Thriving Minds
Behavioral Health Center
10524 Grand River Road, Suite 100
Brighton, MI 48116-9559
810-225-3417
Family Services Center
350 N. Main Street, Suite 220
Chelsea, MI 48118-1370
734-433-5100

Client's Last Name, First Name, Middle Initial:	**Birth Date:**	**Sex:** ☐ **Male** ☐ **Female**
Street Address:	**City, State:**	**Zip Code:**

Parent/Guardian/Person Responsible for Payment Information **NOTE: This should be the address where you want bills sent**		
Last Name, First Name, Middle Initial:	**Birth Date:**	**Relationship to client:**
Street Address (if different from client):	**City, State:**	**Zip Code:**
Home phone:	**May I leave a message at this number?** ☐ **Yes** ☐ **No**	
Cell phone:	**May I leave a message at this number?** ☐ **Yes** ☐ **No**	
Email address:	**Would you like to use this email address to communicate about appointments?** ☐ **Yes** ☐ **No**	
Other Parent/Guardian Information		
Last Name, First Name, Middle Initial:	**Birth Date:**	**Relationship to client:**
Street Address:	**City, State:**	**Zip Code:**
Home phone:	**May I leave a message at this number?** ☐ **Yes** ☐ **No**	
Cell phone:	**May I leave a message at this number?** ☐ **Yes** ☐ **No**	
Email address:	**Would you like to use this email address to correspond about appointments?** ☐ **Yes** ☐ **No**	
Other Adults involved in client's treatment (e.g., stepparents)	**Relationship to child:**	

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Receipt of Notice of Privacy Practices
-4 pages-

BACKGROUND: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by congress to help protect health coverage for workers and their families. It also addresses electronic transaction standards and the need to ensure the security and privacy of health data. We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. The security and privacy of your protected health information is the subject of this Privacy Notice. This notice describes how Psychological and medical information about you (or your child, if your child is the client) may be used and disclosed, and how you can get access to this information.

I. Use and Disclosure of Your Protected Health Information for Treatment, Payment, and Health Care Operations

We may use or disclose information in your records for *treatment, payment, and health care operations* purposes with *your consent*. *Personal health information (PHI*) refers to information in a client's health record that could identify that client. *Use* of this information refers only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. *Disclosure* of information refers to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties. Throughout this notice, the term "you" may refer to the individual who is the client or the individual's parent, legal guardian or adult who has been legally determined to be responsible for the client.

In providing for your *treatment, we* may use or disclose information in your record to help you obtain health care services from another provider, or to assist us in providing for your care. For example, we might consult with another health care provider, such as your child's pediatrician or another psychologist.

In order to obtain *payment* for services, we may use or disclose information from your record, with your consent. For example, we may submit the appropriate diagnosis to your health insurer to help you obtain reimbursement for your care. We also may use or disclose information from your record to allow *health care operations* (e.g., quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination).

II. Use and Disclosure Requiring Authorization

Except as described in this Notice, we may not make any use or disclosure of information from your record for purposes outside of treatment, payment, and health care operations unless you give your written authorization. In particular, we will need to secure an authorization before releasing psychotherapy notes

which we have kept separate from the rest of your treatment records. These are notes have made about our conversations during treatment and evaluation sessions.

You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

III. **Use and Disclosure Without Consent or Authorization**

There are certain circumstances, listed below, in which we are allowed (or, in some cases, required) to use or disclose information from your record without your permission:

Child Abuse: If we know, or have reasonable cause to suspect, that a child is or has been abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that we report such knowledge or suspicion to the Michigan Family Independence Agency or appropriate governmental agency. If we know, or have reasonable cause to suspect, that a child has been abused by a non-caretaker, the law also requires that we report to the Michigan Family Independence Agency, which may be required to submit the report to other governmental agencies.

Adult and Domestic Abuse: If know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we are required by law to report such knowledge or suspicion to the Central Abuse Hotline or other appropriate governmental agency.

Health Oversight: If a complaint is filed against us with the Michigan Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information relevant to that complaint.

Judicial or Administrative Proceedings: Personal Health Information is privileged by state law. If you are involved in a court proceeding and a request is made for your records, we will not release information without the written authorization of your or your legal representative, *or* a subpoena of which you have been properly notified and you have failed to inform us that you are opposing the subpoena, *or* a court order. The privilege does not apply if you are being evaluated for a third party, or if the evaluation is court-ordered, or in certain other limited instances. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If a client presents a clear and immediate probability of physical harm to him or herself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or appropriate authorities.

