Marcia H. Rogers, Ed.S., Psy.D.
DR. LISA CHEYETTE & ASSOCIATES
1115 Upper Hembree Rd., Suite B, Roswell, GA 30076
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Structured Developmental History
Children & Adolescents

Date:_____ Person completing form _____

Child's Information

Child's name: _____ Birthdate: _____ Age: _____

Gender: M___ F___ School:_____ Grade: _____

Primary language of child:_____Other languages_____ Parent's primary language_____

Describe your child's positive traits and strengths: _____

_____

_____

What does your child enjoy doing? _____

_____

What are your current concerns about your child? (academic, cognitive, behavioral, emotional):

_____

_____

_____

_____

Family Information

Child is living with: ☐ Both Parents ☐ Mother ☐ Father ☐ Mother & Stepfather ☐ Father & Stepmother

☐ Legal Guardian ☐ Other: _____

Is child adopted? ☐ yes ☐ no If yes, please indicate the child's age at time of adoption: _____

Parents' marriage status: ☐ Married ☐ Separated ☐ Divorced (child's age at divorce _____)

☐ Widowed ☐ Single [*If divorced, please supply copy of custody papers]*

List all adults and children living in the home:

Name	Age	Relationship	Occupation or School Grade
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Birth and Developmental History

Length of pregnancy in months: _____ Birth weight: _____ Birth Length: _____ Apgar Score:_____

Any illnesses or complications while pregnant?_____

_____

Medications taken during pregnancy: _____

Substances used during pregnancy: ☐ cigarettes ☐ alcohol ☐ illicit drugs: _____

Any complications during the child's birth? ☐ induced birth ☐ Cesarean delivery

Other complications at birth:_____

_____

_____

_____

Did the mother or baby stay in Special or Intensive care? ☐ yes ☐ no

Number of days child spent in the hospital following birth: _____

Please list any other health concerns identified at birth: _____

_____

Please list the child's age when the following developmental milestones were first observed:

Crawled _____ Walked _____

First words_____ Short Sentences _____(give an example)_____

Toilet Trained: bladder_____ bowel_____ toilet trained throughout the night _____

Medical History/Childhood illnesses & injuries

Please check whether the child has experienced any of the following:

☐ Frequent ear infections_____ ☐ Allergies:_____

☐ Strep Throat_____ ☐ Tonsillectomy:_____

☐ Seizures_____ ☐ Adenoidectomy: _____

☐ Tics_____ ☐ Head injury: _____

☐ Physical abuse_____ ☐ Sexual abuse _____

Please explain any other medical problems, symptoms, illnesses or accidents your child has experienced:

_____

_____

Past Medication taken: _____

_____

Current Medication (please list name and dosage):_____

_____

Date of last vision exam: _____ Results of the vision exam: _____

Does the child wear glasses? ☐ Yes □ No Contact Lenses? ☐ Yes ☐ No

Date of last hearing exam: _____ Results of the hearing exam: _____

Does the child wear a hearing aid? ☐ Yes ☐ No

Please check if the child receives or has received any of these services:

☐ Speech/Language services ☐ Occupational Therapy ☐ Physical Therapy ☐ Behavior Therapy

☐ Babies Can't Wait Program ☐ Social Skills Training ☐ Counseling or Therapy

_____

School History

Did this child attend pre-school? ☐ Yes ☐ No If yes, at what age did pre-school begin?_____

Did this child attend pre-kindergarten? ☐ Yes ☐ No If yes, where: _____

Has this child ever repeated a grade? ☐ Yes ☐ No If yes, list grade: _____

Has this child received remedial or RTI services? ☐ Yes ☐ No If yes, list grade: _____

Does this child have an IEP (Individualized Education Plan)? ☐ Yes ☐ No *[Please provide copy of IEP*]

If the student has an IEP, what special education areas are they eligible for services?_____

_____

In what classroom setting is child educated? ☐ General Ed. ☐ Interrelated/Mainstreamed ☐ Small Group

What grades did this student make on their most recent report card?_____

_____

What other support programs or help/assistance does this student receive at school or outside of school?

_____

_____

What are this student's teachers most concerned about? _____

_____

_____

_____

_____

Do I have your consent to talk to his/her teachers and school staff members and send rating scales as needed?

☐ Yes ☐ No

Please provide contact information, <u>including email</u>, for child's current teachers and/or counselors:

_____

_____

_____

_____

_____

Behavior/Temperament

Please indicate whether this child has ever exhibited any of the following behaviors (compared to same age peers).

