachment-trauma informed therapies.

Child Application Form

PLEASE PRINT

Name of Child_____ Birthdate_____

Parent's name

(Parent 1)_____ DOB_____

(Parent 2)_____ DOB_____

Address_____

_____

Contact Information

(Daytime)_____ (Evening)_____

(Parent 1) Cell Phone_____

(Parent 2) Cell Phone_____

(Parent 1) Email_____

(Parent 2) Email_____

Level of Education

(Parent 1)_____

(Parent 2)_____

(School of Child) _____ Grade_____

Others living at home:

Name	Sex	Birth date	Age	School/Grade

Parent 1 Employed by_____

Business Telephone_____

Soc. Sec. #_____

Parent 2 Employed by_____

Business Telephone_____

Soc. Sec. #_____

Family Physician_____

Referred by_____

Telephone#_____

Chief Complaint & Problem_____

_____

_____

Is Child Adopted? _____

If So, At What Age? _____

Child's First Name Prior to Adoption_____

Complications of Birth & Delivery_____

_____

_____

Have there been any physical or emotional separations (i.e. death, hospitalizations, depression) between child and caretaking adult during the first 26 months of life? _____

If so, please elaborate in CHILD'S HISTORY report.

Is there, as far as you know, any possible history that could be considered abusive? If so, indicate type(s) and age of occurrence. _____

_____

If it is hard to remember ages, please simply check the problem areas or areas you feel were/are advanced or slow in development.

Age he/she:		**Does he/she:**		**Is he/she:**	
held head up	_____	have blank spells	_____	shy or timid	_____
crawled	_____	rock	_____	affectionate	_____
walked with help	_____	shuns attention	_____	well-coordinated	_____
used sentences	_____	have temper tantrums	_____	impulsive	_____
fed self	_____	have falling spells	_____	stubborn	_____
dressed alone	_____	have unusual fears		right/left-handed	_____
turned over	_____	bump head	_____	clumsy	_____
sat	_____	hold breath	_____		
walked alone	_____	show dare devil behavior	_____		
was weaned	_____	have sleep problems	_____		
said "no, no" to everything	_____	have eating problems	_____		
smiled at parents	_____				
pull up at crib	_____				
said 4-10 words	_____				
helped with dressing	_____				
dry during day	_____				
dry during night	_____				

PREVIOUS TESTING OR THERAPY:

Dates: _____

_____

Place: _____

_____

With whom: _____

Financial Agreement

Date_____

I, _____(recipient) or

_____(parent, legal guardian, or custodian of minor) am aware that services provided for _____ in this office will not be billed to Medicaid, and I agree to be liable for the fee for service.

Signature _____

If other than parent:

Title _____

Agency _____

Permission to Treat

I/We understand that a variety of techniques will be used in our child's treatment. They may include: use of music, use of animals, nurturing holding by parents and therapists as needed, psychodrama, role play, psychoeducation, cognitive behavioral therapy, traditional therapy, use of pre-adoptive historical information, and family centered therapy. Parents are always included in treatment as the parent-child relationships are critical to the process of treating attachment difficulties.

I/We consent to participate in the therapy described above.

PARENT/GUARDIAN: _____

DATE:_____

CLIENT:_____

DATE: _____

Child History Report

Please write a summary description of your child **IN NARRATIVE STYLE.** Include:

1. History of problem behavior.
2. Medical problems.
3. Adoption history and process, if applicable Please discuss how you made the decision to adopt
4. A summary which will help give us a clear understanding of your child's difficulties Please contact us if you have any questions.

For the Parents/Caregivers Caregiver's/Parent's Autobiography Outline

MENTAL HEALTH OF PARENTS

It is always helpful for us to have as much information about family history, style, and overall functioning as possible before beginning the intensive treatment program. To get this information, we have found that autobiographical statements of the caregivers/parents have proven invaluable. Therefore, it would be helpful if each caregiver/parent would prepare a narrative statement that addresses the issues solicited by the following questions. **PLEASE DO NOT GO THROUGH THIS LIST OF QUESTIONS AND ANSWER THEM. WRITE A SUMMARY OF YOUR LIFE EXPERIENCES IN NARRATIVE STYLE.** Include in the summary discussion of the issues that the questions are addressing. If there are other areas that are important, also include them. Contact us if you have any questions.

