I N T A K E   F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age: ______________________________________

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: ________________________________ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ______________________________________

EDUCATION:
Graduated from High School/GED? ❑ Yes ❑No Year Completed? _______________

College: _________________Major: __________________ Year Completed? _______________

How satisfied are you with your current level of education? _________________________

Strengths/Support____

Stressors/problems____

LEGAL

List all arrests (charges), dates of arrests, and the outcomes
____
____
____

Please describe any past or present services or systems that have been involved in your life (e.g., CPS, Government support, school counseling etc.)____

Have either of your parents been incarcerated ❑No ❑Yes (describe which one and how old you were during the incarcerated period)____

Have any other family members been incarcerated? ❑No ❑Yes (describe which one and how old you were during the incarcerated period)____

Strengths/Support____

Stressors/problems____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No
□ Yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication?

□ Yes
□ No

Please list: ____

____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? _________

What types of exercise to you participate in ______________________________

4. Please list any difficulties you experience with your appetite or eating patterns

____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? ______________________
6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? ________________________

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe ______________________________

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? ____________________

On a scale of 1-10, how would you rate your relationship? ___________

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? Or military affiliation? □ No □ Yes

If yes, what is your current employment situation/military affiliation:

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths?

____

____

____

____

4. What do you consider to be some of your weakness?

____

____

____

____

5. Why are you seeking a psychological evaluation at this time?

____

____

____

____

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some 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 health information (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.moorementalhealth.com, or by calling us at 281-415-1280.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it 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 accept 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 to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

____ ________________________
Signature of client or his or her personal representative Date

____ ________________________
Printed name of client or personal representative Relationship to the client

____
Description of personal representative's authority

____
Signature of authorized representative of this office or practice

Date of NPP: ___________________________________

- ☐ Copy given to the client/parent/personal representative

Notice of Privacy Practices (Brief Version)

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

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent
We will use the information we collect about you 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 notice we will ask you to sign a consent form to let us use and share your Information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health Information without your consent
There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.

Your rights regarding your health Information

1. You can ask us to communicate with you 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 can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health Information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also 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 notice, we will post the new version in our waiting area, and you can always get a copy of it 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 U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise, if you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Dr. Melissa Moore, and can be reached by phone at or by e-mail at moorementalhealth@gmail.com or 281-415-1280.

The effective date of this notice is __________________________.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Abuse of Self
If a client states or threatens that he or she will hurt themselves, the therapist will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, further measures may be taken without their permission in order to ensure their safety.

Abuse of Another Person
If a client states or threatens that he or she will hurt another person, the therapist will contact the authorities.

Abuse of Previous Therapist
If a client states that he or she has been abused by a previous therapist, this information must be reported to the appropriate legal authorities and/or ethics board.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.
I agree to the above limits of confidentiality and understand their meanings and ramifications.

____ Today's Date: _____________
Client Signature

____ Today's Date: _____________
Client Signature

OUTPATIENT SERVICES CONTRACT

Welcome to Moore Mental Health & Behavioral Services. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Moore Mental Health & Behavioral Services, PLLC offers a variety of therapy and assessment services provided by psychologists, licensed psychological associates, counselors, psychology post-doctoral and pre-doctoral interns, and psychology and counseling graduate students.

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If

your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

________ Initial

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours [1day] advance notice of cancellation.

________ Initial

PSYCHOLOGICAL ASSESSMENT

Psychological assessment provides the opportunity to evaluate an individual compared against normative samples in order to determine how similar or different they are from the normative group. Psychological assessment typically presents a relatively low risk to participants. It is possible that individuals may feel uncomfortable or anxious about being tested. Assessors are trained to detect and respond sensitively to indications of anxiety. The benefits of completing a psychological assessment may include obtaining a detailed description of strengths and challenges in the areas covered by the assessment (e.g., intellectual, academic, social-emotional functioning), and recommendations for addressing areas of difficulty. For example, this information might be useful to help a child qualify for special accommodations in his or her educational environment.

________ Initial

PROFESSIONAL FEES

My hourly fee is $150. In addition to weekly appointments, I charge this amount for other professional services (except for psychological evaluations) you may need, though I will break

down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 30 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

________ Initial

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, Moore Mental Health & Behavioral Services, PLLC may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

________ Initial

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Preliminary information will be provided prior to your appointment. However, this is not a guarantee. It is very important that you find out exactly what mental health services your insurance policy covers. I will fill out forms and

provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I (or my billing team) will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before

you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

________ Initial

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by the Moore Mental Health & Behavioral Services, PLLC receptionist team who knows where to reach me or a voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. In the event I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary. In emergencies, please call 911 or go to the nearest hospital.

________ Initial

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. I am sometimes willing to conduct a review meeting without charge. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

________ Initial

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general

information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

________ Initial

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child /elderly person, or disabled person] is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

________ Initial

USE OF ELECTRONIC COMMUNICATION

Please be aware that e-mail or text messages may not be private or confidential and may not be read by the recipient in a timely fashion.

