



Texas Child Study Center
PATIENT INFORMATION

Date _____

Patient Information

Name _____ Nickname: _____

DOB _____ Age _____ Sex _____ Race/Ethnicity: _____

Language(s) spoken at home: _____

Person completing form: _____ Relationship to Child: _____

Child's Address _____

City _____ State _____ Zip _____

Home Phone _____ Other (e.g. Child's Mobile): _____

Medical Doctor _____ Phone _____

Preferred Pharmacy _____

Referred by _____ Phone _____

Caregiver Information **(Custodial)**

Name _____ Age _____ Sex _____ Relationship to

Child: _____

Address if other than above _____

Work Phone _____ Other Phone _____

Please indicate if we may leave a message at home: _____ work: _____ other: _____

Employer _____ Position _____

Caregiver Information **(Custodial)**

Name _____ Age _____ Sex _____ Relationship

to Child: _____

Address if other than above _____

Work Phone _____ Other Phone _____

Please indicate if we may leave a message at home: _____ work: _____ other: _____

Employer _____ Position _____

Caregiver Information **(Non-Custodial)**

Name _____ Age _____ Sex _____ Relationship

to Child: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Other _____

Please indicate if we may leave a message at home: _____ work: _____

other: _____ Employer _____ Position _____ Biolo

gical parent _____ Adoptive parent _____ Foster parent _____ Step-parent _____ Other _____

In Case Of Emergency Notify:

Name _____ Relation _____

Phone _____ Other# _____



Texas Child Study Center
PATIENT INFORMATION

Please tell us what type(s) of services you are seeking:

- Therapy (if so, what type: _____)
- Evaluation (if so, what type: _____)
- Medication

Briefly, please describe the concerns about your child and/or the reason you are seeking services (e.g. any behavioral, emotional, or learning concerns at home and/or school, difficulties with peer relationships, etc):

Family Information

Parents' Marital Status: Married Never married Separated Divorced Widowed

If separated or divorced, how long? _____

Contact with non-custodial parent or custody arrangement if any: _____

Any special circumstances in the family situation? _____

Please list all individuals living in the home:

Name	Age	Relationship	Occupation/School



Texas Child Study Center
PATIENT INFORMATION

School Information

Name of School: _____ School District: _____ Phone: _____
Main Teacher (or teacher who knows your child best): _____ Current Grade: _____

Placement and Services (current or past)	No	Yes	Describe (e.g. when, which subject failed or grade repeated)
Early Intervention			
Repeated Grade			
Suspended			
Failed or is failing a grade or subject			
Received any special education services			

Please describe any current special education services (e.g. IEP, 504 Plan, resource room support):

Previous Evaluations and Treatments (please bring copies of any reports)

Testing (such as educational, emotional, speech/language)

Date	Type of Testing	Where was the testing done? (e.g. School, Private Psychologist, etc)

Outpatient Mental Health Professionals Seen:

Professional's Name/Specialty (e.g. psychiatrist, psychologist, social worker, school counselor)	Start Date	End Date	Type of services received

Texas Child Study Center
 PATIENT INFORMATION

Is there any history of physical or sexual abuse?

Child Protective Services Report? _____

If your child has taken medication for attention, behavior, or emotional problems, please list:

Medication	Dosage (e.g. 20 mg 3x day)	Start	End	Prescribed By	Adverse Effects

Please List ANY Drug or Food

Allergies _____

If your child takes any other medication or supplements for any other reason, please list:

Psychiatric Hospitalization or Inpatient Drug Treatment

Place	Date Started	Date Stopped	Reason for admission

Has your child or family received services or case management through an agency (e.g. Child Protective Services, Department of Mental Health and Mental Retardation, etc.)?

