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Child Clinical Intervention
Preliminary Office Forms

Thank you for reaching me and for your interest in pursuing child clinical services in this office. Your time and effort completing these preliminary materials will make our work together more effective and time-efficient.

These forms are *not* appropriate if you are seeking family or individual adult therapy, or if you are seeking court-ordered (forensic) services unless I explicitly request otherwise.

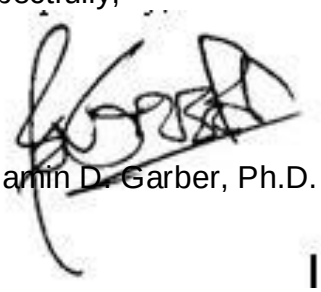
These forms are intended to be completed by at least one parent or legal guardian. When parents or guardians live apart, both (all) may choose to complete these materials separately.

These forms can be completed about one or more children. Please feel free to divide each item and use the children's names to distinguish separate answers. Please feel free to continue any answer on the back of the page and to provide copies (not originals) or any relevant records or documentation.

- Pages 2 through 6 of this packet ask questions about the child's strengths and weaknesses.
- Finally, pages 7 through 11 provide a detailed description of the proposed service. **Your signature is requested on the last page.**

Please reach me at any time via email or phone with questions or concerns. In anticipation of our work together, I am,

Respectfully,



Benjamin D. Garber, Ph.D.

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Revised 07.2017

_____
Please print your name in full

_____ _____
Please print the child's name in full | Please indicate your relationship to the child (e.g., mother, guardian, brother)

_____ _____
What is the child's date of birth? | What is today's date?

_____ _____
Who is the child's primary care physician? | When did the child last have a full physical exam?

1. "I am seeking psychological services for this child because…"
(Please describe the concerns or specific goals that have prompted you to contact this office. Feel free to continue your response on the reverse.)

2. **Medical history:** If YES, please describe:

a. Serious illness?	☐ None	
b. Serious injury?	☐ None	
c. Allergies or asthma?	☐ None	
d. Current medications or supplements:	☐ None	
e. Current physical limitations:	☐ None	

3. **Daily functioning:** If YES, please describe:

a. Sleep: Difficulties sleeping alone, falling asleep, staying asleep or waking? Sleep walking, sleep talking, nightmares or night terrors	☐ None	
b. Appetite: Picky eater, special diet, habits or rituals, Binging, purging, over-eating Weight loss or weight gain	☐ None	
c. Toileting: Wetting, soiling, constipation, diarrhea Fearful, avoidant	☐ None	
d. Self-care: Limitations or resistance dressing, eating, bathing or showering, brushing teeth, maintaining personal hygiene	☐ None	
e. Personal responsibility: Fails to take responsibility for behavior, blames others; irresponsible with money, schedules, possessions	☐ None	

4. **School functioning:** If YES, please describe:

a. Grades: Failing, sudden change of grades	☐ None	
b. Homework: Resistant, refusal, procrastination, Disorganized, demands excessive help, completes but refuses to hand-in	☐ None	
c. Behavior: Disruptive, aggressive, demanding Withdrawn, isolates, passive, fearful Suspension, detention, expulsion	☐ None	
d. Attendance: Avoidant, refusal, separation anxiety	☐ None	
e. Special education needs: IEP or 504 (for what needs?) Please provide copy	☐ None	

5. **Occupational/vocational functioning:** If YES, please describe:

a. Does this child currently have a job, internship, mentorship or otherwise expected to function in a work environment?	☐ None	
b. Impaired performance at work	☐ None	
c. Conflict with co-workers and/or the boss	☐ None	
d. Recent job loss, job change	☐ None	

