THERAPY AND ASSESSMENT

INFORMED CONSENT FORM

(CHILD/ADOLESCENT)

PATIENT NAME: _____

DATE OF BIRTH: _____

I, _____, as the parent/legal guardian of _____,
(name of parent/legal guardian) (name of child)
hereby give my consent for Dr. Natalie Schuberth (Psy.D., BCBA-D, Licensed Psychologist #5563), to treat and/or evaluate my child and/or family. I understand that sessions are confidential and will only be shared with other staff at the practice involved in the client's care and administrative task as necessary (i.e., billing, mail). There are certain circumstances where we are required to disclose otherwise confidential information such as cases of suspected child or elder abuse and neglect or where a patient is threatening imminent harm to himself/herself or others.

I have been informed of the issues and responsibilities related to payment for service. I understand that cash, check, and credit card are accepted forms of payment. All payments will be processed with administrative staff and not directly with the psychologist. Services will be paid for before services are rendered. Failure to pay may result in a disruption or discontinuation in treatment. The client will be presented with a bill at the end of each service that the client may submit to his/her insurance company for reimbursement.

CLIENT RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

You have the right:

1. To receive service appropriate to the needs of your child and/or family and to expect staff to provide safe, professional care at the level of intensity needed. If staff cannot provide the necessary treatment, they will make their best effort to provide appropriate referrals.
2. To be informed of the benefits and risks of receiving treatment vs. not receiving treatment.
3. To be actively involved in all decisions regarding treatment planning.
4. To be notified in a timely manner if you or your child's appointment has to be canceled.

CLIENT RESPONSIBILITIES

You have the responsibility:

1. To attend sessions on a timely and regular basis.
    a. If you arrive over 20 minutes late for your appointment (without first communicating with Dr. Schuberth), you may be asked to reschedule your appointment.
    b. If you fail to show for 2 sessions without canceling, service may be discontinued. Individual clinicians have flexibility in extenuating circumstances.
2. To call in advance if you need to cancel an appointment. If you need to cancel your appointment, please inform your clinician by phone at least 24 business hours before your appointment. Failure to do so will result in responsibility to pay for the missed service. Individual clinicians have flexibility in extenuating circumstances.
3. To not come to sessions under the influence of (non-prescribed) mind altering substances and to keep the therapeutic environment safe (e.g., do not bring weapons in to the office).

I understand that if a clinical emergency arise during business hours (Monday through Friday 9am-5pm, excluding holidays), and I am unable to reach Dr. Schuberth, I can call (609) 419-0400 and ask to have Dr. Schuberth (or my child's psychiatrist if s/he works in the same office) paged. I also understand that if an emergency arises after business hours or on weekends, I should call 9-1-1 or take my child to an emergency room.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Child/Adolescent Date

Alexander Road Associates
707 Alexander Road Building 2 Suite 202 Princeton, NJ 08540
Tel: (609)419-0400 FAX: (609)419-9200
info@araprinceton.com

Dr. William Hayes ___
Dr. Jennifer Kearney___
Dr. Asma Mian ___
Dr. Sara Popkin___

Dr. Matthew Brightman ___
Pasquale Sargiotto ___
Dr. Natalie Schuberth___

Patient Name: _____ **DOB:** _____/_____/_____
Street: _____
_____ Home: (____) _____-_____
City: _____ State:___ Zip: _____ Work: (____) _____-_____
E-Mail Address: _____ Cell: (____) _____-_____
(for adult or responsible party only)

Responsible Party: (if child or dependent)_____
Relationship to Patient: __ Parent __ Spouse __ Other: _____
Street: _____ Home: (____) _____-_____
_____ Work: (____) _____-_____
City: _____State: ___ Zip: _____ Cell: (____) _____-_____

Preferred Payment Method: ___ Cash ___Check ___Credit Card

We are able to e-mail you reminders of your upcoming appointments currently and plan to text message reminders later in 2016. Check if you would like reminder by email or text:
Yes _____ No _____

Known Allergies: _____
_____

Current Medications:

Medication	Dosage	Prescribing Physician

Known Medical Conditions: _____
_____

Referred By:_____
Referral Type __Physician __ School __Other:_____

I understand I am responsible for payment-in-full for services rendered at the time of service. I also understand that Alexander Road Associates does not accept Private Insurance, Medicare or Medicaid. I am also responsible for payment of any appointment cancelled without 24 business hours advance notice.