Agency: _____

Service: _____

Agency: _____

Service: _____

Texas Child Study Center
 PATIENT INFORMATION

Developmental/Health History

Pregnancy and Delivery

Age of mother at birth: _____ yrs
 Medications taken during pregnancy: _____
 Gestational diabetes? Yes No
 Problems with blood pressure or toxemia? Yes No
 Infections (including herpes) _____
 Smoking (if so, how many packs per day) _____
 Alcohol _____
 Drugs taken _____
 Any problems during labor or delivery: _____
 Duration of pregnancy: _____ weeks
 Type of labor: _____
 Birth weight: _____
 Any problems after birth: _____

Infancy/Toddler

Describe your child as an infant and toddler: _____

Problems with feeding	Y	N
Severe colic or excessive crying	Y	N
Irritable	Y	N
Overactive	Y	N
Easily overstimulated	Y	N
Withdrawn	Y	N
Didn't like to be held	Y	N
Difficult to soothe	Y	N

Developmental Milestones:

Indicate the age at which your child achieved the following:

Sit up _____
 Crawl _____
 Walk without assistance _____
 Speak in 2 word sentences _____
 Toilet trained during the day _____
 Dry at night _____

Texas Child Study Center
 PATIENT INFORMATION

Medical History

Major Illness	Date	Hospitalized?	Surgery?

Has your child ever had a head injury with loss of consciousness? If yes, please describe:

Has your child ever had a seizure? If yes, please describe:

Family History

Does anyone in the child' biological family have:	No	Yes	Relationship to child
Attention problems/ADHD			
Behavior problems in youth			
Learning Disability			
Seizures			
Mental Retardation			
Tics/Tourette's Syndrome			
Autistic spectrum disorder			
Thyroid Problems			
Heart Problems before age 50			
Depression			
Bipolar Disorder			
Anxiety or Panic Attacks			
Obsessive Compulsive Disorder			
Schizophrenia			
Alcohol Problems			
Drug Problems			
Trouble with the law			

Any other significant family medical or psychiatric history _____



Texas Child Study Center
PATIENT INFORMATION

Significant psychiatric, behavioral or medical problems in step-, adoptive, or foster family: _____

Other Information

Please add any other information you feel may help us understand your child: _____

Texas Child Study Center
1600 W. 38th St., Suite 212
Austin, TX 78731

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

PATIENT:

X

Signature of Patient or Legal Representative

Date

Witness Signature

OFFICE USE ONLY:

Accepted

Denied

Signature

Title

Date



Texas Child Study Center Policies and Consent for Services

This form describes the policies of the Texas Child Study Center. Please read it carefully and note any questions or concerns you have so we may discuss them. Your signature at the end of this form indicates that you agree to our policies for services.

Nature of Services: At the Texas Child Study Center, we provide individual, group, and family psychotherapy, psychological testing, and psychiatric services for toddlers, preschoolers, children and adolescents referred for behavioral, emotional, and social concerns. The approach, goals, and duration of therapy will be discussed with each patient/family on an individual basis. Developmental, psychological and neuropsychological evaluations are provided for youth referred because of concerns about possible autism spectrum disorder, anxiety disorders, mood disorders, emotional challenges, learning disabilities, attention problems or broader neuropsychological problems related to certain medical conditions or brain injury. These assessments aid in educational and intervention planning, such as developing special school goals and recommending strategies for teaching new skills. Follow-up consultation to the child's school may be provided to assist in implementing recommendations in school, home, or other settings. We do not provide forensic assessments or assessments for custody trials.

Texas Child Study Center is also operated as a training facility for students in doctoral psychology programs and the social work training programs at the University of Texas, as well as psychology, social work interns, and resident physicians. Trainees' work is directly supervised by licensed psychologists and psychiatrists. Trainees will identify themselves as trainees and identify who on the faculty is his or her supervisor(s).

Confidentiality: In general, the law protects the privacy of all communications between a patient and providers of mental health services. In most situations, we can only release information about your treatment or testing to others if you sign a written authorization to release information. There are exceptions and limits to confidentiality. If a patient is a danger to him or herself or others, if child abuse is suspected or reported, we are obligated to divulge information and/or take protective actions. In the case of receiving a legal subpoena for records or testimony, we will notify the parent/guardian prior to fulfilling the obligation to give information so as to allow for suppression of the subpoena if desired.

At the Center, we consult with one another on treatment plans and progress, and some of our therapists and evaluators are in training. Consultation and/or supervision may include discussion of your child's treatment. Anyone providing consultation and supervision on your child's treatment is legally bound to keep information about patients confidential.

