Margaret M. Tripp, Ph.D.

12946 Dairy Ashford Rd, #260 *Clinical Psychologist*
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CHILD / ADOLESCENT CONSENT for EVALUATION and TREATMENT

Patient's Name: _____ Date of Birth: _____-_____-_____

I_____, hereby give full consent for my child to receive services of Margaret M. Tripp, Ph.D. I certify that I have the legal authority to authorize and consent to this evaluation or treatment as parent, managing conservator, or guardian of this child.

CONFIDENTIALITY

Any information my child or I provide to Margaret M. Tripp, Ph.D. is confidential and when possible will not be released to others without my written consent. Professional ethical obligations, state and/or federal law might require Dr. Tripp to disclose confidential information without my consent in certain circumstances. Discloser of confidential information by Dr. Tripp, without my consent, is required in the following situations:

1. If the therapy session reveals any information concerning the abuse of a child, elder or disabled person, Margaret M. Tripp, Ph.D. is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this fact.
2. If the course of therapy reveals any intent my child may have to harm either himself/herself or others, I acknowledge Margaret M. Tripp, Ph.D.'s legal and moral duty to prevent my child from bringing this harm about. If my child reveals an intent to harm himself/herself, Dr. Tripp has my irrevocable permission to prevent my child from accomplishing that intent. More specifically, I give my irrevocable permission for Dr. Tripp to warn police or law enforcement authorities about parties she feels may be harmed.
3. If my child has been referred to this practice by a managed care or insurance company, or I plan to request Margaret M. Tripp, Ph.D. provide detailed session receipts to file for reimbursement with a managed care or insurance company, I am aware information about my child's health status and treatment will be disclosed. As a billing submission requirement of the managed care or insurance company, I understand Dr. Tripp will be required to provide a mental health diagnosis for my child, and in some circumstances (e.g, for specific advance approval or authorization) may be required to provide the company with detailed treatment needs or a complete copy of the treatment records generated in my therapy. Once these records are in the possession of the managed care or insurance company, Dr. Tripp cannot guaranty their continued confidentiality.
4. Additionally, if a law suit is filed by me or my child against Margaret M. Tripp, Ph.D. for breach of duty; or if a court order, legal proceeding, statute, or regulation requires disclosure of records, I understand legal obligations may require the release of my child's therapy records.

TREATMENT RECORDS

It is stated law that psychologists maintain a record of the treatment given to my child. This record will contain the information that will allow Margaret M. Tripp, Ph.D. to chart the course of therapy. This record is used for only that purpose and it is Dr. Tripp's intent that the file remains private.

1. I may get a copy of the file only by providing her with a signed release of information request and once my child becomes of age, he/she will have to provide Margaret M. Tripp, Ph.D. with written request. Dr. Tripp may provide me or my child with a synopsis of the course of treatment and outcome in lieu of the actual record.
2. I may be required to pay in advance for either the copying cost or the time required for the preparation of the treatment summary. This payment may also be required when requesting copies or reports be provided to any court or legal representative or designate.
3. If the therapy sessions contain more than one patient, I agree that no one person may get the complete treatment file. Margaret M. Tripp, Ph.D. will attempt to maintain separate records on each patient. However, only that individual is entitled to his/her own record. I agree Margaret M. Tripp, Ph.D. may synopsize the course of each individual's treatment as opposed to providing a copy of what notes may have been made during any therapy session.

4. In the event that Margaret M. Tripp, Ph.D. becomes in capacitated or dies, it will be necessary for another therapist to take possession of each patient's files and records. In this case another licensed mental health professional, selected by Dr. Tripp, will take possession of my records and if necessary provide me with copies upon request.

COMMUNICATION POLICY

Continuous effort is made to provide secure communication between patient and staff by phone, email, and fax. These forms of communication are subject to use and monitoring by only trained office staff, however, cannot be guaranteed secure. Although software and security measures have been put in place to secure and monitor office communication, please be reminded that any information relayed across phone, email, or fax has the potential to be viewed by an outside party in transit or delivery.

Dr. Tripp and her staff do not use messaging on social networking sites to communicate with patients. Further, it is office policy to *not* accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc.). Communication or connections on social media could compromise patient confidentiality and blur the boundaries of the therapeutic relationship.

