

INTAKE QUESTIONNAIRE
Confidential and Privileged Information

Please complete the following form to help us understand your child. This will decrease the time needed to make an accurate evaluation of your child's needs. Please print or type information. This form will be reviewed by Dr. Corbett prior to or during your first appointment. Thank you!

Identifying Information

From Completed By: _____ Date: _____

Child's Name: _____ Date of Birth: _____

Gender: Male Female Current Age: _____ Grade: _____

Race/Ethnicity: _____

Home Address: _____

City _____ State _____ Zip code _____

Home Phone Number: _____ Okay to leave a message? Yes No

Cell Phone Number: _____ Okay to leave a message? Yes No

Work Phone Number: _____ Okay to leave a message? Yes No

Who has legal custody: _____

Pediatrician: _____

Address: _____

Phone Number: _____

Family Information

Mother's Name _____ Birthdate _____

Highest school grade completed by mother _____

Mother's occupation _____

Place of employment _____

Father's Name _____ Birthdate _____

Highest school grade completed by father _____

Father's occupation _____

Place of employment _____

Is your child adopted? _____ No _____ Yes

If yes, for how long and any information known about biological parents?:

Are parents married? _____ Yes _____ No If yes, when? _____

Are parents separated? _____ Yes _____ No If yes, when? _____

Are parents divorced? _____ Yes _____ No If yes, when? _____

Are there step-parent(s) involved? _____ Yes _____ No

If yes, when was the remarriage for either parent? _____

Step-Parent(s) or Legal Guardian(s) Names: _____

Birthdate(s) _____ Occupation(s) _____

Highest grade completed by step-parent(s) _____

Is there any important information about the parents' relationship which might be helpful to know? _____

List all siblings (full, half, step, living or deceased)

| | <u>Name</u> | <u>Age</u> | <u>Sex</u> | <u>Relationship to child</u> | <u>Grade</u> | <u>Living with Child?</u> |
|----|-------------|------------|------------|------------------------------|--------------|---------------------------|
| 1. | _____ | _____ | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ | _____ | _____ |

Please give the name and relationship of anyone else currently living in the home

History of Current Problem

What are your current concerns regarding your child?

At what age was the problem first noted? _____

Please describe any illness or injury that may have been associated with the problem.

Has your child ever had treatment for this problem? _____

If so, Where? _____ When? _____

Has your child ever had counseling or psychological services for any other problem? Yes No
If yes, when and where?

Have there been any significant changes, events, or losses in your child's life?

Please circle any of the following areas of concern, past or present.

| | | |
|--------------------------|--------------------------|--------------------------|
| Anger Management | Depressed Mood | Aggression |
| School Problems | Lying | Medical Issues |
| Problems Completing Work | Suicidal Thoughts | Helplessness |
| Obsessions/Compulsions | Hallucinations/Delusions | Shyness |
| Body Image | Bullying/Teasing | Impulse Control Problems |
| Physical Complaints/Pain | Nightmares | Low Self-Esteem |
| Family Problems | Separation Anxiety | Food Issues |
| Motor/Vocal Tics | Hyperactivity | Irritability |
| Poor Concentration | Sexual Abuse | Opposition |
| Sleeping Problems | Bedwetting/Soiling | Distractibility |
| Excessive Worry | Self-Injurious Behavior | Cruelty to Animals |

What are your goals for your child's therapy?

Birth, Developmental, & Medical History of Child

Birth History

Did mother use any of the following during pregnancy?

Tobacco Yes No

Alcohol Yes No

Drugs Yes No

Describe any complications during pregnancy _____

Length of pregnancy: Full Term Premature (at weeks) Late

Type of delivery _____ Birth weight _____

Describe any complications during delivery _____

Were there any medical problems noted at or immediately following birth?

Developmental History of Child

Please note the age at which your child reached the following developmental milestones. If unsure of the exact age, give the approximate age.