If your child is under eighteen years of age, you have the right to examine your child's treatment records. Generally, it is desired for best treatment that confidentiality between the clinician and child patient is respected. Parents/Guardians will be kept informed about the progress and issues in the treatment of their child. We strive to do this while still preserving the confidentiality between the clinician and child that is essential for the best outcome.

HIPAA Privacy Policy: Please read the HIPAA Privacy Policy and note that you have read it at the bottom of this form.

Fees: You will be informed of the fees for services provided at the Center at the time the appointment is set, if possible. Fees for services are required to be paid at the time of the service. If there are questions or problems about fees they should first be discussed with the treating/evaluating clinician. This includes any changes in insurance coverage.

Cancellation Policy:

Therapy/Medication: Cancellations require 24 hour notice. Late cancellations or missed appointments will be charged at our full rate. Please note that insurance companies will not pay for missed sessions and payment for these sessions are the responsibility of the parents or guardians of the patient. If you do not show up for two appointments in a row without notifying the Center, it will be assumed that you have terminated your services. To re-establish treatment after it has been terminated, you must initiate a new call to the Center to reestablish a financial and therapeutic relationship.

Testing:

If you are unable to keep a psychological and neuropsychological testing appointment, please call to cancel as soon as possible. Given the lengthy time taken for an assessment a full day's time is saved for you. A fee of \$400 will be charged for appointments that are not cancelled at least 24 hours in advance, except in the case of an emergency or prior arrangement.

Medication Monitoring: A patient followed for medication must be seen by a psychiatrist a minimum of every three months for medication management and much more frequently as medications are started or changed. Sometimes the psychiatrist may feel that psychotherapy is essential for optimal treatment in addition to medications. If therapy is refused under this recommendation, the psychiatrist may refuse to continue to prescribe the medication and refer the patient to another provider with a 60 day time notification.

Potential Negative Effects: Mental health services can have many positive benefits; however receiving psychotherapy, testing, or medication may involve some risks or discomforts.

Therapy often involves discussing problems that may lead to unpleasant feelings. You or your child may experience some discomfort when talking about these problems or experiences. Also, although each treatment is designed to help youth with emotional and behavior problems, there is no guarantee your child will improve. In any of these events, you and your child have the right to withdraw from services at any time without penalty.

Neuropsychological, Psychiatric, and Psychological assessment is not psychotherapy. Completion of an assessment does not imply an on-going clinical relationship with the evaluator without an agreement on a treatment plan. At times, patients and families find the results of evaluations or testing disappointing, discouraging, or unhelpful. Finally, Neuropsychological and Psychological testing results may prove invalid due to a variety of factors, including changes in disease status, some types of on-going medication or medical treatment, lack of motivation, or attempts to manipulate the testing results on the part of the patient.

If your child is receiving medication for emotional or behavioral problems through the Center, your psychiatrist will discuss the potential benefits and potential side effects of these medications with you on an individual basis.

Refill Policy: Due to our physicians having obligations outside of TCSC, we require 48 hours (2 business days) to refill medications.

Complaints: Please do not hesitate to discuss any concerns with the individual providing your mental health services. Often frustrations and upsets in the treatment context yield opportunities for benefit when discussed freely with your clinical provider. If you feel that supervisory issues or operational issues are unresolved you may contact one of our Center's directors: William C. Streusand, M.D., Medical Director or Kevin Stark, Ph.D., Chief of Psychology. If you have a complaint about the Center or a particular provider that you cannot resolve with us, you have the right to call the Texas State Board of Examiners of Psychologists at (512) 305-7709 or Texas State Board of Medical Examiners at (800) 201-9353.

Alternative Services: There are many types of mental health services available within this Center as well as within the city of Austin. You have the right to withdraw from our services at any time and we will assist you with finding an appropriate referral.

Emergencies: For medical emergencies or danger to self or other issues you should call 911. After hours psychiatric coverage by a Child and Adolescent Psychiatrist can be accessed by calling the operator at Dell Children's Medical Center at 324-0000 and asking the operator to page the psychiatrist on-call. Routine medication refills will only be handled during regular hours of the Texas Child Study Center.

Your signature indicates that you have read, understand, and agree to the policies and procedures of the Texas Child Study Center.

Parent printed name

Signature

Date

I have read the HIPAA privacy form and received a copy for my files.

Provider printed name

Signature

Date