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

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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. _____

_____

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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: _____

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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 _____

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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: _____

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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.

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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?

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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?

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NOTICE OF PRIVACY PRACTICES

Our commitment to your privacy.

Our practice is dedicated to maintaining the privacy of your personal information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is a shorter version of the full, legally required Notice of Privacy Practices (NPP), posted in our waiting room that you can refer to for more information. However, we cannot cover all possible situations, so please talk to our Privacy Officer (see the end of this notice) about any questions or problems.

We will use the information about your health that we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. **If you do not consent and sign this form, we cannot treat you.**

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 Form to allow this.

Of course, we will keep your health information private, but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety, or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If law enforcement or official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are other situations similar to these that don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information:

1. You can ask us to communicate with you about your health and related issues in a particular way, or at a certain place, that is more private for you. For example you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care, or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records, but we may charge

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you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing, and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area, and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide you in any way.

If you have any questions regarding this notice, or our health information privacy policies, please contact our Privacy Officer who is Arleta James, LPCC.

The effective date of this notice is July 1, 2015

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NOTICE OF FINANCIAL AND SCHEDULING POLICIES

We are dedicated to providing you with the highest quality healthcare. Beyond services provided to you in this office, we work with many insurance companies who help coordinate your healthcare and also help you meet your financial responsibility. If you have questions about your billing, please do not hesitate to contact our administrative assistants at 440-746-9099, ext. 1 or adoptattachtherapy1@gmail.com.

Your responsibility begins when you call to make an appointment. Please know your PASSS approval and please provide a copy of your PASSS approval. Be aware of what your copay is.

All services are rendered to you as the patient. Therefore, all charges are ultimately your responsibility for payment. You will be expected to sign a form as acknowledgment of your financial responsibility.

Self-Pay
Patients who are not covered by PASSS, a current insurance plan, or who do not present a current insurance care at the first session, are required to pay in full for all charges on the day of service. Checks are made payable to "Adoption & Attachment Therapy Partners LLC." Checks may be given to your therapist or the administrative assistants. There is a $20.00 charge for all returned checks. Payment arrangements can be made under certain circumstances.

PASSS Funding
PASSS is between the county and the family. It is the family's responsibility to know what the PASSS approval covers, and what the family's copay is. We will submit your services to your county as long as you have provided us with the proper information to do so. You will be responsible for copays. You will be responsible for any services that exceed your PASSS approval. It is best to touch base with the administrative assistants throughout the PASSS year to make sure that PASSS funds are available to cover the scheduled services. It is also a good idea for parents to keep track of the PASSS funds spent throughout the course of the PASSS year.

Medicaid
We do not accept Medicaid as a method of payment.

Divorce/Child Custody
The parent accompanying the child to their first visit will be expected to sign the billing form, and is ultimately responsible for the bill. Copies of the divorce decrees providing the court order for mental health treatment are also required.

Unaccompanied Minors/Students
All minors/students must have a parent accompany them to the first appointment to provide demographic information and sign our office policy forms.

Missed appointments/late cancels
Unless cancelled 24 hours in advance, our policy is to charge – full price – for missed appointments. **This charge goes to the family - not to insurance or PASSS funding.** Please allow us to serve you and other clients better by keeping scheduled appointments.

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Additional Information
At times, temporary financial problems may affect the timely payment of your account. You are encouraged to contact and keep in touch with us at 440-746-9099 to do everything possible to keep your account in good standing. Outstanding PASSS copays that carry over from one PASSS year to the next, must be paid in full (or to the satisfaction of the administrative assistants) before services can resume in the new PASSS year.

Scheduling Appointments
Therapists schedule appointments directly with their clients. The therapists certainly do their best to help see to it that children and teens are able to attend school and after school activities. 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.

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____and Adoption and Attachment Therapy Partners LLC. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here:

_____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you, and to provide any treatment to you. We may also share this information with others who provide treatment to you, or need it to arrange payment for your treatment, or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change the NPP, you can obtain a copy from our Privacy Officer.

If you are concerned about some of your information you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer, telling us you no longer consent), and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or parent/legal guardian if minor Date

_____ _____

Printed name of client or parent/legal guardian if minor Relationship to client

_____

Signature of authorized representative of this practice

DATE OF NPP _____ _____Policy given to client/parent/legal guardian

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