The Jones Center for Children's Therapy and Assessment
Jessica O. Jones, PsyD, LPC-S & Alyssa R. Scott, PsyD
604 Strada Circle, Mansfield, TX 76063
Phone: (817) 453-2400 Fax: (817) 453-2414
Website: www.jonescсta.com Email: contactus@jonesccta.com

CONSENT TO SERVICES FOR MINORS

Welcome to The Jones Center for Children's Therapy and Assessment, herein referred to as JCCTA. This document includes important information about our professional services and business practices. Please read it carefully and make note of any questions you may have so they can be discussed and addressed during your child's next session. When you sign this document, it will represent an agreement between you and JCCTA.

Psychotherapy Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems brought forth. There are many different methods your child's clinician may use to deal with the problems you and your child hope to address. Psychotherapy is generally unlike any services your child may receive from a physician in that they require your, and/or your child's, active participation and cooperation.

There are both benefits and risks to psychological treatment. Since therapy often involves discussing unpleasant aspects of life, your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. You may also notice a temporary increase in negative behavior. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better coping skills, healthier behaviors, better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees and you and your child may or may not achieve desired results.

Clinicians at JCCTA typically conduct a clinical interview during the initial session in order to collect relevant developmental history regarding your child and information with respect to current concerns. By the end of the initial session, your clinician will be able to offer you some first impressions of what your child's treatment will include, should you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with that clinician. 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 our procedures, please present them as soon as possible and we will do our best to address them.

Clinicians at JCCTA utilize empirically validated treatment approaches to alleviate a variety of symptoms. The length of treatment may be brief for minor issues or may last longer for more complex problems. Typically, patients are seen for 45 minute therapy sessions once weekly or biweekly, but this may be more or less frequent depending on your child's needs. Once an appointment is scheduled, you are expected to pay for it unless you provide 24 hours advance notice of cancellation, not to include Saturdays, Sundays, and observed holidays. If you need to get in touch with your clinician between sessions, please email the clinician or call our office at (817) 453-2400 and your call will be returned as quickly as possible. ***If you have an emergency, call 911.***

Cancellation of standing appointments – JCCTA reserves the right to modify or cancel all scheduled/standing appointments at any time and, more specifically, if:

1. Two (2) scheduled/standing therapy appointments are missed consecutively without proper notification.
2. The patient does not present for a session with his or her primary clinician for 60 days.
3. Attendance at scheduled/standing therapy appointments is inconsistent for any reason.

Psychological, Neuropsychological, and Psychoeducational Assessment Services

There are a variety of purposes for psychological, neuropsychological, and psychoeducational testing, most notably to provide diagnostic clarity and guide treatment recommendations and goals. These evaluations typically include the following:

- Review of relevant records - You may wish to voluntarily provide your child's records to supplement testing conducted by JCCTA. Records may include results of previous testing and other mental health and medical records.
- Information collected during the clinical interview and from the patient history form.
- Observer report forms typically completed by the child's parent(s) and teacher(s).
- Empirically validated assessment tools administered to your child - These assessment tools include, but are not limited to, tests of intellectual functioning, academic achievement, language ability, perceptual processing ability, executive functioning, communication skills and social interaction, critical thinking skills, and emotional, ideational, and personality functioning.

After the test results are obtained, the testing clinician scores and reports the test data in a comprehensive report which reviews the aforementioned data, provides detailed analysis of the test results, summarizes the data, lists DSM-5 diagnostic impressions, and provides appropriate recommendations for further direction. The supervising psychologist(s) reviews and analyzes all results and the accompanying report.

A feedback session is typically scheduled upon completion of the assessment report with the testing clinician or supervising psychologist. During this session, test results and assigned diagnoses and recommendations with be reviewed and explained. Under most circumstances, you will receive an unofficial copy of the report during the feedback session, which you will be permitted to take with you that day. You will receive an official copy of the report once all financial obligations have been fulfilled.

Clinician Information

Jessica O. Jones, PsyD, LPC-S and Alyssa R. Scott, PsyD are Clinical Psychologists licensed to practice independently in the state of Texas. They provide direct patient services and supervise other clinicians employed at JCCTA. Dr. Jones is also a Professional Counselor licensed in the state of Texas and certified to supervise LPC Interns.