6. **Relationships:** If YES, please describe:

a. With parents or guardians: Clingy, needy, overly-dependent Resistant, refuses contact Passive, withdrawn; aggressive, demanding	☐ None	
b. With siblings: Clingy, needy, overly-dependent Resistant, refuses contact Passive, withdrawn; aggressive, demanding	☐ None	
c. With other children outside the home: Clingy, needy, overly-dependent Resistant, refuses contact Passive, withdrawn; aggressive, demanding	☐ None	
d. Teachers, employers, authority figures: Clingy, needy, overly-dependent Resistant, refuses contact Passive, withdrawn; aggressive, demanding	☐ None	
e. In general: Socially inappropriate, fails to respect "personal space;" sexualized; bully; victim; Confused, left out, lonely, loner	☐ None	

7. **Emotion expression and regulation:** If YES, please describe:

a. Withholds emotion, refuses or unable to express	☐ None	
b. Explosive, abrupt, extreme expressions	☐ None	
c. Inappropriate, bizarre, inconsistent and/or Unpredictable	☐ None	
d. Violent or destructive: Self-harm (e.g., cutting), suicidal, homicidal violent to others, harms pets, siblings intentionally destructive of property	☐ None	

Please be aware that if Dr. Garber believes that any person poses a threat to another person's safety (and in some instances a threat to damage real property) he must alert relevant authorities, e.g., the police.

8. **Addictions and dependencies:** If YES, please describe:

a. Exposure to or experimented with tobacco products	☐ None	
b. Exposure to or experimented with Alcohol products?	☐ None	
c. Exposure to or experimented with Marijuana products?	☐ None	
d. Exposure to or experimented with Other “street drugs”?	☐ None	
e. Behavioral addictions: Pornography, video games, gambling shopping	☐ None	

9. **Environmental safety concerns:** If YES, please describe:

a. Does the child have access to weapons in the home or elsewhere?	☐ None	
b. Does the child have unsupervised access to medications, drugs, and/or alcohol products?	☐ None	
c. Do you have concerns about the child’s use of car seats or seat belts in vehicles, helmets, floatation devises, and other physical health precautions?	☐ None	

10. **Experience of trauma:** If YES, please describe:

a. Exposure to or experience of abuse or neglect of any kind?	☐ None	
b. Grief, loss, death, separation from A loved one?	☐ None	
c. Natural disaster, terrorism, war, Motor vehicle accidents, house fire	☐ None	
d. Domestic violence, adult separation divorce	☐ None	

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Revised 07.2017

Child Clinical Interventions:
Adult Informed Consent/Youth Informed Assent[1]

- Please read the following description of Dr. Garber's practice completely. Learn more about relevant matters at www.HealthyParent.com and by reaching Dr. Garber directly.

- At least one parent or legal guardian must sign and date this document on the last page.

- Young adults can be invited to read and sign this document at the adults' discretion.

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and reach me via email or telephone to discuss any questions or concerns that might arise. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES: Psychotherapy ("therapy") is a relationship-based intervention in which a skilled professional (therapist) intends to help one or more individuals (clients or patients) to make significant behavioral, emotional, and/or cognitive (thinking) changes. This process requires the active participation of the client and, in the case of a child therapy, it also requires the active support and participation of other family members.

Psychotherapy can have benefits and risks. Since therapy often addresses unpleasant matters, it can raise uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. The goal, of course, is to decrease the client's distress and dysfunction so as to improve functioning, health and happiness. Unfortunately, it is impossible to guarantee the results of any particular therapy.

Providing therapy services to a child typically involves the following steps:

1. Initial parent/guardian interview: Dr. Garber will invite all parents and/or guardians to participate in one 90-minute interview in order to gather basic history and background. This meeting will conclude with recommendations for next best steps suited to achieve the parents' or guardians' goals for the child.

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[1] Adapted 07.2017 with permission from APAIT:
https://trustinsurance.com/Portals/0/documents/Informed%20Consent.doc?ver=2015-12-23-134309-760

In those situations in which two or more adults who share responsibility to a child cannot or will not meet together, Dr. Garber will schedule two separate 90-minute initial interviews.

