Early Development and Home Background (EDHB) Form—Parent/Guardian

Child's Name: ___________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**__________

Instructions to Parent or Guardian: Questions P1-P19 ask about the early development and early and current home experiences of your child. Some questions require that you think as far back as to the birth of your child. Your response to these questions will help your child's clinician better understand and care for your child. Answer each question to the best of your knowledge or memory.

What is your relationship with the child receiving care? ____

Please choose one response (✓ or x) for each question.					
Early Development		**No**	**Yes**	**Can't Remember**	**Don't Know**
P1.	Was he/she born before he/she was due (premature)?	☐	☐	☐	☐
P2.	Were the doctors worried about his/her medical condition immediately after he/she was born?	☐	☐	☐	☐
P3.	Did he/she have to spend any time in a neonatal intensive care unit (NICU)?	☐	☐	☐	☐
P4.	Could he/she walk on his/her own by the age of 18 months?	☐	☐	☐	☐
P5.	Has he/she ever had a seizure?	☐	☐	☐	☐
P6.	Did he/she ever lose consciousness for more than a few minutes after an accident?	☐	☐	☐	☐
Early Communication					
P7.	By the time he/she was age 2, could he/she put several words together when speaking?	☐	☐	☐	☐
P8.	Could people who didn't know him/her understand his/her speech by the time he/she reached age 4?	☐	☐	☐	☐
P9.	Have you ever been concerned about his/her hearing or eyesight?	☐	☐	☐	☐
P10.	By the time he/she was age 4, was he/she interested in playing with or being with other children?	☐	☐	☐	☐
Home Environment					
P11.	Was there ever a time when he/she could not live at home and someone else had to look after him/her?	☐	☐		☐
P12.	Has he/she ever been admitted to the hospital for a serious illness?	☐	☐	☐	☐
P13.	Does anyone at home suffer from a serious health problem?	☐	☐		☐
P14.	Does anyone at home have a problem with depression?	☐	☐		☐
P15.	Does anyone at home regularly see a counselor, therapist, or other mental health professional?	☐	☐		☐
P16.	Does anyone at home have a problem with alcohol, drugs, or other substances?	☐	☐		☐
P17.	Would you say that the atmosphere at home is usually pretty calm?	☐	☐		☐
		Less Than Once a Month	**Between Once a Week and Once a Month**	**More Than Once a Week**	**Most Days**
P18.	How often are there fights or arguments between people at home?	☐	☐	☐	☐
P19.	How often does your child get criticized to his/her face by other family members when he/she is at home?	☐	☐	☐	☐

David Shaffer, F.R.C.P., F.R.C., Psych.

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DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: ______________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**___________

Relationship with the child: ____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes	❑ No		❑ Don't Know		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes	❑ No		❑ Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes	❑ No		❑ Don't Know		
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes	❑ No		❑ Don't Know		
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	❑ Yes	❑ No		❑ Don't Know		
	25.	Has he/she EVER tried to kill himself/herself?	❑ Yes	❑ No		❑ Don't Know		

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CHILDPLACE, INC. COUNSELING SERVICES

2420 E. 10th Street Jeffersonville, IN 47130 P: 812-282-8248 F: 812-206-8289

PLEASE PRINT

CLIENT INFORMATION (MINOR – under 18 years of age)

Client's Name: **(First Name)** **(Middle Name)** **(Last Name)**

Address:

City:	**State:**	**Zip:**

Home Phone: May we leave a message at this number? ☐ No ☐ Yes	**Cell Phone:** May we leave a message at this number? ☐ No ☐ Yes	**Social Security Number:**	**Date of Birth:**

PARENT or LEGAL GUARDIAN INFORMATION

Who has custody of the child? ☐ Mother ☐ Father ☐ Joint ☐ Other: ____

Mother's Name:	**Father's Name:**
Address:	**Address:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Cell Phone: May we leave a message at this number? ☐ No ☐ Yes	**Cell Phone:** May we leave a message at this number? ☐ No ☐ Yes