In accepting services from Dr. Tripp and authorizing communication with her office, patient agrees to knowledge of limitations/ restrictions of online communication and agrees to hold harmless Margaret M. Tripp, Ph.D. and staff for information loss due to technical failure or cyber occurrence.

PAYMENT POLICY

Payment is due at the time of service. Payment schedule will be made known to me before my initial session. My consent to treatment includes an electronic payment permission, authorizing Dr. Tripp and her staff to deduct service fees from my designated account. It is my responsibility to file and collect my own insurance claims and Dr. Tripp cannot guarantee coverage of my services by my insurance company.

Payment after the date of service will include a late payment charge. I understand if I do not uphold my responsibility to pay for services, this may result in the termination of treatment with Dr. Tripp and referral for appropriate treatment services elsewhere.

MISSED SESSION POLICY

If I need to cancel a session with Margaret M. Tripp, Ph.D., I agree to provide at least 24 hours notice.

1. 24 business hours notice of cancellation is required, and 48 business hours is preferred. I understand that my appointment is reserved for me only. Dr. Tripp does not double book patients and therefore, if I fail to show up and/or provide appropriate notice of cancellation she is unable to fill my appointment time with someone who can use that time instead.
2. Cancellation with less than 24 business hours notice or no communication of change will result in a $75 fee. Multiple 'no notice' cancellations or 'no show' for scheduled appointments will result in a charge of the full session fee. I understand and agree that the credit card on file with the office will be charged the cancellation fee whether I choose to return for follow up services or choose to terminate services.

TERMINATION OF TREATMENT

The length of time required for therapy will be determined by my child's personal situation. Margaret M. Tripp, Ph.D. will do her best to fulfill my therapeutic needs and to provide my child with her best professional care. For my part, I agree to participate in the process as needed to the best of my ability. It is intended that when my child's needs are met, to the extent that they can be, we will terminate our relationship. There is no guarantee of a cure.

I may terminate treatment at any time. This may include, but is not limited to, requesting to terminate (verbally or in writing), declining to follow treatment recommendations, or failing to maintain my appointment schedule. Dr. Tripp will respect my wishes to terminate treatment.

My signature below indicates that I have read and agreed to the terms of service outlined above and that I voluntarily give consent for evaluation/treatment of my child.

_____	_____	_____
Parent's Signature	**Printed Name of Parent**	**Date**
_____	_____	_____
Additional Parent's Signature	**Printed Name Additional Parent**	**Date**

CHILD / ADOLESCENT HISTORY QUESTIONNAIRE

CONTACT INFORMATION

Child's Name :		**Today's Date:**
Child's Date of Birth:	**Child's Age:**	**Child's Grade:**
Child's School:		
Parent 1 (Mother or Father or Step Parent):		
Parent 2 (Mother or Father or Step Parent):		
Other Caregiver(s):		
Child's Primary Address:		
	City:	**Zip:**
Primary Parent Address (if different):		
	City:	**Zip:**
Alternate Parent Address:		
	City:	**Zip:**

Phone Contact Numbers		**Can I leave a message on this line?**	
Primary Parent Cell		**YES**	**NO**
Alternate Parent Cell		**YES**	**NO**
Primary Parent Work		**YES**	**NO**
Alternate Parent Work		**YES**	**NO**

Home Phone	**YES NO**	**Child's Cell**	**YES NO**

Dr. Tripp provides the option of communicating or sending appointment reminders by email. Please be aware that email is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for treatment or intervention. By listing email addresses below, you are acknowledging your understanding of these statements.

Primary Parent email:	
Child's email:	

How did you find out about Dr. Tripp?

What has you seeking therapy at this time?

At what age was the issue/concern first noticed?

What are you hoping to achieve with therapy?

ACADEMIC INFORMATION

Is your child in any special programs at school, such as GT, Special Ed, Speech or Occupational Therapy, Content Mastery, Alternative Schooling, Home Bound Schooling, etc? If so, please describe:

Does your child receive any formal or informal modifications at school? Please describe:

Has your child had any previous educational, psycho-educational, neuropsychological, or psychological testing? If so, please BRING A COPY OF THE TESTING RESULTS. Please also describe your understanding of the results of this testing.

If not already described, do you have any concerns about your child's behavior or functioning at school?