When parents are divorced and share decision-making authority ("legal custody"), Dr. Garber will require that the parent requesting services at least alert and at best invite the other parent to the initial meeting. Dr. Garber may decline to provide services in any instance in which one parent seeks to keep the child's therapy secret from the other.

When parents are divorced and the court has granted one parent exclusive decision-making authority ("legal custody"), that parent can enroll the child in psychotherapy unilaterally. In some situations, Dr. Garber may still request permission to communicate with or involve the other parent in the child's psychotherapy.

2. Preliminary assessment: Following the initial adult interview(s), Dr. Garber may recommend a preliminary assessment. This often includes:
   (a) School observation
   (b) Two 50-minute interviews with the child
   (c) One 50-minute family meeting with each family group
   (d) One 50-minute follow-up with the adults to summarize impressions and recommend next best steps.

3. Ongoing communication and episodic check-ins: It is important that the adults remain in close communication throughout the course of a child's psychotherapy. Dr. Garber often recommends communication via e-mail, copy to all adults and/or use of tools like www.OurFamilyWizard.com. Dr. Garber will ask to meet with parents/guardians episodically to review progress, provide parenting recommendations and to anticipate important events (e.g., family changes).

MEETINGS: Our meetings together will typically be either 50- or 90-minutes long. When two or more family members are present, 90-minutes is commonly more productive.

Our meetings will commence when all persons expected to attend are present. I reserve the right to postpone or cancel a meeting if a person expected to attend is absent.

Our meetings will end on time unless there is reason to interrupt a meeting earlier. I reserve the right to pause or discontinue any meeting that I believe has ceased to be constructive.

Our meetings will be safe. Please do not bring weapons of any kind onto the premises for any reason at any time. I will always treat you with respect and dignity and ask that you make the commitment to treat me and the other members of your family and participants in this therapy similarly.

The charge for this service will be based on an hourly rate that I will specify. Payment is requested in full at the time of service. The full fee for the scheduled duration of any meeting will be due even if the meeting is discontinued prematurely. The full fee for the scheduled duration will be due if you or any party expected to attend a scheduled meeting fails to arrive, except in case of extreme weather, abrupt illness, or injury.

Our meetings will be scheduled in advance. I am not available to provide emergency or walk-in service. Please be advised that scheduling is available on a first-come, first-served basis. Typically, after school and late day times are in highest demand and may require planning well in advance.

PROFESSIONAL FEES: I charge an hourly rate for all services relevant to our work together, including but not only the time invested in our face-to-face meetings. This may include

communications with you and relevant others, correspondence, review of records, provisions of summary materials, travel, and administrative endeavors (e.g., filing, copying).

The hourly fee is determined in part on the nature of the service. This child therapy will be charged at the hourly rate of:

_____/hour

All fees are due in full at the time of service. I withdrew from participation in all managed care and third-party insurance reimbursement panels in 1999. You may be eligible for insurance reimbursement, but I will leave this between you and your insurance carrier. I will not communicate with your insurance carrier, but I would be glad to provide you with documentation in support of any claim that you may wish to make.

If you chose to seek insurance reimbursement, 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.

I will resist any effort to involve our work together in litigation. Nevertheless, if any person demands that I participate in litigation via court order, subpoena or otherwise, that person will become responsible for all associated costs at a higher (forensic) hourly rate due as an advance retainer.

Prompt payment in full of all costs incurred and payment in full of any requested retainer is a necessary precondition for continuation of this service. This means that overdue balances can be cause to discontinue our work.

When parents/guardians are living apart, divorcing, or divorced, it is important to be clear in advance about who will pay for this service. I have no preference whether the adults involved split the costs incurred or how. Please communicate with the other adults in your family so as to clarify this matter in advance of meeting together.

DIAGNOSIS AND PROCEDURE CODES: Because this is a child-centered intervention, the child will be the client or patient. My record will be held as LASTNAME, CHILDNAME.