MOTOR

Sat alone _____

Walked alone _____

Potty Trained _____

LANGUAGE

Started using single words (other than "mama" or "dada") _____

Used 3 word-sentences _____

Infancy or Toddler concerns? _____

Developmental Concerns? _____

Please note any difficulties your child has experienced with the following:

Toileting _____ In the past _____ Currently _____ Never
Eating _____ In the past _____ Currently _____ Never
Sleeping _____ In the past _____ Currently _____ Never

If you are bringing your teenager (12 and over) to the office, does your child have any problems with alcohol or drugs?

Tobacco _____ Yes _____ No _____ Unsure
Alcohol _____ Yes _____ No _____ Unsure
Drugs _____ Yes _____ No _____ Unsure

Medical History of Child

Describe any serious accident, illness, or injury which your child has experienced and what age:

Please list any operations your child has undergone and when: _____

Please list any allergies that your child has: _____

List any medications your child is currently taking (name of medication and dosage):

Child's current height _____ weight _____

Please list any significant medical problems of anyone in the family.

Please list any family mental health history (Include immediate and extended family members).

Educational History of the Child/Teen

Attended Daycare? _____ In home daycare _____ daycare facility _____ At home

Attended Pre-school? _____ Yes _____ No

Attended Kindergarten ? _____ Yes _____ No

In gifted program? _____ Yes _____ No If yes, describe: _____

Receive special education or additional support? _____ Yes _____ No

Does your child have an Individualized Education Plan (IEP) _____ Yes _____ No

If yes, why does your child have an IEP? _____

Ever had psychoeducational testing? _____ Yes _____ No

Ever repeated a grade? _____ Yes _____ No

Ever been suspended or expelled? _____ Yes _____ No

If yes, what grade and why? _____

Current School: _____ Grade: _____

Type of School: _____ Public _____ Private _____ Home Schooled

What grades does your child receive? _____

Any recent changes in grades? _____

School Address: _____

School Telephone Number: _____

Name of primary teacher: _____

Feelings about school work (circle all that apply):

Anxious Passive Enthusiastic Fearful No expression Bored Rebellious Tedious

Other: _____

Approach to school work (circle all that apply):

Organized Industrious Responsible Interested Self-directed No initiative Refuses

Does only what is expected Sloppy Disorganized Cooperative Does not complete work

Other: _____

Aynsley M. Corbett, Psy.D.
(404) 847-9560

CONSENT AND AGREEMENT

I. **PSYCHOLOGICAL SERVICES.** Psychological services vary depending on the reason for referral. In all cases, the initial appointment is set up with the parents/guardians of the child and it is spent gathering background information and relevant information regarding the current concerns or difficulties. After sufficient information is gathered, the next appointment is scheduled with the child. All therapy provided is based on empirically-validated and/or well researched methods and determined based on the presenting problem. Art and play will be integrated into therapy depending on the age of the child. If you have any questions about the procedures, please discuss them as they arise. Often times, therapy requires active participation and there may be times when homework is recommended to ensure that improvements in behavior will be seen in the home and school environments. Openness and honesty are recommended to ensure that I have as much information as possible to help you and/or your child.

II. **SESSIONS.** The initial diagnostic interview typically lasts from one to two hours depending on scheduling and availability. Recurrent psychotherapy sessions last approximately 45 minutes. Weekly appointments are recommended in most cases, but sessions every other week can be scheduled depending on the situation or need of the family.

III. **CANCELATION POLICY.** **Once an appointment is scheduled, you will be expected to pay for the entire session (\$150) unless you provide a 24-hour advance notice of cancellation.** It is important to note that most insurance companies will not reimburse me for a missed or canceled appointment, so the full \$150 fee will be your responsibility. Since your appointment time is reserved for you, please notify me as soon as possible if you will be unable to attend the appointment. You may leave a message on my voicemail after hours or on weekends if you need to cancel an appointment. However, Monday appointments must be canceled by noon on Friday in order to avoid a cancellation fee. Please plan on leaving enough time to travel to your appointment to ensure a prompt start time. Traffic and weather will not be accepted as an excuse for missing an appointment and the cancellation fee will apply. **If DeKalb County Schools are closed due to snow, ice, or severe weather**, I will not be able to be in the office. When this occurs, please call to confirm your appointment prior to traveling to the appointment. These appointments will be rescheduled as soon as possible.