PARENT or GUARDIAN EMPLOYMENT INFORMATION

Are you currently employed? ☐ No ☐ Yes **If YES, please provide the following information:**

Employer Name:	**Employer's Address:**	**City:**	**State:**	**Zip:**

Work Phone:	**May we contact you at work?** ☐ No ☐ Yes	**May we leave a message with your employer?** ☐ No ☐ Yes

WHAT PROMPTED YOU TO SEEK COUNSELING? (Presenting Problems or Concerns)

INSURANCE INFORMATION

Do you have insurance? ☐ No ☐ Yes **If YES, please provide the following information:**

WE MUST HAVE A PHOTOCOPY OF THE FRONT & BACK OF ALL INSURANCE CARDS (PRIVATE OR MEDICAID) *

PRIMARY INSURANCE COMPANY: ____

Member's Name: ______________________ **Member's DOB:** __________ **Relationship to Client:** ______________

ID# ______________________________ **Group #** ______________________________

SECONDARY INSURANCE COMPANY: ____

Member's Name: ______________________________ **Relationship to Client:** ______________________

ID# ______________________________ **Group #** ______________________________

****WE MUST BE NOTIFIED IMMEDIATELY ANY TIME A CHANGE IN INSURNACE COVERAGE OCCURS****

MEDICAL INFORMATION

Primary Care Physician:	Physician's Phone Number:

Address:	City:	State:	Zip:

Please list any known allergies (food, medications, etc.):

Please list any physical limitations, illnesses, or other information regarding the client's overall health:

Is the client currently taking any medications? ☐ No ☐ Yes **If YES, please list ALL MEDICATIONS:**

	Name of Medication:	Dosage/Frequency:	Name of doctor who prescribed medication:
1.			
2.			
3.			
4.			

Pharmacy: ______________________ **Location:** ______________________ **Phone:** ______________________

PAST COUNSELING AND/OR PSYCHIATRIC TREATMENT

Has the client ever been hospitalized due to mental health/psychiatric reasons? ☐ No ☐ Yes

If YES, list name of hospital(s) and dates of hospitalization(s): ______________________

Has the client ever received counseling or psychiatric care in the past? ☐ No ☐ Yes

If YES, list names of agencies, therapists, and doctors client has worked with: ______________________

____

IN CASE OF EMERGENCY (Physical or Mental Health) WHO SHOULD WE NOTIFY?

First Name:	Middle Name:	Last Name:	Relationship to Client:

Address:	City	State:	Zip:

Home Phone:	Cell Phone:	Employer Phone:

REFERRAL INFORMATION

How did you hear about Childplace Counseling Services?

NO SHOW & CANCELLATION POLICY

We require 24 hours' advance notice to cancel or reschedule appointments. If an appointment is cancelled/rescheduled without 24 hours' advance notice, it is considered a LATE CANCEL. If a client does not show up for his/her appointment and does not call, it is considered a NO SHOW. If a client is more than 10 minutes late for an appointment, it is considered a LATE CANCEL, and a client will need to reschedule. IF A CLIENT HAS 3 NO SHOWS AND/OR LATE CANCELS within a 6 month period, he/she will be discharged from our care and the client's case will be closed. *_Please initial:_ ______________

ACKNOWLEDGEMENT

Your signature on this form indicates that you have read and understand all information presented.

______________________________ ______________________

Signature of Parent or Legal Guardian **Date**

Counseling Services

Consent For Treatment &Financial Responsibility Agreement

The below named client, guardian, or custodial agency hereby authorizes CHILDPLACE COUNSELING SERVICES to provide individual, group, family therapy, psychiatric treatment and support through the practitioners associated with Childplace, Inc., which include master's- level therapists, psychiatrist(s) and nurse practitioner(s).