Is easily overstimulated in play	☐ Now	☐ Past	_____
Has a short attention span	☐ Now	☐ Past	_____
Lacks Self-Control	☐ Now	☐ Past	_____
Seems unhappy most of the time	☐ Now	☐ Past	_____
Has fears/anxious	☐ Now	☐ Past	_____
Seems overly energetic in play	☐ Now	☐ Past	_____
Seems impulsive	☐ Now	☐ Past	_____
Overreacts when faced with a problem	☐ Now	☐ Past	_____
Seems uncomfortable meeting new people	☐ Now	☐ Past	_____
Requires a lot of parental attention	☐ Now	☐ Past	_____
Difficulty getting along with other kids	☐ Now	☐ Past	_____
Difficulty making friends	☐ Now	☐ Past	_____
Oppositional/defiant	☐ Now	☐ Past	_____
Learning difficulties	☐ Now	☐ Past	_____
Physically or verbally aggressive	☐ Now	☐ Past	_____

Other concerns: _____

_____

Family Health History

Have any biological family members had any of the following? If yes, please list relative/s. (If child is not living with biological parents, please include health information on biological parents, if known.)

Seizure disorder/Epilepsy ☐ Yes _____

Behavior Disorder ☐ Yes _____

Alcohol/drug abuse ☐ Yes _____

Depression ☐ Yes _____

Bipolar Disorder ☐ Yes _____

Anxiety ☐ Yes _____

Learning disability/problems ☐ Yes _____

ADHD/attention problems ☐ Yes _____

Asperger's/Autism ☐ Yes _____

Schizophrenia/Psychosis ☐ Yes _____

Other significant Information: _____

_____

Notes:

_____

_____

_____

_____

_____

Marcia H. Rogers, Psy.D.
Licensed Psychologist

Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

Effective 4/14/03

I. COMMITMENT TO YOUR PRIVACY: Marcia H. Rogers, Psy.D. is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that Dr. Rogers maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, Marcia H. Rogers, Psy.D. is required to ensure that your PHI is kept private. This Notice explains when, why, and how Dr. Rogers would use and/or disclose your PHI. Use of PHI means when Dr. Rogers shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when Dr. Rogers releases, transfers, gives, or otherwise reveals it to a third party outside of the Dr. Rogers. With some exceptions, Dr. Rogers may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, Dr. Rogers is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by Dr. Rogers Please note that Dr. Rogers reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that Dr. Rogers has created or maintained in the past and for any of your records that Dr. Rogers may create or maintain in the future. Dr. Rogers will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of Dr. Rogers' Notice of Privacy Practices.

IV. HOW DR. ROGERS MAY USE AND DISCLOSE YOUR PHI: Dr. Rogers will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: Dr. Rogers may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, Dr. Rogers may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, Dr. Rogers will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: Dr. Rogers may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

3. To Obtain Payment for Treatment: Dr. Rogers may use and disclose your PHI to bill and collect payment for the treatment and services Dr. Rogers provided to you. Example: Dr. Rogers might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. Dr. Rogers could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for Dr. Rogers' office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, Dr. Rogers will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to Dr. Rogers by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, Dr. Rogers will have a written contract that requires the employee or business associate to maintain the same high

standards of safeguarding your privacy that is required of Dr. Rogers.

Note: This state and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how Dr. Rogers may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – DR. ROGERS may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, Dr. Rogers may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: Dr. Rogers may make a disclosure to the appropriate officials when a law requires Dr. Rogers to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** Dr. Rogers may disclose information about you to respond to a court or administrative order or a search warrant. Dr. Rogers may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. Dr. Rogers will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** Dr. Rogers may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** Dr. Rogers may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** Dr. Rogers may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if Dr. Rogers determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, Dr. Rogers may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), Dr. Rogers may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** Dr. Rogers may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If Dr. Rogers has a reasonable suspicion of child abuse or neglect, Dr. Rogers will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** Dr. Rogers may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. Dr. Rogers may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** Dr. Rogers may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, Dr. Rogers may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, Dr. Rogers may release PHI about you as required by

military command authorities. Dr. Rogers may also release PHI about foreign military personnel to the appropriate military authority.

11. **National Security, Protective Services for the President, and Intelligence Activities:** Dr. Rogers may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, Dr. Rogers may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, *DR. ROGERS* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** *DR. ROGERS* may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** *DR. ROGERS* is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** *DR. ROGERS* may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *DR. ROGERS*'s compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**
18. **In the Following Cases, *DR. ROGERS* Will Never Share Your Information Unless You Give us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization:

In any other situation not covered by this notice, *DR. ROGERS* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *DR. ROGERS* in writing of your decision. You understand that *DR. ROGERS* is unable to take back any disclosures it has already made with your permission, *DR. ROGERS* will continue to comply with laws that require certain disclosures, and *DR. ROGERS* is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in *DR. ROGERS*'s possession, or to get copies of it; however, you must request it in writing. If *DR. ROGERS* does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from *DR. ROGERS* within 30 days of receiving your written request. Under certain circumstances, *DR. ROGERS* may feel it must deny your request, but if it does, *DR. ROGERS* will give you, in writing, the reasons for the denial. *DR. ROGERS* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. *DR. ROGERS* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that *DR. ROGERS* limit how it uses and discloses your PHI. While *DR. ROGERS* will consider your request, it is not

legally bound to agree. If *DR. ROGERS* does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that *DR. ROGERS* is legally required or permitted to make.