Responsible Party: _____**Date:** _____/_____/_____

Alexander Road Associates
707 Alexander Rd.
Bldg. 2, Suite 202
Princeton, NJ 08540
Phone (609) 419-0400
Fax (609) 419-9200

RELEASE OF INFORMATION FORM

I _____ hereby authorize _____ and Alexander Road Associates to disclose information to the following persons and or to receive information from the following persons regarding patient:

Name:_____ Date of Birth _____

Purpose of Disclosure:

Information and/or records are to be released to or from the following:
(Cross out any not applicable)

Family Physician/Pediatrician: Dr. _____
Group Name and Address: _____
_____
_____ **Phone # ( )** _____

School: Name and Address: _____
_____
_____ **Phone # ( )** _____

Therapist: Name and Address: _____
_____
_____ **Phone # ( )** _____

Other: Name and Address: _____
_____
_____ **Phone # ( )** _____

_____ _____
(Patients Signature) **(Date of Signature)**

_____ _____
(Witness) **(Signature of Responsible Party {when applicable})**

To the recipient:

This information has been disclosed to you from records whose confidentiality is protected by state & federal law. New Jersey and federal law prohibits you from making further disclosure of this information, unless further disclosure if expressly authorized by written consent of the persons to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute and alcohol or drug abuse patient. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and will expire one year from the date of signature.

Rev. 10/05

Child's name: _____ Child's age: _____

Today's date: _____ Person completing form: _____

Date of birth: _____ Relationship to the child: _____

Phone Number: _____

Child's home address: (Street Address) _____ (Apt.#) _____

(City) _____ (State) _____ (Zip) _____

Who referred you here? Name: _____ Agency: _____

Phone: _____ Fax: _____

What are your primary areas of concern?

_____

_____

_____

If your child is here for an evaluation, what questions would you like that evaluation to address?

_____

_____

What are the child's greatest strengths and/or accomplishments?

_____

_____

What does the child enjoy doing most?

_____

_____

List any extracurricular activities (e.g., music, sports, boy/girl scouts, etc.)

_____

_____

FAMILY HISTORY

	Biological Mother	Biological Father
Name:		
Years of education:		
Learning problems in childhood:		
Current occupation (job):		
Emotional problems:		
Substance abuse:		
Medical problems:		

Does this parent:

Live with the child?	o Yes o No	o Yes o No
Have regular contact with child?	o Yes o No	o Yes o No
Have legal guardianship?	o Yes o No	o Yes o No
Is there joint custody?	o Yes o No	o Not Applicable

Are the biological parents married to each other? o Yes o No

If biological parents are <u>not</u> the legal guardians of the child, please list who is the legal guardian:

Name: _____ Relationship: _____

How long has the child been in this person's care? _____

SIBLINGS

Please list the names, ages, relationship (full-sibling, half-sibling, step-sibling, foster/adoptive), grade/job, and any learning, emotional, or medical problems siblings may have. Please circle the names of siblings that currently live with the child.

Name	Age	Relationship	Grade/Job	Learning, emotional, or medical problems

Please list anyone else who lives in the household with the child who is not a parent, guardian, or sibling:

_____

Please list anyone in the family who has had any medical problems, attentional problems, developmental delay, learning disability, intellectual dis, psychological problems, or speech or language problems. Please be sure to include the child's grandparents, siblings, aunts, uncles, and cousins. Please list the nature of the problem and the person's relationship to the child:

_____

_____

_____

Please list any major family changes in the past year? (moving, death, marriage, births, etc.)

_____

PREGNANCY, BIRTH, AND DEVELOPMENTAL HISTORY

Mother's age at child's birth: _____ Father's age at child's birth: _____

While pregnant, what medications (prescribed or over-the-counter) did the mother take?_____

Did the mother receive regular prenatal care? o Yes o No

Did the mother use any of the following substances during pregnancy?

- o Alcohol
- o Marijuana
- o Tobacco
- o Caffeine (coffee, colas, etc.)
- o Other drugs (cocaine, heroin, etc.)
- o None

The mother's general physical health during the pregnancy was: o Good o Fair o Poor

Was this child born: o Early o On time (38-42 weeks) o Late

How much did the baby weigh at birth? ____ lbs. ____oz.