Workers' Compensation: If you file a workers' compensation claim, we may disclose information from your record as authorized by workers' compensation laws.

IV. Client's Rights and Psychologist's Duties

Client's Rights:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected heath information. However, we are not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request to have confidential communications of PHI delivered by alternative means and/or at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we may be able to arrange to send your bills to another address.)

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, given your written request. This may be subject to certain limitations and fees. Upon request, we will discuss with you the details of the request process. Please understand that older records may be destroyed, and therefore no longer available, in accordance with applicable law or standards.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request must be in writing, and we may deny your request.
Right to an Accounting: You have the right to request an accounting of certain disclosures made by us. Upon request, we will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:
We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

If we make significant revisions to our policies and procedures which might affect the privacy of your personal health information, we will provide you with a copy of those revisions. If you are still in treatment with us, you will be provided with a copy of the revisions in the manner permitted by law, generally by hand delivery at your next appointment. As needed, former clients may be mailed a copy of significant revisions to the most recent mailing address on file at our office. Updated notices of our privacy policies will always be available for review upon request at our office.

Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact us at our office (10524 E Grand River, Ste. 100, Brighton, MI 48116). We recommend that such inquiries be done in writing.

If you believe that your privacy rights have been violated and wish to file a complaint with us, you may send your written complaint to us at our office address (above).

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, or the appropriate administrative office. Our office manager or we can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint, in accordance with the provisions of applicable law.

Effective Date, Restrictions and Changes to Privacy Policy

Restriction: In the case of a minor child, the child's legal guardian has the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about the child for as long as the PHI is maintained in the record. However, psychotherapy notes including statements made by a child during therapy sessions will not be released, in order to protect the child's right to confidentiality, unless required by law or deemed by us to be in the best interests of the child.

Restriction: In most cases, we are also prohibited by law from disclosing raw psychological test data and test materials to anyone other than a licensed psychologist qualified to interpret such data.

This notice will go into effect on May 18, 2008.

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Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth:_____

Given to Patient on: _____ Effective Date: 5/16/08

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Printed Name Relationship to Patient

_____
Relationship of the Personal Representative to Patient

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Financial Policy

Patient Name:	Date of Birth:

The intent of this document is to inform patients about the financial policies of Thriving Minds. All policies are created in an effort to minimize discrepancies not only for Thriving Minds but, more importantly, for all patients. Please feel free to ask any questions regarding this policy, in case further clarification is needed.

CANCELLATION FEE:

- There is a $100.00 no show or cancellation fee for all appointments with any of our providers, office wide. If you cancel less than 24 hours in advance, we will give you one bypass. Any future late cancellations or no-shows will be charged $100. If you are seeing more than one provider you are only allowed one bypass office wide. It is not our intention or desire to assess this fee, **so please call the appropriate office (listed above) to cancel or reschedule at least 24 hours prior to your appointment**. We ask that you call in advance so that patients waiting for appointments can use your previously reserved time slot.
- If a cancellation call is made less than 24 hours in advance, and this cancellation is due to unplanned emergency circumstances (e.g., the illness of the child, death in the family, etc.), the cancellation fee will be waived. However, this is at the discretion of Thriving Minds and is counted toward any future appointment(s) with any provider.
- Should a patient no show or cancel an appointment without the required 24 hour notice, a bill for the fee will be automatically sent to the patient's home residence or charged to the credit card on file.

LATE FEE:

- If you arrive for your appointment more than 10 but less than 20 minutes late, you will be charged a $40 late fee.
- If you arrive more than 20 minutes late, the appointment will be considered cancelled without 24 hours notice and the $100 cancellation fee will be charged. The appointment will need to be rescheduled.

COLLECTION FEE:

- Outstanding balances greater than 60 days past due will be charged to the credit card on file unless other arrangements are made. If there is an outstanding balance on the account that we are unable to collect or charge to the credit card on file, we will add a $10 non-payment fee to the account each month until the balance is paid in full.
- If the account is sent to our collection agency as a result of non-payment, a collection fee of 33% of the outstanding balance will be applied to the account prior to submitting to the collection agency.
- If the account is sent to our collection agency, we agree to only share with them information required to collect the balance due, including fees listed above.

CREDIT CARD PROCESSING FEES:

- Due to increasing costs for processing credit card payments, we will add a 3% fee on all payments made using credit cards. To avoid this fee please use cash or check for payments.