3. The Right to Choose How *DR. ROGERS* Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *DR. ROGERS* is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that *DR. ROGERS* has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

DR. ROGERS will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. *DR. ROGERS* will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Choose Someone to Act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that *DR. ROGERS* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *DR. ROGERS's* receipt of your request. *DR. ROGERS* may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than *DR. ROGERS*. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *DR. ROGERS's* denial will be attached to any future disclosures of your PHI. If *DR. ROGERS* approves your request, it will make the change(s) to your PHI. Additionally, *DR. ROGERS* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to *DR. ROGERS'* at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision *DR. ROGERS* made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. *DR. ROGERS* will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. *DR. ROGERS'* Responsibilities: We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell

us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Date of Last Revision: 09/23/13

Marcia H. Rogers, Ed.S., Psy.D.
DR. LISA CHEYETTE & ASSOCIATES
1115 Upper Hembree Rd., Suite B, Roswell, GA 30076
770-685-6412
admin@drrogers.hush.com

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your psychologist, and I am sincerely looking forward to assisting your family. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment or the treatment of your child. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding treatment or evaluation at any time.

Background Information

The following information regarding my educational background and experience as a psychologist is an ethical requirement of my profession:

I am a licensed clinical psychologist in Georgia and a Nationally Certified School Psychologist. I specialize in comprehensive psychological assessment and therapeutic treatment of children, adolescents, and adults with a variety of academic, social, and emotional concerns. I have also provided therapy and assessment for individuals and families in Georgia and California for over 20 years.

I received my Bachelor of Science degree with honors from Georgia Institute of Technology. I also obtained an Ed.S. in school psychology from Georgia State University and a doctorate in clinical psychology (Psy.D.) from Argosy University – San Francisco. My professional experience includes work in individual private practice, public schools and preschools, day treatment facilities, infant-parent programs, and clinical outpatient settings,

My private practice includes psychological assessment and individual therapy for individuals from preschool through college. Areas of particular expertise include Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorders, Mood Disorders, Dyslexia, and other learning disorders and associated issues. I also provide parent consultation, educational consulting, ADHD & Executive Function Coaching, Parenting Skills Training, and educational advocacy regarding Section 504 Plans and Individual Educational Plans in schools. In addition, I perform adult ADHD evaluations.

Professional Relationship

Psychotherapy, psychological assessment, or consultation are professional services I will provide to you or your child. Because of the nature of therapy and assessment, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Initial_____

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that psychologists are required to keep the identity of their clients confidential. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy and/or assessment is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my locked office. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

If you are under 18 years of age, the law may give your parents or legal guardians the right to access your records. It is my policy to request an agreement from legal guardians that they will give up this right so that clients under 18 years of age may have privacy in their sessions. If they agree, I will provide them only with general information on how your treatment is proceeding. Of course, an exception to this would be if I believe that you are in imminent danger of harming yourself or someone else, in which case I will let them know my concerns.

Divorce and Custody

I am not a custody evaluator and cannot make any recommendations on custody. I can refer you to a list of licensed forensic psychologists who provide custody evaluation if needed.

I require a copy of the current, standing court order showing custodial rights for each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session before I am able to meet your child. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for assessment or therapy and will need to obtain written consent for the child to participate in assessment and/or therapy from the legal custodian, and prefer to have contact with both parents prior to seeing the child.

Initial_____

I ask all of my clients to waive the right to subpoena me to court. The policy is set in order that I can preserve the efficacy and integrity of my therapeutic process and my relationship with you and your child(ren). My appearance in court can damage the therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy, confidentiality, and best interests of my clients. By signing this agreement, you are waiving your right to have me subpoenaed and agreeing in fact not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if you would prefer.

Court Testimony

I am not trained in matters that involve the legal system. If required to testify for court (by a judge), speak with legal counsel, prepare documentation, etc., my fee is $500 an hour plus mileage and expenses incurred. A two hour minimum will be charged. Medical insurance does NOT pay for these services.

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Insurance

I am no longer an in-network provider for Aetna or Blue Cross/Blue Shield insurance. Most health insurance companies provide some coverage for mental health treatment and assessment. If your insurance includes out-of-network benefits, you will need to file your own insurance claims. I can provide you with an itemized payment receipt that contains all of the information that most insurance companies require. Some insurance companies may require you to pre-certify treatment. It is your responsibility to contact your insurance company and discuss with them. If the insurance company requires me to complete authorization paperwork, you will be billed at a rate of $160/hr.