IV. **PROFESSIONAL FEES.** My hourly fee is \$150.00 for psychotherapy and assessment. The fee for the initial diagnostic session is \$185. In addition to therapy sessions, I charge for other professional services you may need. These services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent completing school forms. Charges for consultation outside of the therapy session (i.e., school observations, hospital visits, depositions, etc.) will be determined on an individual basis. If I am involved in any legal proceedings on your behalf, you will be expected to pay for all of my professional time, including preparation and transportation costs. Fees for these services are \$150/hour for preparation and \$300/hour for attendance to a legal proceeding. Fees should be paid at the end of every session. If you are unable to pay for a session and/or have an exceptional circumstance, this should be discussed at the beginning of the session. Cash, check, Visa, and MasterCard are accepted for your convenience. Any balances unpaid after 60 days are subject to a 1.5% per month finance charge. Returned checks will be subject to a \$30 fee, as well as any unpaid balance fee that may accrue prior to receipt of payment.

V. **INSURANCE.** If you choose to use insurance, preauthorization is usually required. It is your responsibility to contact your insurance company to determine your outpatient mental health benefits. If I am not on the panel for your insurance company, it is possible that they will reimburse you for a percentage of the fee for "out-of-network" providers. I will file out-of-network claims on your behalf. A receipt is available to help you submit insurance claims. In addition, the office manager will kindly verify your insurance and benefits. If you are a member of a managed care company in which I participate, I will file insurance for you. I certify that all information given is true and correct and that I have no other coverage applicable to these services. After the office manager has verified your insurance eligibility and level of benefits, I will gladly

accept only the co-payment. Until that time, please plan on paying the full contracted amount. Regarding insurance, it is important to note that the amount collected is based on information provided from your insurance company and it is common for insurance companies to deny coverage at a later date. For that reason, you may receive a bill for services after a session because your insurance company does not reimburse as anticipated or requests a refund for previously paid services. Please also note that insurance companies often may authorize a certain number of sessions per year. You will be responsible for keeping track of the number of sessions utilized and you must notify me when we approach the end of these authorized sessions. If notified in a timely manner, I am more than happy to submit paperwork for additional sessions if needed. However, I cannot guarantee the authorization of these sessions.

VI. **PSYCHOLOGICAL or PSYCHOEDUCATIONAL TESTING.** Psychological or psychoeducational testing will be targeted to the individual needs of the patient and the reason for referral. This is generally accomplished through a diagnostic interview with parents and child, standardized testing (e.g., intelligence and academic tests), informal testing, questionnaires, observations, and review of previous records or reports. Each assessment often involves multiple visits to my office for a background interview, individual assessment sessions, and a feedback interview. I may also visit the student's school in order to meet with teachers and observe your child in the classroom. The results of the assessment include a description of your child's current level of functioning in the areas assessed, as well as detailed recommendations. Feedback is provided both in a face-to-face meeting and in the form of a written report. My assessment fee includes time spent interviewing, administering tests, scoring tests, interpreting tests, report writing, consultation with other professionals involved in the case, and direct feedback to you. A complete evaluation often takes at least 8 to 10 hours. Payment in full is expected at the time of testing. By the end of our time together, you will have better understanding of your strengths, challenges, and difficulties. I shall also provide you with a written report and recommendations. You will also have an opportunity to ask any questions regarding your child's results. **It is important to note that most insurance companies will not cover psychoeducational evaluations.**

VII. **THERAPIST CONTACT.** Due to patient appointments, I am not always immediately available by telephone. When unavailable, my telephone is answered by the office manager who can take a message for me or direct you to my voicemail. I will make every effort to return your phone call the same business day or within 48 hours, with the exception of weekends or holidays. If you are difficult to reach by phone, please leave me the best times when you will be available. If you are unable to reach me and feel the matter cannot wait for me to return your call, please call your physician and/or go to the nearest emergency room and ask for the psychologist on call. When I will be away for an extended period, the answering service can provide you with one of my colleagues if needed. After making initial contact, I can offer my email address if it is determined that this will be the best mode of communication. However, it is important to note that confidentiality cannot be ensured over the internet. Every effort will be made to keep your information confidential, but communicating via email has some disadvantages. If this is the case, for your own protection, please do not include any private identifying information in any of your emails.