My signature below indicates that I understand and agree to the above Financial Policy. I agree to pay any no show/cancellation, late fees, collection fees or credit card fees that may fall under the policies listed above.

_____ _____
Patient/Guardian Signature Date

_____ _____
Printed Name Relationship to patient

_____
Patient Address

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Out of Network
Consent for Mental Health Evaluation and/or Treatment

Patient Name:	Date of Birth:

I voluntarily consent that my child will participate in a mental health evaluation and/or treatment from Thriving Minds. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will be responsible for is paying for the services I have already received.

This agreement shows my commitment to pay for this therapist's services. The prices for services include, but are not limited to, the following:

- Initial Clinical Interview 2 hours (Diagnostic Evaluation 90791 + Family Therapy 90846): $275
- Individual (90837) and Family Therapy (90847) (per 60 minute session): $170
- Selective Mutism Evaluation (Psychological testing 96101): $351
- Testing and Intensive Therapy prices vary based on individual need.

I agree to pay for services rendered at the end of each session. Insurance may cover part or all of the cost of treatment, however, I understand that it is my responsibility to look into my coverage and be knowledgeable about my benefits. I also understand that there may be some types of treatment that may not be covered by insurance, but may be clinically recommended by my therapist. My therapist will provide an estimate cost to me for such services before they are rendered.

I agree to pay for services at the time they are provided. I understand Thriving Minds Behavioral Health will provide me with a detailed superbill that I can use to attempt to get reimbursement from my insurance plan, if I choose.

If a therapist is required to attend court for any reason (e.g., subpoena or expert witness testimony), I understand that I will be liable for a Legal Consultation cost of $200/hour (this will be charged for all time spent in court and travel to and from court; not simply the time required to testify). This will be the responsibility of the patient, as insurance will not cover legal fees.

I understand that I must call to cancel an appointment at least 24 hours before the appointment time. If I do not cancel or do not show up, I will be charged $100 for that appointment. I agree to pay for uncancelled appointments or those where I fail to give enough notice that I will not attend. The only exceptions are unforeseen or unavoidable situations that arise suddenly. I understand that insurance does not pay for these uncancelled appointments, so I will be solely responsible for the cost.

I have read and understand the above statements and consent to evaluation/treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____
Signature of client or client guardian Date

_____ _____
Printed Name Relationship to client

_____ _____
Therapist Date

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Consent and Agreement for Psychological Testing and Evaluation

Patient Name:	Date of Birth:

I, _____, agree to allow Thriving Minds to perform the following services:

____ Psychological testing, assessment, or evaluation
____ Report writing
____ Consultation with school personnel or legal consultation
____ Other: (describe) _____

The estimated cost for these services are detailed at the bottom of this consent form.

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the psychologist's time for the reading of reports, consultation with other psychologists and professionals, scoring of tests, interpreting of results, and any other activities to support these services.

I agree to pay for services rendered at the end of each session. Insurance may cover part or all of the cost of treatment, however, I understand that it is my responsibility to look into my coverage and be knowledgeable about my benefits. I also understand that there may be some types of treatment that may not be covered by insurance, but may be clinically recommended by my therapist. My therapist will provide an estimate cost to me for such services before they are rendered.

I agree to pay for services at the time they are provided. I understand Thriving Minds Behavioral Health will provide me with a detailed superbill that I can use to attempt to get reimbursement from my insurance plan, if I choose.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

If this therapist is required to attend court for any reason (e.g., subpoena or expert witness testimony), I understand that I will be liable for a Legal Consultation cost of $200/hour (this will be charged for all time spent in court and travel to and from court; not simply the time required to testify). This will be the responsibility of the patient, as insurance will not cover legal fees.

I know that I must call to cancel a testing appointment at least 48 hours before the appointment time. If I do not cancel or do not show up, I will be charged for that appointment. I agree to pay for uncancelled appointments or those where I fail to give enough notice that I will not attend. The only exceptions are unforeseen or unavoidable situations that arise suddenly. I understand that insurance does not pay for these uncancelled appointments, so I will be solely responsible for the cost.

I have read and understand the above statements and consent to testing and evaluation of my child. I also attest that I am the legal guardian and have the right to consent for the testing and evaluation of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____
Signature of client or client guardian Date

_____ _____
Printed Name Relationship to client

_____ _____
Therapist Date

TO BE COMPLETED IN OFFICE:

Test	CPT's	DX	Estimated Cost

BCBS Patients: The above costs can change slightly due to Blue Cross Blue Shield reimbursement rate changes or other benefit changes. BCBS reimbursement for services is not guaranteed and will be considered based on medical necessity, provider specialty, procedure code, diagnosis billed and the member's status on the date of service. If the services meet the criteria listed then they are typically covered with the deductible/copay/coinsurance. Parents are responsible for all costs not covered by insurance, including copay, coinsurance, and deductible, and services not covered by individual plans.