-Did either of your parents often complain of physical problems that were not medically confirmed?

-Was either of your parents often depressed, noticeably unhappy or irritable?

-Did either of your parents have problems with alcohol?

-Did your parents often argue?

-Was there ever physical violence between your parents?

-Were there other significant difficulties of your parents particularly during your early childhood?

-Please describe the good and bad characteristics of your parents.

DIVORCE AND STEPPARENTS

-Did your parents' divorce? If so, please answer the following:

-At what age were you when your parents separated?

-With whom did you live?

-Was there a stepparent in the home?

-How old were you when the stepparent entered your life?

-How did the stepparent handle control issues with you?

AFFECTION

-Please describe affectionate behavior of your parents or caretakers, or lack of it. Please give frequency and your reactions. Would you be more or less affectionate with your child? Why?

ROLE IN FAMILY

-What role did you have in your family of origin and how do you see that influencing your relationship to a child?

DISCIPLINE

-How did your parents discipline you?

-Do you agree with their behavior? Why?

-In what ways have you changed? ABUSE

-Do you feel that either of your parents, or caretakers was ever abusive? If so, in what way?

-How have you dealt with your feelings about this issue? NEGLECT

-Were there any issues of loss or abandonment in your childhood? -If so, do you see that issue causing some problems in your relationship with a child?

COMMUNICATION

-How did verbal communication differ from each of your parents toward you?

-Did either of your parents understand your feelings? Please explain.

-How did communication progress during the teenage years?

-Did either parent use: (please indicate which parent and to what excess)

-Disapproval?

-Withdrawal?

-Threats of physical punishment?

-Threats of abandonment?

-Hitting or spanking?

-Verbal criticism?

-Did actions (good or bad) show your feelings to your parents better than words? Please describe.

-In what ways, if any, has your communication process changed from that of your parents? If change has occurred, what caused this change?

INFORMED CONSENT/NOTICE OF PRIVACY PRACTICES

PRIVACY PRACTICES

Adoption & Attachment Therapy Partners LLC (AATP) is dedicated to maintaining the privacy of client's personal healthcare information as part of providing professional care. We are also required by law to keep clients' information private. AATP policies meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) as well as the requirements of the Counselor, Social Worker, and Marriage and Family Therapist Board of Ohio - www.cswmft.ohio.gov. If you have any questions about this information, please contact the privacy officer, Arleta James, LPCC, at arletajames@gmail.com or 330-813-2525.

Please know that client is defined as the family. The treatment model is a family model. Parents and children participate in the services.

AATP will use the information about your healthcare that we get from you or others to provide you with treatment, to arrange payment for our services, and for some other business activities that are called - in the law - healthcare operations. Your annual PASSS documents fall under other "healthcare operations" for example. Once submitted the documents act as An Authorization to Release Healthcare Information should the state have questions, for a licensee, about the documents. AATP staff does notify clients in the event there is contact between our office and PASSS.

If we, or you, want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you, and ask you to sign an Authorization to Release Healthcare Information form to allow this. There are 4 exceptions to this policy. The law requires that we disclose relevant information when,

- Anything related to child physical abuse, sexual abuse, emotional abuse, or neglect must be reported.
- We have a duty to warn an individual if we believe that he or she is in danger. We must warn identifiable third parties or authorities of serious, foreseeable threats.
- We have a duty to ensure every client's safety. If we believe that a client is at imminent risk of suicide or serious self-injury, we will do what is necessary to keep the client safe.
- Records may be subpoenaed by courts. We may be court-ordered to testify.

For all practical purposes, the above situations are rare, and in most cases, we will talk with you about these situations prior to taking any action.