VIII. **LIMITS OF CONFIDENTIALITY.** All communication between a psychologist and a patient will remain confidential as provided by the Georgia Law. This privilege can be waived by the patient under normal circumstances. However, there are three exceptions to the law, and under these circumstances, a psychologist ethically and legally would need to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, and (3) actual or suspected incidents of child abuse. If any of the above situations arise, I will make every effort to discuss this with you first before taking the appropriate and necessary actions and I will limit my disclosure to what is only absolutely necessary. Children and adolescents will have the same confidentiality as adults, with one exception. Parents and guardians will be made aware of their child's progress in non-specific terms, but they will not be informed of specific details of what is discussed in therapy. However, this psychologist will inform parents of any serious health or safety issues of which their child may be at risk, with the understanding that this determination will be made by the psychologist.

IX. **CONSENT FOR SERVICES.** I hereby authorize and voluntarily consent for Dr. Aynsley Corbett to provide psychological services considered reasonably necessary for myself and/or my minor child, _____ (DOB ____/____/____).

X. **CONSENT FOR RELEASE OF INFORMATION FOR PAYMENT PURPOSES.** I authorize Dr. Aynsley Corbett to release any medical or psychological information necessary to any representative or agent of any entity that may pay for any part of the expenses incurred in connection with the permitted services (including any insurance company, health maintenance organization, employer, or government or social agency) for the purpose of evaluating or processing claims for payment for services rendered. I also hereby authorize any representative or agent or any entity mentioned above that may pay part of expenses incurred in connection with permitted services to release any documentation to apply for said payment. I acknowledge that this consent is valid until such time as bills related to the permitted services have been paid in full.

XI. **CONSENT FOR RELEASE OF INFORMATION TO CARE PROVIDERS.** I hereby authorize Dr. Aynsley Corbett to release any and all information contained in the medical record to the care providers listed below in connection with permitted services for continuity of care. I hereby release Dr. Corbett from any and all liabilities, responsibilities, damages, and claims that might arise from the release of information authorized above. I hereby waive any privilege with respect to records released as authorized above. I further understand that I can withdraw this consent for release of information at any time by contacting Dr. Corbett except to the extent that action has been taken in reliance thereon.

Provider Names _____, _____,
_____.

XII. **GUARANTOR AGREEMENT.** For and in consideration of the professional services rendered by Dr. Aynsley Corbett, I hereby guarantee payment of all fees and charges incurred by said patient for permitted services. I accept personal responsibility for paying in full any balance that may remain after my insurance has processed the claims , including those that may be determined as “not medically necessary” by my insurance carrier.

XIII. **ASSIGNMENT OF MEDICAID BENEFITS, PATIENT CERTIFICATION, AND PAYMENT REQUEST.** I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request that payment of authorized benefits be made and assign the benefits payable for the permitted services to Dr. Aynsley Corbett I am responsible for and agree to pay charges not covered by this agreement including any Medicare deductibles and/or co-insurance.

XIV. **CERTIFICATION AND SIGNATURE.** I certify that I have received a copy of my HIPPA rights, have read and understand this consent, and have signed this consent in the capacity indicated below as of the date indicated below:

- ___ As an independent (adult) consenting for myself.
- ___ As a parent (whether adult or minor) consenting for my minor child.
- ___ As a guardian consenting for his or her ward.
- ___ As a person temporarily standing in loco parentis consenting for the minor under his or her care.

Name (print full name)

Parent/Guardian Signature

Date

Patient Signature

Date