JCCTA employs licensed clinicians at both the doctoral and master's levels, including Psychologists, Professional Counselors, Marriage and Family Therapists, Psychological Associates, and Specialists in School Psychology. These individuals are duly authorized to practice psychology in the state of Texas, independently or under the direct supervision of Dr. Jones or Dr. Scott, as dictated by the applicable licensing board.

At JCCTA, we are also dedicated to the future advancement of the field of psychology and the professional development of those who are actively being trained to become Psychologists. Part of our dedication entails offering post-doctoral fellows the opportunity to gain first-hand experience in a private practice setting. Post-Doctoral Fellows are those individuals who have earned a Doctoral degree in psychology and are completing a tenure of one (1) to two (2) years as part of the requirements for Texas state licensure as a Psychologist.

Patients of Divorced Parents/Legal Guardians

The parent or guardian who brings the child patient for therapy and/or an assessment at JCCTA will be responsible for payment at the time that service is rendered, or if any fees for other services are accrued, regardless of what a divorce decree may state. Any judgment regarding court ordered financial responsibility must be determined between the individuals involved, without the inclusion of JCCTA personnel.

Confidentiality

In general, the privacy of all communications between a patient and a psychologist, or other mental health professional, is protected by law, and information about services provided can only be released to others with written permission. However, when working with minors, the law may provide parents the right to examine their child's treatment records and receive information regarding the child's treatment.

It is the policy of JCCTA to request an agreement from parents to allow their child the right to confidentiality unless that child assents, or provides permission, to have certain information revealed. If you agree, you will be provided with general information about your child's therapy and his or her progress. However, if there is reason to believe your child is at risk for harming him or herself or someone else, you will be notified of that concern. If there is reason to believe your child has been harmed seriously by someone else, you will be made aware of this. Before giving you any additional information, your child's clinician will discuss the matter with your child and, if possible, will do his or her best to handle any objections your child may have with what needs to be addressed with you.

There are additional conditions in which confidentiality may be violated. These include:

1. Evidence of abuse of a minor, elder, or mentally impaired individual.
2. Evidence of imminent suicidal or homicidal intent.
3. Your child is a client referred by the court or an agency.
4. Your child's records have been subpoenaed by a court of law (see Litigation Policy).
5. Your child's health insurance company (payer source) requires certain patient information as dictated by law.
6. Your child is being treated by a supervised clinician, in which case said treatment will be discussed with Dr. Jones and/or Dr. Scott, clinical supervisors.
7. It is determined by your child's treating clinician consultation or collaboration with another clinician employed by JCCTA is clinically appropriate and warranted.
8. Certain patient information is submitted to a collection agency in order to collect the balance of an overdue account.

Professional Records

The laws and standards of the profession of psychology require clinicians to keep treatment records. Because these records contain information that can be misunderstood and/or misinterpreted by someone who is not a mental health professional, it is JCCTA's general policy patients and/or their parents/legal guardians not review them. However, a treatment summary may be provided at your request, if appropriate and if doing so would not be emotionally damaging. If you choose, JCCTA will send records and/or a summary of treatment to another qualified health professional who is working with your child, with proper authorization.

Professional Fees

The fee for the initial clinical interview, which must occur prior to initiation of therapy and/or assessment services, is $250.00. Subsequent individual therapy sessions are $150.00, unless the appointment lasts a duration of 53 minutes or more, at which time the cost of the session is $175.00. The fee for a family therapy session is also $150.00. Insurance benefits can be utilized for psychotherapy services, as is applicable.

The charges for psychological, neuropsychological, and psychoeducational assessments vary depending on the testing conducted. Insurance benefits can be utilized for assessment services, as is applicable.

Services related to the independent diagnosis of Irlen Syndrome are ***not*** billable to insurance and are as follows:

1. Irlen Screening - $250.00
2. Irlen Overlay Color Check - $125.00
3. Irlen Diagnostic Filter Evaluation when Irlen Screening was conducted at JCCTA - $450.00
4. Irlen Diagnostic Filter Evaluation when Irlen Screening was conducted outside JCCTA - $525.00
5. Irlen Diagnostic Filter Evaluation when no Irlen Screening has been conducted - $675.00
6. Irlen Filter Check - $225.00
7. The cost for Irlen Spectral Filters, worn as glasses or contact lenses, varies depending on, for example, the individual's lens prescription and chosen filter color or color combination. These fees will be outlined more specifically following the Irlen Diagnostic Filter Evaluation and at the time the filter order is placed.