The procedure or CPT code relevant to this service will usually be 90791 “Initial Interview” and thereafter 90834 “Individual therapy.” I would be glad to discuss any exceptions that may arise at your request.

CONTACTING ME: Please direct your questions and concerns directly to my attention. I do not employ a secretary or receptionist. The most immediate and direct means of communication is via e-mail to papapben@HealthyParent.com. Feel free to reach my answering machine at 603.879.9100. I am not typically available to answer your calls directly, but will usually be able to reply within one business day.

My office is usually open Monday through Friday 8:00 a.m. through 6:00 p.m. EST except during national holidays. In case of extreme weather, I will usually close the office when Nashua (NH) High School North is closed. Please be aware that my work includes out-of-office meetings and travel. I will alert you in advance if I plan to be away for any reason. I will do my best to alert you as far in advance as possible should I become ill or otherwise unexpectedly unavailable.

I am not available to provide emergency or walk-in services. Please be certain to have access to emergency services and to be comfortable dialing 9-1-1 in any such circumstance.

PROFESSIONAL RECORDS: The laws and standards of my profession require that I maintain records of our work together. This record will be archived in conditions and for a period consistent with relevant ethics and laws.

Because this is a child-centered intervention, I will require the informed consent of all legally entitled adults in order to release a copy of this record. Your request alone may not be sufficient.

Because treatment records are easily misunderstood, I will usually request that parties who request a copy of the record of treatment allow me to provide them instead with a summary report. You will be responsible for all costs involved copying and delivering and/or preparing a summary report. In some instances, all parties' written informed consent allowing me to have a professional copy shop duplicate the record may be required.

I retain the discretion to refuse requests to release records and/or to provide summary reports in any instance in which I believe that complying will cause harm and as the law might otherwise require.

MINORS: Individuals who are less than eighteen years old are entitled to different rights as participants in psychotherapy.

Minors may not have access to records of their treatment without their parents' or legal guardians' written consent.

Please be aware that the law allows that a minor may, in some instances, prohibit his or her therapist from disclosing matters that arise in therapy with their parents or guardians.

CONFIDENTIALITY: In general, the privacy of all communications between a client or patient and a treating mental health professional is protected by law. This means that I cannot disclose matters that arise in our work together to others, with some important exceptions:

1. I will not keep child-centered information shared by parent/guardian A from parent/guardian B, unless a court has specifically entitled the former to control such disclosure (for example, when a parent/guardian is granted exclusive decision-making authority).
2. I may request that all parties involved respect the child's wish for privacy in his or her therapy AND that the child respect that I have a responsibility to his or her parents. This means striking a careful balance that facilitates the child's ability to use the service constructively and the parents'/guardians' wishes to understand the child's needs.
3. I am legally obligated to disclose otherwise confidential information in any instance in which I believe that an individual poses a threat to the well-being of him- or herself, another person and -in some instances- to the integrity of physical structures. In any such instance, I may need to communicate with the police, child protective services or similar agencies.
4. The court can compel disclosure of otherwise confidential information via court order.
5. Regulatory agencies such as the New Hampshire Board of psychologists can access otherwise confidential information.
6. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I will make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

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 when they arise. 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.

Adult informed consent: I am 18 years old or older. I am a parent or legal guardian of the child to be enrolled in therapy. I have read and understand these pages. I agree to these terms in full.

_____ _____
Please sign your name Today's date

_____ _____
Please print your name Your role in this family
(e.g., mother, son, uncle)

Consent to digital communications: I am 18 years old or older. I am a parent or legal guardian of the child to be enrolled in therapy. I understand that digital communications are not secure. I agree to allow Dr. Garber to communicate otherwise confidential information about myself and my child to me via digital media.

_____ _____
Please sign your name Today's date

_____
Please print your name

_____ @ _____
Your e-mail address

Youth informed Assent: I am less than 18 years old. I want to know about my therapy. I have read and understand these pages and I agree to participate.

_____ _____
Please sign your name Today's date

_____
Please print your name