When parents are participating in services with a minor child, only the parents can authorize the release of the minor child's records. When the age of adulthood is reached, the young adult may now request a copy of his or her record OR he or she can request that the record be transferred.

PAYMENT POLICIES

Self-Pay Clients

Clients who choose to pay out-of-pocket are required to pay in full on the day of services. Credit cards and checks are acceptable forms of payment. Checks are made payable to "Adoption & Attachment Therapy Partners LLC." There is a $35.00 charge for returned checks. Credit card information is NOT stored online.

PASSS Funding

PASSS funding is between the family and the state of Ohio. It is the family's responsibility to know what the PASSS approval covers, and what the family's copay is. AATP will submit your services to the state as long you have provided AATP with a copy of your PASSS approval letter. The family is responsible for copays assigned by PASSS. Families will be invoiced directly for their copays. Copays are due upon receipt of the invoice. Checks or credit cards are acceptable forms of payment. Credit card information is NOT stored online.

It is a good idea for parents to keep track of PASSS funds throughout the PASSS year. Parents may also ask their therapist for a tally of their PASSS funds throughout the year.

Medicaid

AATP does not accept Medicaid as a form of payment.

Divorce/Child Custody

Copies of divorce decrees providing the court order for mental health services are required for treatment and payment.

Additional Information

At times, temporary financial problems may affect the timely payment of your family or self-pay account. You are encouraged to keep in touch with AATP at arletajames@gmail.com or 330-813-2525. Payment plans may be available in such instances.

SCHEDULING

The hours of operation are 11:00am to 9:00pm Monday - Friday. Saturday and Sunday hours are 11:00am to 5:00pm. Scheduling outside of these hours is at the discretion of the therapist.

AATP staff schedules directly with clients. Staff do their best to help see to it that children and teens can attend school, after school activities, and work. Yet, this is not always possible. We cannot always guarantee after school and weekend appointments. In such situations, parents will need to make a choice as to what the most important priority is for their son or daughter.

Unless cancelled 24 hours in advance, AATP policy is to charge for missed appointments. This charge goes to the family - not to PASSS. Proof of emergency may be requested by the affected AATP staff professional or provided by the family to avoid a charge.

TELETHERAPY

Definition of Teletherapy per Ohio CSWMFT Licensure Board - www.cswmft.ohio.gov

Teletherapy means the use of real-time audio or audiovisual communications that permit accurate and meaningful interaction between at least two persons, one of whom is a licensed professional referred to as "licensee." For the purpose of this rule, teletherapy modalities in Ohio include but are not limited to phone, video, text, email, instant messaging/chat. At AATP, we do NOT participate in instant messaging/chat.

Teletherapy can only take place if the client and the licensee are both in Ohio at the time of the service. So, for example, if the client or the licensee is NOT in Ohio, then no modalities of teletherapy are permitted. **In this situation, if the client is experiencing a crisis, the client should call 911 or 988 Suicide and Crisis Hotline.**

AATP staff are required to terminate a teletherapy session if clients are engaged in something considered dangerous to themselves or others - driving while participating in therapy for example.

A licensee is prohibited from providing teletherapy when either the client or licensee is in a setting that could reasonably be expected to compromise confidentiality. This could include conducting therapy outdoors or in a parking lot of a store for example. A private place where the conversation cannot be overheard is considered optimal for confidentiality.

The licensing board prohibits alcohol or other substance use during teletherapy or in-person sessions.

From time to time, clients do experience serious crises. During such times, the therapist and client can determine if teletherapy is the best modality or if in-person is a better option.

Some clients exhibit behaviors that can cause safety issues to family members during teletherapy. The preference in these cases is to conduct appointments in-person until such time as the unsafe behavior is dissipated.

At times, emergencies do occur during teletherapy sessions. For example, once a parent left the session and wound up falling down the staircase. Please keep your emergency contact/current address information up to date with Arleta James, LPCC.