The below named client, parent/guardian, or custodial agency hereby authorizes Dr. Mashiur Khan, MD, or other medical doctors/nurse practitioners associated with the counseling department to provide psychiatric services. These services include, but are not limited to, consultation/psychiatric support to the therapist overseeing treatment, an initial psychiatric evaluation and medication evaluation, and ongoing medication management for the client and thereafter if needed. (Note: A Client receiving ongoing medication management at Childplace is expected to meet at a minimum of 1X per month with his/her therapist.)

NO SHOW & CANCELLATION POLICY—24 hours' advance notice to cancel or reschedule an appointment is required. If an appointment is cancelled/rescheduled without 24 hours' advance notice, it is considered a LATE CANCEL. If a client does not show for his/her appointment and fails to call, it is considered a NO SHOW. If a client is more than 10 minutes late for an appointment, it is considered a LATE CANCEL, and client will need to reschedule. IF A CLIENT HAS 3 NO SHOWS AND/OR LATE CANCELS within a 6 month period, he/she will be discharged from our care and the client's case will be closed.

Childplace agrees to file Medicaid and other insurance claims on behalf of the client. The client is responsible for providing accurate insurance information to our billing department. The client is also responsible for providing any updated information to their insurance company, which may be needed to process claims. Copies of all insurance cards must be provided at the first scheduled visit.

The client, parent, or guardian is responsible for paying any insurance co-payments prior to services being rendered at each visit. **THE CLIENT, PARENT, GUARDIAN OR PLACING AGENCY IS RESPONSBILE FOR PAYMENT OF SERVICES THAT ARE DENIED BY INSURANCE**. **CHILDPLACE WILL ACCEPT ASSIGNMENT FROM MEDICAID AS FULL PAYMENT OF THE CLIENT'S FEE FOR SERVICES.** If a client applying for Medicaid schedules appointments prior to receiving confirmation from Medicaid of active coverage, client will be responsible for full payment of services provided prior to the activation date determined by Medicaid. Client will also be responsible for payment of services rendered if the client was not eligible for Medicaid for any reason on the day the services were rendered. **IN CASES WHERE THERE IS NO INSURANCE COVERAGE, FULL PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED.**

Each insurance company has a different policy covering your medical costs—even within the same company the coverage and benefits vary. You are responsible for knowing the details of your coverage, including knowledge of covered and non-covered services. **IN ADDITION, YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS OR DEDUCTIBLE NOT COVERED BY YOUR INSURANCE.**

By signing below, I authorize release of information required by third party payer. I also authorize Childplace to receive direct payment and will act as their agent in helping to obtain payment from my third party payer, if a third party payer is involved. If my insurance company sends payment directly to my place of residence/home, instead of directly to Childplace, I understand that I am responsible for providing Childplace with this money for services rendered within 15 days of receiving the payment at my place of residence/home.

I have read and understand the information contained in this agreement and agree to my financial responsibilities as stated above, and I acknowledge by signing below that I consent for treatment to take place. This consent will remain in effect until the below listed client has been discharged as a client and is no longer under the care of Childplace Counseling Services. Or if the named client, or if client is a minor, the parent, guardian, or custodial agency revokes this consent for treatment in writing.

____
Client's Name (PLEASE PRINT)

____ __________________
Signature of Client, Parent, Guardian or Placing Agency Representative Date

____
Relationship to Client or Custodial Agency

Client Rights (Counseling Services)

The client has the right to considerate and respectful care.

The client has the right not to be discriminated against. This right, however, does not include the potential denial of services when a client's diagnosis and/or issues may put Childplace staff and/or other Childplace clients at risk.

The client has the right to obtain from their practitioner complete and current information concerning the diagnosis, treatment, and prognosis in terms that he/she may be reasonably expected to understand. When it is not advisable to give such information to the client, the information should be made available to an appropriate person (medical proxy) on the client's behalf.

The client has the right to know the credentials and training of the staff responsible for his/her care.

The client has the right to expect Childplace Counseling Services to make reasonable responses to his/her requests.