~~Apgar Score(s): 1 minute _____ 5 minute _____ 10 minute_____~~

Did the child or mother have any problems with delivery? o Yes o No

If so, please describe: _____

Did the child have any problems during the first year of life? o Yes o No

If so, please describe: _____

Motor Skills

Crawled forward	o Early	o Average (8-10 months)	o Late	o Not Yet
Walked with hands held	o Early	o Average (10-12 months)	o Late	o Not Yet
Walked alone (2-3 steps)	o Early	o Average (11-13 months)	o Late	o Not Yet

Language Abilities

Said "dada" or "mama"	o Early	o Average (11-14 months)	o Late	o Not Yet
Said other single words	o Early	o Average (12-14 months)	o Late	o Not Yet
Used two-word sentences	o Early	o Average (20-24 months)	o Late	o Not Yet

HEALTH HISTORY

Which hand does your child use most? o Right o Left o Uses both equally

Has the child ever had a temperature of 104° F or higher for more than a few hours? o Yes o No

If yes, what age(s) and how long did it last? _____

Has the child ever been hit hard on the head or suffered a head injury? o Yes o No

If so, did the child lose consciousness (get knocked out)? o Yes o No

Has the child been diagnosed with seizures or epilepsy? o Yes o No

Has the child ever had a bad reaction to any medication? o Yes o No

If so, what medication: _____

Was the child ever in the hospital for an accident, injury, or operation? o Yes o No

Has the child ever been exposed to lead? o Yes o No

If so, please describe: _____

Has the child ever swallowed any poison, non-food, or drug accidentally? o Yes o No

Has the child had frequent ear infections? o Yes o No

Difficulties with or changes in appetite? _____

Has the child had any other medical problems? _____

Does the child currently have any medical problems? _____

Difficulties or changes in sleep? _____

Does the child take any medications *currently* prescribed by his/her physician? o Yes o No

If so, please list what he/she takes, how much, when, and why:

Start Date	Medication Name	Dosage	When Taken

What is the name of the physician that prescribes/monitors the medications?

_____

Does the child *currently* take any non-prescribed (over-the-counter) medication (i.e., Tylenol, Motrin, cold medicine) or herbal remedies? o Yes o No

If so, please list what he/she takes, how much, when, and why:

Start Date	Medication Name	Dosage	When Taken

How consistently have the medication(s) been given: o Inconsistently o Most of the time o Always

Has your child had any thoughts of hurting or killing himself/herself or others? If yes, please provide details.

Has your child ever been involved with Child Protective Services (CPS) or the Department of Social Services (DSS) for concerns of abuse or neglect? If yes, please provide details.

What therapies have been provided to the child?

- o No therapies
- o Physical therapy
- o Psychotherapy or counselling
- o Early Intervention
- o Occupational therapy
- o Speech therapy
- o Other _____

If any, what evaluations has the child had?

- o Hearing/vision testing (note below if problem)
- o Psychological or neuropsychological testing
- o Speech and language testing
- o Neurological examination or testing
- o School testing/Educational Assessment
- o Psychiatric Evaluation

SCHOOL HISTORY

Name of present school: _____ Phone number: _____

Contact person / Teacher: _____ Fax number: _____

Current grade: _____ Number of children in class: _____

Was the child ever held back to repeat a grade? o Yes o No Which grade: _____

Is the child in special education? o Yes o No Beginning when: _____

If yes, please place a mark next to the educational handicapping condition:

- o Speech/Language Disorder
- o Intellectual disability
- o Traumatic Brain Injury
- o Visually Impaired (Legal blindness)
- o Autism/PDD/Asperger's Syndrome
- o Deaf/Hearing Impaired
- o Learning disabilities, Area of disability: _____
- o Emotional problems, Please describe: _____
- o Other Health Impaired (ADHD, etc.), Please specify: _____

If the child receives special education, how many hours of services does the child receive per week? ____

Does the child:

Have problems getting along with other children in class?	o Yes	o No
Have problems making friends in school?	o Yes	o No
Have problems getting along with teachers?	o Yes	o No
Tend to get sick in the morning before school (e.g. headache, stomach ache, etc)?	o Yes	o No

Describe the teacher's concerns about the child's schoolwork or behavior:

_____

What kind of grades has the child received in the past year? (Check all that apply)

o A's & B's o B's & C's o C's & D's o D's & F's

Or

o Outstanding o Good o Satisfactory o Improvement needed o Unsatisfactory

In which subject(s) does the child do best? _____

Which subject(s) are the most difficult? _____