FAMILY INFORMATION

Please list all family members who live in the home:

Name	Relationship	Age

Are there any family members who live elsewhere? If so, list their names, ages, and reasons for moving out:

Primary parent highest level of education completed:

Primary parent employment status:

Alternate parent highest level of education completed:

Alternate parent employment status:

Has there been a divorce in the family? YES NO

If divorced, what are the custody arrangements?

If divorced, is either parent remarried? If step-parent(s) was not named in contact information, please list name(s) here:

Are there any parents or step-parents who travel frequently? If so, who and how often?

Are there any significant caregivers in your child's life (grandparent(s), nanny, etc.)?

RECREATIONAL / SOCIAL INVOLVEMENT

How does your family spend free or unscheduled time?

What are your child's favorite hobbies and interests?

Does your child have difficulty making or keeping friends? If yes, please describe:

Please check the following activities in which your child participated in the last month:

- ☐ Exercised or played a sport, how frequently?
- ☐ Played with friends outside of school, how frequently?
- ☐ Engaged in group activities outside of school, what activities?
- ☐ Read or was read to, how frequently?
- ☐ Watched T.V., how much?
- ☐ Played videogame or computer games, how many hours per day?

Which social media applications are you aware of your child utilizing to track or communicate with peers?

Do you know/suspect that your child uses tobacco, alcohol, and/or any recreational drugs? If so, please describe your knowledge or suspicions:

Has your child experienced any of the following:

- ☐ Being teased or bullied
- ☐ Teasing or bullying another peer
- ☐ Loss of friendships
- ☐ Change in school setting, teacher, or childcare setting?
- ☐ Other?

Please describe several strengths that your child has in their interactions with others:

STRESSORS

Has your family experienced any stressful events in the last year? Please check the following.

- ☐ Death in the family
- ☐ Death of a close friend
- ☐ Serious illness or injury, your child
- ☐ Serious illness or injury, a loved one
- ☐ Family fighting
- ☐ Marital problems
- ☐ Divorce or separation
- ☐ Marital reconciliation
- ☐ Problems with child rearing
- ☐ Move to a new home
- ☐ Son or daughter leaves home
- ☐ Conflict with in-laws
- ☐ Change in job- new position, new company, laid-off, retired, quit
- ☐ Change in financial status- more or less money
- ☐ Change in daily responsibilities
- ☐ Change in social network
- ☐ New marriage in the family
- ☐ Outstanding personal achievements
- ☐ Other stressors (significant or traumatic events):

MEDICAL HEALTH

Does your child have any of the following medical problems?

Current	Past		Current	Past	
☐	☐	Heart Problems	☐	☐	Head Injury
☐	☐	Digestive Problems	☐	☐	Surgeries
☐	☐	Hypothyroidism	☐	☐	Tics
☐	☐	Hyperthyroidism	☐	☐	High Blood Pressure
☐	☐	Diabetes, Type I	☐	☐	Unexplained Pains
☐	☐	Diabetes, Type II	☐	☐	PMS Symptoms
☐	☐	Overweight	☐	☐	Muscle Tension
☐	☐	Underweight	☐	☐	Headaches
☐	☐	Back or Neck Pain	☐	☐	Cancer
☐	☐	Alcohol use/abuse	☐	☐	Drug use/abuse

If you checked any of the boxes above, please describe the health problem:

Are there any other medical problems not listed above that your child experiences?

Primary Physician's Name:	Phone Number:
Is your child currently taking any medications?	
If so, please list here:	
Have multiple medication trials gone on before this current list of medicine(s)?	
Are there any medical problems for someone in the family that may be impacting your child?	

MENTAL HEALTH

How would you describe your child's overall mood?
Have you sought psychotherapy for your child or your parenting before? If so, what were the circumstances?
Did you find therapy helpful?
If your child is taking medication for emotional or behavioral struggles, who is the prescribing physician?
Is the medication helpful?
Please describe your child's sleep habits. How many hours per night of sleep are typical for your child? Do you have any concerns about your child's sleep?
Please describe your child's eating habits. Do you feel satisfied with the variety and quantity of food consumed by your child? Do you have any concerns about your child's eating?