The client has the right to the protection of the confidentiality of his/her relationship with Childplace staff, except when legal expectations or ethics dictate otherwise.

The client has the right to know that his/her health records will be treated as confidential material as stated in the HIPPA guidelines. Any disclosure to another party will be time limited and made with the full written, informed consent of the client, except when legal expectations—such as a court order—dictate otherwise. This right, however, does not exclude Childplace from providing requested information—such as diagnosis, prognosis, type of treatment, time and length of treatment, and cost—to secure third party payment.

A client may bring any concerns, comments, or ideas regarding his/her treatment to the practitioner with whom he/she is working.

If a client has problems or concerns that are not adequately addressed by his/her practitioner, the client may contact the Childplace Program Supervisor or Chief Operating Officer.

____
Client Name

___________________________________ ___________________________
Signature of Client, Parent or Guardian Date

CHILDPLACE, INC. COUNSELING SERVICES

2420 East 10th Street Jeffersonville, IN 47130 812-282-8248 Fax: 812-206-8289

Protocols for Obtaining Medical/Mental Health Records, Treatment Summary Letters, and Services for Legal Purposes

Release of Information

Records may be released to another agency or physician via fax or mail upon signature of a Release of Information form. Records are released once the form has been signed by all adult participants. A fee of $1 per page may be collected (cash only). Records are not released directly to clients, although clients may request a summary of treatment. Clients must schedule a session with their therapist to review records.

Treatment Summary Letter

Summary letters of treatment are $50 per page for master-level clinicians and $100 per page for a MD, Ph.D., or Psy.D. practitioner. The cost associated with a one-page report must be provided in cash to Childplace Counseling Services at a minimum of seven business days prior to date the report is needed. Balances for reports exceeding 1-page must be paid within 14 days.

Services for Legal Purposes

Services for legal purposes will be billed at $100 per hour including travel time. This fee must be prepaid in cash to Childplace Counseling Services for 3 hours totaling $300 at a minimum of 7 business days prior and is non-refundable. Balances for time over 3 hours must be paid with in 14 pays.

Verification of Treatment and/or Diagnosis

The cost associated with verification letters of treatment and/or diagnosis may be charged at a fee of $15 per letter. (cash only)

***A $25.00 fee to complete FMLA paperwork may apply.**

Your signature on this form indicates that you have read and agree to all information presented.

______________________________________ ____________________

Signature (Parent or Guardian if under age 18) Date

CONSENT TO RELEASE AND OBTAIN INFORMATION/RECORDS

Client's Name: ____ **Date of Birth:** __________________
(First/Middle/Last) (Month/Day/Year)

I hereby authorize Childplace, Inc. to OBTAIN________ / RELEASE_______ (*please initial the one(s) that applies*) the health/mental-health care information described below to/from the individual or entity listed here:

____
Name

____
Address

____
City/State/Zip Code

____
Phone Number

Note: this information must be completed at the time this form is dated and signed.

Given the information I have provided above, I understand that by checking the specific item(s) below, I authorize the following item(s) to be OBTAINED / RELEASED between Childplace, Inc. and the person or organization named above (*please check all that apply*):

☐ Intake Information
☐ Verbal communication
☐ Psychiatric Assessments
☐ Initial Assessments
☐ Treatment Plans
☐ Psychosocial Assessment
☐ Insurance Information
☐ Admission Interview
☐ Psychological Testing
☐ Discharge Summary
☐ Progress Summaries
☐ Other:____
☐ Psychological Testing Results/Report
☐ Medication Information/History
☐ School Records/Information/Testing
☐ Alcohol/Drug Assessment
☐ Alcohol/Drug Laboratory Results
☐ Any and all health care/mental health care records in file inclusive but not limited to all of the above listed information.

The ***Purpose of Disclosure*** is to facilitate client's treatment and/or promote continuity of care.

I understand that the medical records released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or blood borne diseases, which are subject to federal and/or stated restriction on disclosure.