AATP staff offer a 15-minute grace period for clients to sign in to their scheduled sessions. Unless notified by the client about being late or cancelling late, the AATP therapist can end the meeting after the 15-minute waiting period. The appointment will be re-scheduled.

TECHNOLOGY

AATP staff communicate via teletherapy platform, phone, email, and text messaging. Staff do their best to respond to phone calls, emails, and text messages within 24 hours.

Text Messaging

If you are texting with Arleta James, LPCC, the text messaging is encrypted end to end.

If you are texting with the QEEG technician, Kayla Boros, her text messaging is not encrypted. Clients may request to be contacted by phone.

Email

If you are emailing Arleta James, LPCC, the email is not encrypted. It is password protected as well as requires two-factor authentication to access.

Kayla Boros can access all AATP devices in the event Arleta James, LPCC has died or become incapacitated.

Please note - therapists do not check their voicemail, text messages, or email when they are in appointments with clients. If a client is experiencing an emergency, the client should call 911 or 988 Suicide and Crisis Hotline.

Social Media

AATP staff do NOT communicate with, contact, or accept friend requests from clients on social media platforms like Twitter, Facebook, etc. Clients are welcome to join official AATP social media sites. These sites exist to disseminate information relevant to trauma, attachment, and adoption.

Online Reviews

Online reviews exist everywhere today. Clients are to be made aware that there is a risk of inadvertently revealing confidential information when completing such reviews. Clients need to weigh this issue as a part of making the decision to complete a review or not.

AATP staff will NOT ask clients to provide reviews or testimonials. In fact, client testimonials are prohibited by the Ohio CSWMFT Licensure Boad - www.cswmft.ohio.gov

Web Searches

AATP staff never conducts online searches to gain information about potential or existing clients. The only exception to this is that a client's criminal record may be verified using online methods.

RECORD KEEPING

Documents that comprise a client file include Informed Consent, in-take assessments, releases of information, case notes, treatment plans which include diagnosis, text messages, email correspondence, letters, and items such as IEP's, medical records, psychological testing, etc. if a parent has requested such information to be forwarded to AATP.

When there is a client request to transfer AATP records, only those records generated by AATP are transferred. Records transferred to AATP by professionals outside of AATP are NOT transferred. These records fall under what is referred to as a "re-release of information". Re-release of information is prohibited under Ohio CSWMFT Licensure Board.

Client files are kept for seven years from the last date of service provided to the client OR until the client reaches the age of adulthood - age 18. The disposal of paper client files is shredding via a HIPPA compliant shredding service. All AATP electronic devices are disposed of by a HIPPA and FACTA compliant shredding company. FACTA is the Fair and Accurate Credit Transaction Act of 2003.

In the event of the death or incapacitation of the owner of AATP, Arleta James, LPCC client files will be transferred to the "record custodian" for AATP. The "record custodian" is Kayla Boros.

LICENSE VERIFICATION

Should a client want to verify the license of any AATP licensee, this information is available on the Ohio CSWMFT Licensure Board - www.cswmft.ohio.gov Specifically, the link to license verification
Is https://cswmft.ohio.gov/about-the-board/board-resources/online-license-verification

RESPONSIBILITY TO CLIENTS OF SERVICES AS TO DISCRIMINATION•

AATP is a non-discriminatory practice. Counselors, social workers, and marriage and family therapists shall not practice, condone, facilitate or collaborate with any form of discrimination on the basis of age, sex, gender identity and expression, sexual orientation, race, ethnicity, national origin, immigration status, disability, religion, language, culture, veteran status, marital status, political belief, housing status, and socioeconomic status. This information is an excerpt from Ohio Revised Code Chapter 4757.07 and the CSWMFT Licensure Board's code of ethics as outlined in Ohio Administrative Code Rules 4757-5-02 and 4757-5-06. Clients' who would like to seek out more information about "prohibiting discrimination" requirements are directed to these sources.

This Informed Consent supersedes all others. It is in effect as of this date: 8/3/2026.

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