SYMPTOM	Child, current	Child, past	Primary Parent	Alternate Parent	Sibling: _____	Other: _____
Please check all that apply:						
Depression, sadness						
Suicidal Thoughts/ Attempts						
Bipolar or Manic Episodes						
Anxiety/ Excessive Worry						
Obsessions and/ or Compulsions						
Panic Attacks						

(continued from last page)

SYMPTOM	Child, current	Child, past	Primary Parent	Alternate Parent	Sibling: _____	Other: _____
Post Traumatic Stress/ PTSD						
Attention Deficit/ Hyperactivity						
Autism/ PDD/ Asperger's						
Tourette's/ Tourette Syndrome						
Learning Disabilities						
Explosive Outbursts						
Oppositionality/ Defiance						
Problems with Anger						
Problems with Assertiveness						
Schizophrenia or Psychosis						
Heavy Alcohol Use						
Drug Use/ Abuse						
Eating Disorder						
Abused in Any Way						

Other Family History of Emotional or Behavioral Symptoms?

Do you have any additional comments that you think would be helpful?

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TO BE COMPLETED BY DIVORCED or DIVORCING PARENT(S) SEEKING TREATMENT FOR CHILD

Custody Dispute Contract

PATIENT NAME: _____ PATIENT DOB: _____

The purpose of this contract is to obtain written agreement that the psychologist, Margaret M. Tripp, Ph.D. will not be asked to participate in any litigation regarding any custody or child access disputes. If Dr. Tripp is asked to participate in any litigation, Dr. Tripp's neutral role with the family can be compromised. Involvement of Dr. Tripp is likely to jeopardize any progress that may have been made in therapy, to hinder likelihood of future progress, and possibly to limit the patient's willingness to seek help from a psychologist at any later time in his/her life. In order to prevent these potential problems, it is crucial that Dr. Tripp, the parents, and the patient have every reassurance that there will be absolutely no involvement on Dr. Tripp's part in any current or future litigation between parents. This is best accomplished by both parents signing this statement:

We wish to enlist the services of Margaret M. Tripp, Ph.D. in the treatment of our child, _____ _____. We understand that such treatment will be compromised if information revealed therein is brought to the attention of the court in the course of a custody dispute. Accordingly, we mutually pledge that we will neither individually nor jointly involve Dr. Tripp in any litigation. Specifically, we will neither request nor require Dr. Tripp to provide testimony in court or to turn over her notes to the court, attorneys, or other personnel involved in any custody dispute process in order to maintain treatment sessions with Dr. Tripp as a secure place of disclosure for our child.

If the services of a mental health professional are desired for court purposes, the services of a person other than Dr. Tripp must be enlisted.

_____ _____
Signature of Parent **Date**

_____
Printed Name of Parent

_____ _____
Signature of Parent **Date**

_____
Printed Name of Parent

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SERVICE AGREEMENT

FEE SCHEDULE

Initial Evaluation/New Patient	$215 per 60 minute session
Treatment/Psychotherapy Session	$185 per 50 minute session
No Show or Late Cancel Fee (<24 hours)	$75
Fee after 3 or more No Show/Late Cancel	$185
Late Payment Fee -charged after day of service	$25
Letter Writing or Treatment Summary	$90 per 30 mins
Forensic or Court Involvement	$360/60 mins, $90/15 mins
Consultation/Class Fee	$215 initial 60 minutes, $185 each additional 60 mins

12 months between visits constitutes New Patient, requires New Consent Form

TELEHEALTH GUIDELINES

To engage in video-conferencing services, patient and provider agree to the following:

- There are potential benefits and risks of video-conferencing that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and neither will record the session without permission from the other person(s).
- Each will conference in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- For confidentiality, each will use a secure internet connection rather than public Wi-Fi.
- An alternate phone number or email has been arranged where each can be reached in the event of technical problems.
- Patient required to provide at least one emergency contact for use by provider in the event of a crisis.
- As with in person therapy, patients under the age of majority require the permission of parent/legal guardian to participate in telepsychology sessions.
- Patient is aware that his/her insurance company may not reimburse for teletherapy session(s).
- Provider may determine that due to certain circumstances, telepsychology is no longer appropriate and in person therapy should resume.

_____
Patient's Name

_____ _____ _____
Parent's Signature Printed Name of Parent Date

Margaret M. Tripp, Ph.D., P.C.
Clinical Psychologist

CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

In my Notice of Privacy Practices, I provide you with information about how I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been made available to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

I am required by law to notify you if there is a breach of your PHI/ePHI which would allow your clinical or financial information to be identified or compromised.

_____
Patient's Name (Printed)

_____ _____
Signature of Patient, Parent, or Legal Representative Date