Insurance companies typically authorize a maximum of 12 assessment hours and generally will not pay for testing associated with learning disorders, such as achievement testing. Most insurance companies will require me to provide a clinical diagnosis if you wish to get reimbursed. This information becomes part of the insurance company files. In some cases, your insurance company may send the information to a national medical information data bank. This raises concerns about privacy and confidentiality for many people. To avoid the possibility of insurance companies obtaining any information about your mental health care, you might wish to pay for services yourself. Many clients have chosen this option.

Professional Fees

The professional fees charged for therapy, assessment, or other services on a private pay basis will be discussed individually during the first intake session. My current private pay fees are as follows: Initial Intake session $250/hr.; Therapy/consultation session ($175/hr.); Psychological testing ($175/hr.); Comprehensive Psychological Evaluation for children & adolescents, which includes intake, assessment, scoring, report writing, and review of results ($2500). A comprehensive psychological evaluation includes approximately 15-20 hours of the examiner's time. This can be paid separately as $625 over 4 sessions (Intake, 2 testing sessions/Review of results). If additional testing sessions are needed, there will be no additional charge. The fee for Adult ADHD testing is $700 (Intake & testing session/s; meeting to review the results, brief report). Please be advised that psychological testing reports will NOT be released until payment for the evaluation is made in full. Forms, letters, and affidavits will incur a fee of $175/hr. A fee of $25 plus additional expenses incurred will be applied should your check be returned.

Attendance at school meetings, including 504 Plans, special education eligibility, and other conferences, as well as classroom observations, will be billed at a rate of $200/hr. Additional travel and time expenses will be charged for meetings outside a 10-mile radius of my office.

Initial_____

I accept almost all major credit cards, including American Express, Visa, and MasterCard. You may also pay by personal check. You will be responsible for any expenses incurred to collect unresolved balances as well as an additional fee of $25.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Repeated late cancellations or failure to show for scheduled appointments may result in your termination as a client.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with me. **However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations.** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. **You also need to know that I am required to keep a copy of all emails and texts as part of your clinical record.**

Facebook, LinkedIn, Instagram, Pinterest, Etc.: It is my policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality.

Google, etc.: It is my policy not to search for my clients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material out and bring it to your session.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

Hearing and Vision

Parents of minors receiving a comprehensive psychological evaluation are **strongly encouraged to secure a current hearing and vision screening** (within the past year or more current if intermittent hearing loss is suspected) for their child before the evaluation is started. Please note that the validity of all or some of the results would be called into question if the child was found to have hearing or vision problems after the evaluation was completed. In addition, if you are planning on using the results of this evaluation for an Individual Educational Plan at their public school, the results might not be accepted without cleared hearing and vision. It is the parent's responsibility to make sure that the child has passed a hearing and vision evaluation within the past year. If the parent chooses not to do so, then the parent will be charged additional fees for additional administration of assessments and/or rewriting the report. This additional testing would probably not be covered by your insurance plan.

Initial_____

In Case of an Emergency

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- **Call Behavioral Health Link/GCAL: 800-715-4225**
- **Call Ridgeview Institute at 770.434.4567**
- **Call Peachford Hospital at 770.454.5589**
- **Call 1-800-SUICIDE (784-2433)**
- **Call 911.**
- **Go to your nearest emergency room.**

Our Agreement to Enter into a Therapeutic Relationship

I am sincerely looking forward to working with you. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name/s below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form **as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you and/or you child.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

Initial_____

Marcia H. Rogers, Ed.S., Psy.D.
DR. LISA CHEYETTE & ASSOCIATES
1115 Upper Hembree Rd., Suite B, Roswell, GA 30076
770-685-6412
admin@drrogers.hush.com

PATIENT INFORMATION FORM

TODAY'S DATE: _____

NAME OF PATIENT: _____
Last First Middle

BIRTHDATE:_____GENDER_____
MM/DD/YYYY M/F

HOME PHONE:_____ CELL: _____ OTHER: _____

E-MAIL:_____

*Communications will be discrete but please indicate any restrictions:*_____

ADDRESS: _____
(Number) (Street) (Apt. #, Suite)

_____
(City) (State) (Zip)

EMPLOYER'S Name or SCHOOL Name: _____

STATUS: _____
(Single, Married, Other, Employed, Full-Time Student, Part-Time Student)

If patient is a minor (under 18):

WHO HAS LEGAL CUSTODY?:_____
(please provide documentation if divorced)

MOTHER/GUARDIAN Name_____

Phone # (s)_____

Address if different_____

E-mail_____

FATHER/GUARDIAN Name_____

Phone # (s)_____

Address if different_____

E-mail_____

EMERGENCY CONTACT & PHONE #: _____

REFERRED TO MY PRACTICE BY: _____

May I have your permission to thank this person for the referral? *YES* *NO*