________ Initial

PSYCHIATRIC CONSULTS AND MEDICATION

Moore Mental Health & Behavioral Services, PLLC does not retain a psychiatrist on staff, nor do we prescribe or dispense psychiatric medications. Moore Mental Health & Behavioral Services, PLLC can provide you with a psychiatric referral if deemed necessary. You may sign a release to enable Moore Mental Health & Behavioral Services, PLLC to consult with your Psychiatrist.

________ Initial

____ ____________
Signature of client (or person acting for client) Date

____
Printed name

I, the therapist, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this brochure. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

____ ____________
Signature of therapist Date

CONSENT TO RELEASE INFORMATION

Client's Name: ____

Address: ______________________ City: ____________ State: ____ Zip: _______

Phone: __________________________ DOB: ____________________

I, _______________________________, authorize ____________________________
(Parent/Guardian/Self) (Professional/Hospital/Agency)

Address:

____

____

Phone: ( )_______________________ **Fax:** ( )_______________________

AND

___________________________(Therapist) to **exchange** information (verbally or in writing) regarding ________________________ whose date of birth is ______________.

Such information includes (but not exclusive) to the following:

___ Academic testing results
___ Behavior programs
___ Progress reports
___ Intelligence testing results
___ Medical reports
___ Personality profiles
___ Psychological reports
___ Psychological testing results
___ Service plans
___ Summary reports
___ Vocational testing results
___ Entire record, except progress notes
___ *Psychotherapy Notes
___ Other, specify___________________

The above information will be used for the following purposes:
___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program
___ Case review ____ Updating files
___ Other (specify) ____

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I

have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: __Self __Parent/legal guardian __Personal representative
__Other (describe)_______________________________________

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: ___________________________________ Date: ___/___/____

Parent/guardian/personal representative (if applicable)
Signature: ___________________________________ Date: ___/___/____

Witness (if client is unable to sign)
Signature: ___________________________________ Date: ___/___/____

Credit Card
Authorization Form

Today's date: _________ /______________/_______________

Credit Card Information:

Name as it appears on the Card:

____

Type of Card: □ VISA □ MASTERCARD □ DISCOVER □ AMERICAN EXPRESS

Credit Card Number________- ________- _______ Expiration Date______/_________

Security Code BACK of Visa OR Master Card: (3 digits) ________________________

Security Code FRONT of Amex Card: (4 digits) ________________________

Credit Card Billing Address:
Street: ____

City: _______________________State: _________________ Zip Code: ___________

Telephone: __________________________________

Cardholder Signature: ______________________________________

Date: ________/________/________

I certify that I am the authorized holder and signer of the credit card reference above.

I certify that all information above is complete and accurate.

I hereby authorize collection of payment for all charges according to services rendered and for missed appointments without 24-hour notice.

Please sign again for future authorization:

____

This Authorization can be faxed to 713-434-3234 or Emailed to moorementalhealth@gmail.com

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of $ 150.00 is charged for missed appointments or no-show cancellations with less than a 24-hour notice will be charged to the credit card on file. Please note that your insurance company cannot be billed for missed appointments.

Thank you for your consideration regarding this important matter. Your signature below indicates your agreement to adhere to Moore Mental Health & Behavioral Services Cancellation Policy if you fail to show up for or cancel an appointment without a 24-hour notice.

____ Today's Date: ____________
Client Signature

Consent to Evaluation

I agree to undergo (or I give consent for this person, ________________________________, to undergo) a complete psychological/psychiatric/mental health/family evaluation at the direction of this third party: ***Moore Mental Health & Behavioral Services, PLLC***. I understand and agree that the results of this evaluation are to be the sole property of this third party. I agree that I will not hold this third party legally responsible for any events resulting from this evaluation or the records created by it.

I understand that the purpose(s) of this evaluation are:
1. ***To assess psychological functioning***

I understand and agree that no doctor–patient or therapist–client relationship exists or will be created between myself (or the person being evaluated) and the evaluator.

I understand that I may withdraw my consent to this evaluation and to the transfer of information at any time by means of a written letter. However, I also understand that my withdrawal will not be retroactive (that is, it will not apply to testing and information transfer that have already taken place). If I do not withdraw my consent, it will automatically expire in 90 days from the date I signed this form.

I agree that a photocopy of this form is acceptable, but that the photocopy must be individually signed by me and a witness. I understand I have the right to receive a copy of this form upon my request.

____ ___________
Signature of client (or custodial parent/guardian of young child) Date

____
Printed name

____ ___________
Signature of adolescent client Date

____
Printed name

I, the psychologist, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses gives me no reason to believe that this person is not fully competent to give informed and willing consent.

____ ___________
Signature of psychologist Date

___ Copy accepted by client ___ Copy kept by psychologist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.