Please review the following list which outlines fees for services rendered due directly to you.

1. Any missed therapy appointment or standing therapy appointment not cancelled with 24 hours advance notice, not to include Saturdays, Sundays, and observed holidays, will result in a $50.00 fee. Payment of any assessed cancellation fee(s) is due by the date of the next scheduled appointment.
2. Any missed testing appointment or testing appointment not cancelled with 48 hours advance notice, not to include Saturdays, Sundays, and observed holidays, will result in a $250.00 fee. Testing cannot be rescheduled until this fee is paid in full.
3. Any missed Irlen Screening appointment or screening appointment not cancelled with 24 hours advance notice, not to include Saturdays, Sundays, and observed holidays, will result in a $75.00 fee. An Irlen Screening cannot be rescheduled until this fee is paid in full.
4. Any missed Irlen Diagnostic Filter Evaluation with prior Irlen Screening appointment or Irlen Diagnostic Filter Evaluation with prior Irlen Screening appointment not cancelled with 48 hours advance notice, not to include Saturdays, Sundays, and observed holidays, will result in a $150.00 fee. An Irlen Diagnostic Filter Evaluation cannot be rescheduled until this fee is paid in full.

5. Any missed Irlen Diagnostic Filter Evaluation without prior Irlen Screening appointment or Irlen Diagnostic Filter Evaluation appointment without prior Irlen Screening not cancelled with 48 hours advance notice, not to include Saturdays, Sundays, and observed holidays, will result in a $250.00 fee. An Irlen Diagnostic Filter Evaluation cannot be rescheduled until this fee is paid in full.
6. Any missed Irlen Filter Check appointment not cancelled with 48 hours advance notice, not to include Saturdays, Sundays, and observed holidays, will result in a $100.00 fee. An Irlen Filter Check cannot be rescheduled until this fee is paid in full.
7. Each additional Irlen overlay purchased beyond those provided at the time of the Irlen Screening or Irlen Overlay Color Check is $6.00.
8. Cost of an Irlen Magnifying Bar is $11.00.
9. All checks returned to JCCTA will result in a $35.00 fee.
10. Any parent/legal guardian requested completion of a form will be finalized within three (3) business days following payment of a $25.00 fee.
11. Any letter written at the request of a patient's parent/legal guardian (i.e., letter to a school or another mental health or medical profession) will be completed within three (3) business days following payment of a $25.00 fee.
12. Any parent/legal guardian requested faxed or mailed copy of patient mental health records (with proper authorization) will be provided within three (3) business days following payment of a $25.00 fee. Records requested by another mental health or medical professional are not subject to this fee.
13. A parent/legal guardian requested replacement copy of a patient assessment report will be provided within three (3) business days following payment of a $25.00 fee. A copy of said report requested by another mental health or medical professional is not subject to this fee.

Litigation Policy

Active litigation, such as custody disputes, is often detrimental to the therapeutic relationship and can hinder a clinician's ability to treat a patient, namely due to the fact it often involves full disclosure of matters of a confidential nature. As such, it is agreed that, should there be legal proceedings, you (the parent/legal guardian presenting this child for treatment), your attorneys, or anyone acting on your behalf will *NOT* subpoena JCCTA records, or any JCCTA clinician or employee to provide a deposition, testify in court, or engage in any other legal process or proceeding. If any JCCTA employee is subpoenaed to provide records or testimony in violation of this agreement, you agree to pay any and all fees accrued for document preparation and professional time, even if said records or testimony is requested by another party. Should this occur, which is again in violation of this agreement, JCCTA reserves the right to terminate treatment of the child patient and/or his/her family immediately. Referrals to other mental health professionals will be provided.