_____ _____ _____
Parent/Guardian Date Therapist

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Attendance Policy

Patient Name:	Date of Birth:

Background: The purpose of this document is to inform patients and therapists of clinic policies related to appointment attendance. This policy was developed to support a standardized procedure for communicating expectations for attendance and to outline potential implications for persistent cancellations or missed appointments.

WHY IS ATTENDANCE IMPORTANT?

Thriving Minds seeks to provide behavioral health care which is informed by research, is developed in collaboration with the patient and/or their family, and is carried out with integrity. We believe consistent attendance may be the most important part of caring for our patients, their families, and the larger community for many reasons.

1. ***We value your time.*** We understand each patient and their family makes a commitment when they seek regular services from our clinic. In order to offer you the most appropriate care, attendance and participation is key. Many evidence-based approaches used at Thriving Minds involve ideas which build upon each other over time (i.e., lessons learned in Session 2 are important for lessons in Session 7). The more appointments you attend, the more opportunities you have to learn and grow.
2. ***Attendance supports growth*.** Patients are more likely to see improvement when they attend most scheduled appointments. Consistently making your appointments will ensure that you are learning, growing, and maintaining momentum from week to week.
3. ***We value our therapists' time.*** We are grateful for the time and effort our therapists give to supporting their patients' needs. Our therapists spend time outside of scheduled appointments preparing lessons, materials, and activities to use during session to help patients meet their personal goals. Inconsistent attendance affects the plans and goals your therapists develop, too.
4. ***We have a growing waitlist of patients eager to receive treatment.*** We are also attentive to the needs of potential patients who may be in need of treatment. We typically have a long waitlist of individuals or families who may wait weeks or months for an opening. When current patients consistently miss their scheduled appointments, we are aware that this time could be offered to others on the waitlist.

PATIENT RESPONSIBILITIES

- Patients with weekly appointments are expected to attend 75% of their regularly scheduled appointments in a given month.
- Patients whose appointments occur every other week are expected to attend 75% of their regularly scheduled appointments over the course of two months.
- All patients (or guardians of patients under the age of 18) are responsible for communicating with the therapist when they expect to miss an upcoming appointment.

If a patient or patient's family is unable to meet the expectation stated above, the therapist will initiate a conversation about the importance of session attendance. Patients will be offered the following options:

- Lose access to preferred time slot
- Move back to the clinic waitlist until a therapist has availability at the patient or family's preferred time

Note: These expectations for attendance include all cancelled appointments, even if the patient cancels 24 hours or more in advance. Please refer to the Financial Policy for details about cancellation fees.

THERAPIST RESPONSIBILITIES

- Therapists are expected to review this policy with all patients and/or guardians during the intake session. Therapists should clearly review patient expectations, as well as the implications of frequently missed appointments, in a way that the patient and/or their guardian understands.
- Therapists are responsible for tracking attendance for each patient on their caseload.
- Therapists should also initiate conversations about attendance with their patients, especially when attendance is inconsistent.
- Discuss with patients during the therapy process:
- After the *first* missed appointment, remind the patient of the clinic cancellation and attendance policies.

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Attendance Policy

Patient Name:	Date of Birth:

- After the *second* missed appointment in the aforementioned time frame, provide a warning and remind the patient about the potential implications (i.e., lose preferred time slot, return to waitlist) of missing multiple appointments in a given time period.
- After the *third* missed appointment, give patient and/or their guardian(s) the option of either moving to a daytime appointment with the potential to move back into a more preferred appointment later or return to the clinic waitlist.

My signature below confirms that I understand and agree to the above Attendance Policy. I am aware of the potential implications of frequently missing appointments, including the choices I will be offered if I do not meet the above expectations.

_____ _____
Signature of client or client guardian Date

_____ _____
Printed Name Relationship to client

_____ _____
Therapist Signature Date

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Credit Card Authorization Form

Please fill out, sign, and return this form to Thriving Minds.