REDISCLOSURE ACT: *This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibit the receiver of this information from making any further disclosure of the same, except with the WRITTEN consent of the person to whom it pertains. A GENERAL AUTHORIZATION for the release of medical/psychiatric information is not sufficient for this purpose.*

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it, and I understand this consent expires automatically one year from the signature date below.

_______________________________________ _______________________________
Client/Parent or Legal Guardian Signature Date

If the signature above is that of a parent or legal guardian, please provide the following:

_______________________________________ _______________________________
Name (Printed) Relationship to the Client

Counseling Services

LIMITS OF CONFIDENTIALITY

The contents of a counseling session, intake information, or an assessment are considered confidential. Both verbal information and written records about a client cannot be shared with another party without written consent of the client or the client's guardian. EXCEPTIONS to this policy are as follows:

DUTY TO WARN AND PROTECT

When a client discloses to the therapist intentions or an actual threat of physical violence or other means of harm against a reasonably identifiable victim or victims, or evidences conduct or makes statements indicating an imminent danger that the client will use physical violence or use other means to cause serious personal injury or death to others, the therapist is required to warn the intended victim and or

victims and report the information to legal authorities.

ABUSE AND/OR NEGLECT OF A CHILD AND/OR VULNERABLE ADULT

If a client states or suggests that he or she is abusing or neglecting a child or a vulnerable adult or has recently abused or neglected a child or vulnerable adult or if a child or vulnerable adult is in danger or abuse or neglect, the therapist is required to report this information to the appropriate social service agency and or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

The therapist is required to report admitted prenatal exposure to controlled substances that are potentially harmful.

COURT ORDERS

Childplace Counseling Services and the therapist are required to release records of a client when a court order has been placed.

INSURANCE COMPANIES / MEDICAID

Insurance companies and/or Medicaid are provided with necessary information needed to file a claim. The information they request may consist of the following but is not limited to, the type of services rendered, dates and times of service, diagnosis, treatment plans, progress of therapy, case notes and summaries. Note: as of 1/1/07, Managed Care Companies that provide services on behalf of Indiana Medicaid require that mental health practitioners provide a client's primary care physician with the following information: an overview of the initial assessment, including diagnosis, and treatment recommendations.

PSYCHIATRIC & CLINICAL SUPERVISION

Childplace Therapists will be consulting with our psychiatrist at times in regards to a client's overall care, including but not limited to diagnosis, medication management, course of treatment, alcohol and drug related issues, and recommendations related to discharge.

Our masters level clinicians, which may include social workers and marriage and family therapists are required to participate in direct face-to-face clinical supervision as deemed appropriate by the state in which they are licensed until they have obtained the required number of supervisory hours. The clinician will be discussing cases with their direct supervisor in individual and group supervision on a regular basis. This information is kept in confidence with the exception of the above listed areas of concern.

____ __________________

Signature of Client or Guardian Date

2420 East 10th Street
Jeffersonville, IN 47130
(812)282-8272

As a convenience to me, I authorize Childplace Family Services to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:
● Such communication does not provide a completely secure means of communication.
● Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
● Electronic transmission of information cannot be guaranteed to be secure or error-free.
● Data may be vulnerable to access by unauthorized third parties.

As such, Childplace Family Services shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Childplace Family Services to me.

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time.

I understand that Childplace Family Services may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Childplace Family Services in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

Placing my name in the field below acknowledges my authorization of electronic communication via text or email address on file with your office.

Email Address: ____

Client Name: ____

Client Signature: ______________________________________

Acknowledgement

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices.

____

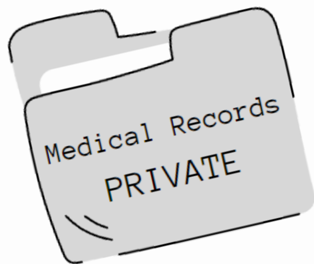
Name of Child/Client

____

Signature of Child's Personal Representative/Client

____

Date



Would you like a copy of the notice for your records?

______ YES

______ NO