By signing this Consent to Services for Minors, you hereby agree to this Litigation Policy in its entirety. You also acknowledge the applicable fees outlined below represent reasonable compensation for the expertise of our clinicians, and are hence considered liquidated damages in the event this agreement is violated, regardless of which party issues the subpoena. These fees are to be paid in full *at least five (5) business days prior* to preparation of requested documents or appearance at any legal proceeding:

- **$200.00 –** One (1) copy of the child's mental health records and other pertinent documentation.
- **$1200.00** – Availability of the treating licensed clinician from 8:00 am to 12:00 pm or 1:00 pm to 5:00 pm (half day) within 50 miles of the JCCTA office.
- **$2000.00** – Availability of the treating licensed clinician from 8:00 am to 5:00 pm (full day) within 50 miles of the JCCTA office.
- **$3000.00** – Availability of the treating licensed clinician for any amount of time between 8:00 am to 5:00 pm beyond 50 miles of the JCCTA office.
- **$2000.00** – Availability of the treating clinician, who provides services under the required supervision of Dr. Jones or Dr. Scott, and Dr. Jones or Dr. Scott from 8:00 am to 12:00 pm or 1:00 pm to 5:00 pm (half day) within 50 miles of the JCCTA office.
- **$3500.00** – Availability of the treating clinician, who provides services under the required supervision of Dr. Jones or Dr. Scott, and Dr. Jones or Dr. Scott from 8:00 am to 5:00 pm (full day) within 50 miles of the JCCTA office.
- **$4500.00** – Availability of the treating clinician, who provides services under the required supervision of Dr. Jones or Dr. Scott, and Dr. Jones or Dr. Scott for any amount of time between 8:00 am to 5:00 pm beyond 50 miles of the JCCTA office.

Insurance Reimbursement

If your child has a health insurance policy, it will usually provide some coverage for mental health treatment. JCCTA will fill out forms and provide you with whatever assistance we can in helping you determine and receive the benefits to which your child is entitled. If benefits cannot be determined prior to or at the time of service, and/or when there is any doubt regarding financial responsibility, payment is expected in full. Keep in mind, your child's insurance policy is a contract between the carrier of the insurance and the provider and we are not a party to that contract. You should carefully read the section in your child's insurance coverage booklet that describes mental health services. If you have questions about the coverage, call the plan administrator. Of course JCCTA will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your child's insurance company. If it is necessary to clear confusion, JCCTA will be willing to call the company on your behalf.

In accordance with Texas law, actively licensed psychologists have the authority to delegate the provision of therapeutic and assessment services to other Licensed Psychologists, Post-Doctoral Fellows, Licensed Psychological Associates, and Licensed Specialists in School Psychology who are not eligible for managed health care (insurance) panels. The supervising Licensed Psychologist (i.e., Dr. Jones or Dr. Scott) remains responsible for the psychological services rendered by these individuals and is the billing provider. Certain insurance providers also permit JCCTA to submit for reimbursement fees for covered services provided by a licensed clinician employed by JCCTA (i.e., Licensed Professional Counselor or Licensed Marriage and Family Therapist), in which case Dr. Jones or Dr. Scott will appear as the billing provider. These provisions do not ensure, however, your insurance company will duly reimburse for said services.

All co-payments, co-percentage payments, payments toward a deductible, and costs of services not covered by your child's insurance are due and payable at the time services are rendered, unless agreed upon otherwise. Any balances due to JCCTA after your child's insurance carrier has provided any applicable payment will be billed to you. Remember, ***YOU*** *(not your child's insurance company) are responsible for full payment of all fees.*

If your child's account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, JCCTA reserves the right to use legal means to secure payment. This may involve hiring a collection agency or going through small claims court.

You should also be aware most insurance companies require you to authorize JCCTA to provide them with a clinical diagnosis for your child. Sometimes we have to provide additional clinical information, such as treatment plans or summaries or copies of the entire record. 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, JCCTA has 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. JCCTA will provide you with a copy of any report submitted, if requested.

If you are using insurance benefits, please review the statements below and initial here. ____________

1. I authorize use of this form for all of my child's insurance submissions.
2. I authorize release of information to my child's insurance company.
3. I understand I am ultimately responsible for my child's bill.
4. I authorize the provider to act as my agent in helping me obtain payment from my child's insurance company.
5. I authorize payment directly to JCCTA.