Patient Name:_____

Patient Date of Birth:_____

Credit Card Holder's Name as it Appears on Card:_____

Credit Card Type (Circle One): MasterCard Visa Discover American Express

Credit Card Number:_____

Expiration Date: _____ CCV:_____

Billing Address:_____

City: State: Zip:_____

Credit Card Holder Email:_____

Credit Card Holder Phone:_____

On_____ (insert today's date) I authorize Thriving Minds to initiate charges to the credit card indicated above for any outstanding charges or balances. I understand I will only be charged for completed appointments and any late cancellation fees when an appointment is cancelled with less than 24 hours' notice.

I understand that I may cancel my authorization for charges upon written notice to Thriving Minds at office@thrivingmindsbehavioralhealth.com, or by writing to Thriving Minds Behavioral Heath, 10524 East Grand River Avenue, Suite 100, Brighton, MI 48116 or Thriving Minds Family Services, 350 N. Main Street, Suite 220, Chelsea, MI, 48118.

If you have any questions about this transaction or if the credit card indicated above is lost or stolen, I agree to notify Thriving Minds at once by calling Thriving Minds at 810-225-3417 (Brighton) or 734-433-5100 (Chelsea), or by contacting them by mail or email.

Card Holder Signature:_____ Date_____

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Child Developmental History Record

CHILD'S NAME: _____ **DOB:** _____
NAME OF SCHOOL: _____ **GRADE:** _____
TEACHER(S): _____
CHILD'S PHYSICIAN: _____ **PHYSICIAN'S NUMBER:** _____
CHILD'S HOME ADDRESS: _____

If necessary, I give Thriving Minds permission to call me at the following numbers:

Home Phone: _____ **OK to leave a message** **Yes** **No**
Cell Phone: _____ **OK to leave a message** **Yes** **No**
Work Phone: _____ **OK to leave a message** **Yes** **No**

If necessary, I give Thriving Minds permission to contact me at the following email (emails will not be distributed or sold):
Parent's Email Address: _____

A. Please list the problems with which you want help for this child.

1. _____
2. _____
3. _____
4. _____
5. _____

When did you first notice the problem?

_____

What seems to make the problem better?

_____

What seems to make the problem worse?

_____

B. Where you specifically referred by someone? **Yes** _____ **No** _____
If so, whom? _____

C. Has this child had previous evaluations outside of school? **Yes** _____ **No** _____
If so, by whom and when? It will be helpful to bring any available report(s).

_____

_____

D. Has this child received any psychological or psychiatric treatment? If so, please list

approximate dates and types of treatment (including name of medication):

_____

_____

_____

_____

E. Development

1. Pregnancy and Delivery

Prenatal medical illnesses and health care:

_____

_____

Was the child premature? _____ Weight and height at birth: _____

Any birth complications or problems?

_____

_____

2. The first few months of life Health problems:

_____

_____

Personality/Temperament:

_____

_____

3. Milestones: At what age did this child do each of the following?

Sat without support _____ Crawled _____

Walked independently _____ Fully toilet trained day _____

Fully toilet trained night _____ Able to dress self _____

Age when child said first words: _____

Age when child said first sentences:

_____

Any speech, hearing, or language difficulties?

_____

What is the principal language spoken in the home?

_____

Indicate others that are also used.

_____

F. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents/injuries, surgeries, seizures, and other medical conditions.

Condition	Age	Treatment	Consequences

G. Family History

Please list any psychological condition, attentional weaknesses, learning issues, behavioral problems, or other mental illness in any immediate or extended family member.

Diagnosis or Condition	Family Member

1. **Father's present age _____ School level completed _____**
   Present occupation _____
   General health _____
2. **Mother's present age _____ School level completed _____**
   Present occupation _____
   General health _____
3. **Brother(s): Age(s)**

   _____

   _____

   _____

   Sister(s): Age(s)

   _____

   _____

   _____

4. **Was the child adopted? _____**
5. **What is marital status of parents? _____**
6. **If divorced/separated, child mainly lives with _____**
7. **Has this child endured any extremely stressful experience?**

_____

H. Education

1. **Any previous schools attended?**

_____

_____

2. **Academic issues:**

_____

_____

3. **Behavioral issues:**

_____

_____

4. **Special skills or talents of child (list hobbies, sports, etc.)**

_____

_____

I. Behavioral Concern Inventory

Please indicate (by circling) any possible behavioral concerns you might have about your child's behavior.

Is moody
Worries a lot
Seems sad
Makes negative comments about self
Has many fears
Panics easily
Has lost interest in things he/she used to enjoy
Gets angry easily
Complains of headaches or stomach aches
Wets bed
Has bowel accidents
Makes odd sounds
Goes through certain rituals or odd habits regularly
Is extremely preoccupied with cleanliness
Frequently complains of being tired
Is rejected by peers
Annoys peers
Has trouble forming new friendships
Gets picked on or bullied by others
Lacks close friends
Disobeys parents
Is mean to animals
Argues a lot
Has temper tantrums
Fights with other students
Uses bad language excessively
Is mean to siblings
Takes things that don't belong to him/her

J. Other Behavior

What are your child's favorite activities?

1._____ 2._____

3._____ 4._____

What activities would your child like to engage in more often than he/she does at present? 1._____ 2._____

3._____

What activities does your child like least?
1._____ **2.**_____
3._____

Has your child ever been in trouble with law? Yes _____ No _____
If yes, please describe briefly: _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Check Disciplinary technique	Check Disciplinary technique
_____ Ignore problem behavior	_____ Tell child to sit on chair
_____ Scold child	_____ Send child to his or her room
_____ Spank child	_____ Take away some activity or food
_____ Threaten child	_____ Redirect child's interest
_____ Reason with child	_____ Don't use any technique
_____ Other (describe):	

_____

Which disciplinary techniques are usually effective?

_____

_____

Which disciplinary techniques are usually ineffective?

_____

_____

Thriving Minds
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810-225-3417
Family Services Center
350 N. Main Street, Suite 220
Chelsea, MI 48118-1370
734-433-5100

AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

I, _____ (parent name) hereby authorize Thriving Minds to release information contained in the patient records of:

Child Name:_____ Date of Birth: _____/_____/_____

Including alcohol and drug abuse records protected under the regulations in 42 code of Federal Regulations, Part 2, psychological records, communications, psychological assessments and treatment,

1. Person(s) or organization(s) to whom the disclosure is to be made:
    a. Name: _____
    b. Address: _____
    _____
    _____
    c. Phone Number: _____
    d. Fax Number: _____

    a. Name: _____
    b. Address: _____
    _____
    _____
    c. Phone Number: _____
    d. Fax Number: _____

    a. Name: _____
    b. Address: _____
    _____
    _____
    c. Phone Number: _____
    d. Fax Number: _____

This release covers two-way disclosure from both parties.

_____ _____
Signature of patient or caregiver Date

_____ _____
Printed Name Relationship to patient

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CONSENT FOR AUDIO-VIDEO RECORDING

Patient Name:	Date of Birth:

Thriving Minds has playrooms with HIPAA compliant video cameras that run 24/7. The audio-video recording may be used in the following ways:

1. Observation of parent-child interactions to guide treatment recommendations
2. An observation which is part of an evaluation (e.g., this is an essential component of Selective Mutism evaluations).
3. To guide supervision by Aimee Kotrba, Ph.D.
4. To demonstrate treatment strategies to parents and/or other caregivers, teachers, and treating professionals (with parental consent).
5. To train professionals on specific treatment strategies.

Audio-video recordings are never distributed, sold, or played on the internet, social media, or YouTube for general viewing. Videos will not be part of the medical record.

The videos are securely stored and automatically deleted after 10 days.

I give permission to Thriving Minds to use audio-video recordings of myself and/or my minor child(ren) listed below:

_____ _____
Name Date of Birth

_____ _____
Name Date of Birth

_____ _____
Name Date of Birth

I consent to the use of the audio-video recordings as described above, and NOT for public circulation or sale. I understand that I may refuse or revoke this authorization at any time.

_____ _____
Signature of Client or Guardian Date

_____ _____
Printed Name Relationship to Patient

☐ I do not give permission for audio-video recordings to be used for professional training purposes.

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PARENTAL AGREEMENT

I understand that I am consenting to the treatment of my child:

Name:_____ Date of Birth:_____

I understand that this treatment is focused on assisting my child emotionally, and is not a psychological evaluation for the court system. I will not ask Thriving Minds to attend court hearings, speak to legal counsel, or provide expert testimony in court concerning my child's welfare, my abilities as a parent, or my child's preference for parent custody. I understand that Thriving Minds will not begin treatment for my child until this agreement is signed by both parents.

_____ _____
Parent Signature Date

_____ _____
Printed Name Relationship to patient

_____ _____
Address City, State, Zip

_____ _____
Parent Signature Date

_____ _____
Printed Name Relationship to patient

_____ _____
Address City, State, Zip

_____ _____
Witness Signature Date