If you are NOT using insurance benefits, please review this statement and initial here. ______________

I am not using insurance benefits and understand I am, therefore, responsible for 100% of the applicable fee at the time the service is rendered.

Termination of Services

If the treating clinician and/or clinical supervisor determine appropriate services can no longer be provided to your child and/or his/her family for any reason, treatment will be terminated and referrals to other professionals will be provided.

Consent to Services

I, ______________________________________ (authorized representative), hereby give clinicians at JCCTA permission to provide appropriate psychological services to my child, as necessary. I have read the consent to services, including the limits of confidentiality, and the Patient Privacy Notice (HIPPA).

I acknowledge I have read The Jones Center for Children's Therapy and Assessment Consent to Services for Minors form in its entirety. I agree to all terms set forth in this document. I understand I have the right to revoke this consent, in writing, at any time. I also understanding any changes to JCCTA policies and procedures occurring after the date indicated below will be discussed with me in a timely manner.

____ ________________

Signature of authorized representative Date

____

Relationship to patient

LEGAL RIGHT TO ACCESS RECORDS

The Health Insurance Portability and Accountability Act (HIPPA) is a federal regulation which outlines laws, rules, and procedures health care providers, including mental health professionals, must abide by in protecting and disclosing an individual's Protected Health Information (PHI). PHI takes account of, but is not limited to, all identifying information, such as name, date of birth, social security number, address, and family members, as well as all data concerning an individual's treatment, including dates of services, services rendered, interventions, diagnoses, progress, prognosis, etc.

Per HIPPA regulations, PHI cannot be released to outside parties without explicit authorization by the patient or the patient's legal guardian(s) or representative(s). At the same time, PHI is accessible, in the best interest of the patient and as is clinically appropriate, to said patient and/or his/her legal guardian(s) or representative(s). JCCTA recognizes and adheres to all guidelines set forth by HIPPA concerning protection and disclosure of all PHI. Please review JCCTA's Consent to Services for Minors in detail for additional information.

The following individuals have the **LEGAL** right to access PHI for:

____ ________________
Minor Child Date of Birth

Name: ______________________________ DOB: ______ Relationship to Minor: ___________

Name: ______________________________ DOB: ______ Relationship to Minor: ___________

Name: ______________________________ DOB: ______ Relationship to Minor: ___________

Acknowledgement

I, ____, legally authorized guardian or representative for ____, minor child, acknowledge the following by *initialing* below:

_________ I have the legal right to consent to the psychological treatment of this minor.

_________ All individuals with the legal right to access this minor's PHI are listed.

_________ I have not intentionally omitted any individual with the legal right to access this minor's PHI.

___________ A JCCTA representative and/or my child's treating clinician may, in the best interest of the minor and as is clinically appropriate, contact any or all of the individuals with the legal right to access this minor's PHI.

___________ Should an aforementioned individual with the legal right to access this minor's PHI contact JCCTA, representatives and employees of JCCTA may, in the best interest of the minor and as is clinically appropriate, disclose relevant information concerning the minor's care at JCCTA.

___________ In the event an individual contacts JCCTA and asserts the possession of the legal right to access release of this minor's PHI, a representative of JCCTA may contact me and request official legal documents which affirm or refute the individual's declaration.

___________ If an individual contacts JCCTA and asserts the possession of the legal right to access this minor's PHI, a representative of JCCTA may request from that individual official legal documents which affirm or refute the individual's declaration. No patient identifying information will be released until said official legal documents are provided, and those documents affirm the declaration of the right to access.

___________ I agree to inform JCCTA as soon as possible should any changes occur in terms of who has the legal right to access and/or authorize release of this minor's PHI. I understand I may be asked to provide official legal documentation of any such change.

___________________________________	________	________________________	_______
Name	DOB	Relationship to Minor	Date

Patient Acknowledgement of the Health Insurance Portability and Accountability Act (HIPAA)

Patient Name: ____ Date of Birth: ___________________

I acknowledge I have reviewed the Jones Center for Children's Therapy and Assessment (JCCTA) Patient Privacy Notice (Notice) which provides detailed information concerning the uses and disclosures of my/my child's Protected Health Information (PHI) by JCCTA, my individual rights, how I may exercise these rights, and JCCTA's legal duties regarding my/my child's PHI.

I understand JCCTA reserves the right to change the terms of its Notice. If changes to this notice occur, JCCTA will provide a copy of the revised Notice upon request.

____ _____________________________

Signature of authorized representative Relationship to Patient

The Jones Center for Children's Therapy and Assessment
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SOCIAL SKILLS GROUP CONSENT

Name: ______________________________________ **Date of Birth:** ___________ **Age:** _____

I, ____ (authorized representative), hereby give clinicians at JCCTA permission to provide social skills training in a group setting to my child, as named above.

By initially below, I acknowledge and agree to the following:

_______ I have read the Jones Center for Children's Therapy and Assessment (JCCTA) Consent to Services for Minors in its entirety and have appropriately consented to the general psychological treatment of my child.

_______ My child's treatment will be discussed with Dr. Jones and/or Dr. Scott, clinical supervisors.

_______ If my child participates in individual and/or family psychotherapy at JCCTA, my child's treatment goals, performance, and progress in group may be discussed with his/her treating clinician.

_______ This group is not a replacement for individual psychotherapy.

_______ An inherent risk with group therapy is the confidentiality of information disclosed. Specifically, while all group members are asked to verbally acknowledge they will hold information disclosed as confidential, laws and ethics do not bind this agreement.

_______ I will not disclose information pertaining to the following, and will instruct my child he/she is to do the same:

- the names and identifying information of group members and/or their family members, and
- the historical and personal information, presenting concerns, behavior and presentation in group, information brought forth in group, etc., of any group member, even if names are not used.

_______ The fee for participation in a group is $150.00 per five week period, $180.00 per six week period, and $210.00 per seven week period, which is due in its entirety prior to the outset of the initial group session.

_______ If the clinician leading my child's group is duly licensed in the state of Texas or a Post-Doctoral Fellow who is under the supervision and direction of Dr. Jones and/or Dr. Scott and permitted to bill insurance companies for group therapy

services, my child's insurance benefits, as applicable, may be utilized. This will be discussed with me prior to the outset of the initial group session.

______ If my child's insurance benefits apply and can be utilized, the aforementioned monies paid prior to the outset of the initial group session will be duly applied to each session, as determined by any applicable copay, deductible, and/or co-insurance.

______ The cost for parent/guardian sessions, as is applicable, will be applied to the aforementioned monies paid prior to the outset of the initial group session, as this service is NOT billable to any insurance company.

______ If my child fails to attend a group for ANY reason, a $30.00 fee will be applied from the aforementioned monies paid prior to the onset of the initial group session.

______ If there is a credit in my child's account following conclusion of the five to seven week session, those monies may be applied to a future group session, other services rendered at JCCTA, and/or refunded to me.

I acknowledge I have read the JCCTA Social Skills Group Consent form in its entirety. I agree to all terms set forth in this document. I understand I have the right to revoke this consent, in writing, at any time. I also understanding any changes to JCCTA policies and procedures occurring after the date indicated below will be discussed with me in a timely manner.

____ ______________
Signature of authorized representative Date

____
Relationship to patient

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The Jones Center for Children's Therapy and Assessment
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SOCIAL SKILLS GROUP PARTICIPANT HISTORY FORM

Name: ________________________________ **Date of Birth:** ___________ **Age:** _______

Dear Parent,
To help establish your child with our Social Skills Group, please provide us with the following information. Thank you and we look forward to working with you and your child!

In your own words, please describe why you are seeking social skills training for your child: _________
____
____
____

Family Members/Others Residing in Home	Age	Relationship to Child

How does this child get along with other family members in the home? Defiant? Antagonistic? Alliances? Other problems?
____
____

Family Members/Others Residing Outside Home	Age	Relationship to Child

How does this child get along with family members/important people residing outside the home? ________________
____
____

Has your child been assigned a formal mental health diagnosis(s)? Yes or No If yes, what? ______________________
____

Does your child have a significant medical condition? Yes or No If yes, what? ____________________________
____

Academic History

Current grade (or most recently completed)?________ School and ISD?_____________________________________
Has he/she ever received RtI, 504, Special Education (IEP), or other intervention services? Y or N If Yes, how was he/she qualified and what service(s) did he/she receive?____
____
____

Is this child currently experiencing academic problems? Y or N If Yes, please explain:___________________________
____

Does this child exhibit behavioral problems at school? Y or N If Yes, please explain:______________________________

____

At what level do you estimate your child's intelligence? ______below average ______average ______above average

GENERAL EMOTIONAL/BEHAVIORAL FUNCTIONING	OFTEN	SOMETIMES	RARELY
Anxiousness			
Irrational/excessive fears			
Panic attacks			
Depression			
Irritability			
Anger			
Mood Swings			
Elevated moods/mania			
Obsessive-compulsive tendencies			
Hyperfocus on preferred activity or item			
Hyperactivity and/or impulsivity			
Inattention			
Verbal and/or physical aggression			
Defiance			
Disrespect toward adults			
Temper tantrums			
Lack of empathy			
EMOTIONAL REGULATION	**OFTEN**	**SOMETIMES**	**RARELY**
Identifies likes and dislikes of others			
Identifies personally experienced emotions			
Identifies others' emotions			
Demonstrates affection and empathy toward peers			
Refrains from being verbally aggressive toward peers			
Refrains from being physically aggressive toward peers			
Can calm him/herself when upset			
Can self-regulate when energy level is excessive			
Accepts consequences of his/her behavior			
Accepts unexpected changes			
Accepts being told "no" without becoming upset/angry			
Accepts losing at a game and/or not being first without becoming upset			
Responds appropriately to gentle teasing			
Refrains from being overly affectionate with strangers			
Displays affection toward family members			
PLAY BEHAVIOR	**OFTEN**	**SOMETIMES**	**RARELY**
Prefers solitary play activities over play with a peer(s)			
Takes turns appropriately during simple games			
Shares toys and preferred items when asked to do so			
Shares toys and preferred items spontaneously			
Returns and initiates greetings with peers			
Demonstrates awareness of appropriate ways to join an activity with peers			
Invites others to play			
Accepts offers from others to play			
Verbally requests items from peers during play in a polite manner			
Spontaneously offers items to peers during play			
Takes turns during structured activities			
Takes turns during unstructured activities			
Obeys game rules			
Engages cooperatively in imaginative play with peers			
Organizes play by appropriately suggesting ideas to peers			
Follows peers' plans for play			
COMMUNICATION SKILLS	**OFTEN**	**SOMETIMES**	**RARELY**
Makes and maintains adequate eye contact			

Orients body and/or face toward whomever is speaking			
Uses facial expressions to nonverbally convey thoughts and/or emotions			
Reads others' facial expressions			
Uses different tones of voice to convey messages			
Correctly interprets others' changes in tone of voice			
Appropriately introduces him/herself to someone new			
Initiates verbal interactions with peers			
Responds fittingly when someone else initiates a conversation			
Remains attentive when someone else is speaking			
Stays on topic during conversations			
Engages in reciprocal conversation			
Refrains from interjecting when someone else is speaking			
Maintains a comfortable distance from the other person during conversation			
Ends conversations appropriately			
Says "please" and "thank you"			
Asks permission when needed			
Gives appropriate compliments to others			
Receives compliments appropriately			
Asks for favors appropriately			
Spontaneously apologizes when appropriate			
Understands when someone is being sarcastic			
Uses sarcasm appropriately			
PROBLEM SOLVING	**OFTEN**	**SOMETIMES**	**RARELY**
Identifies and/or defines problems			
Generates potential solutions to problems			
Considers others' suggestions for possible solutions to problems			
Attempts identified problem solving solutions			
Applies effective problem solving solutions to future problems			
Seeks help from peers			
Seeks help from adults			
Understands how his/her behavior impacts others			
Resolves differences of opinions, arguments, and/or conflicts well			

Has this child been abused? Y or N (circle one and all that may apply)
Sexually Verbally Physically Mentally Emotionally Other:____________________
When? ___________________ Who was the abuser? ______________________________________
Has this child experienced any other traumatic event(s)? Y or N If Yes, please explain: ____________________________

____
Has this child ever participated in therapy? Y or N If Yes, which modalities: Play Individual Family Group

Please provide any additional information you would like us to know.

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Signature and Date