ASHA JANE
THERAPY FOR THRIVING

Asha Jane, MA, LMFTA
Licensed Marriage & Family Therapist Associate
11300 Antler Lane
Austin TX 78726
P: 512.567.6944
E: aj@ashajane.com

Child and Adolescent History Form
(To be filled out by parents of children and adolescents)
Please return with accompanying paperwork at or before first visit.

Name of Child/Adolescent_____ Date_____

Sex_____ Date of Birth_____ Age_____ Race _____

School attending_____ Grade_____

Father (biological/adoptive)_____ Occupation _____

Yrs. of Education_____

Address_____

Home phone_____ Cell phone _____ Work phone_____

Mother (biological/adoptive)_____Occupation_____

Yrs. of Education _____

Address_____

Home phone_____ Cell phone _____ Work phone_____

Is your child adopted?_____ If so, age at adoption_____

Do child's parents currently live together?_____

Are parents: Divorced?___ Separated?___ Widowed?___

If parents live apart, how old was your child when parents began living apart?_____

Please describe custody and visitation arrangements._____

_____

_____

List any other adults who live in the home, including stepparents:

Name_____ Relationship_____

Name_____ Relationship_____

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Please list other children in the home:

Name_____ Age_____ Relationship_____

Name_____ Age_____ Relationship_____

Name_____ Age_____ Relationship_____

If the child has brothers or sisters who do not live in the home now, please list:

Name_____ Age_____

Name_____ Age_____

Name_____ Age_____

Name_____ Age_____

Please list the name and locations of grandparents who interact often with the child (in person or by mail & visits):

Grandparent(s)_____ Location_____

Grandparents(s)_____ Location_____

Please describe your goal in making this appointment._____

_____

_____

When did the problem(s) begin?_____

_____

_____

List anything you did to improve the problem._____

_____

_____

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PRENATAL HISTORY

Were there any significant problems in the pregnancy? Yes_____ No_____

If so, please specify._____

_____

Were alcohol, medications, and/or street drugs used?_____

Length of: Pregnancy _____ Labor and delivery_____

Medications during labor and delivery:_____

Were there any complications in labor/delivery? Yes___ No___

Please specify:_____

_____

NEONATAL HISTORY

Birth weight:_____ Were there any significant problems for the child at birth or in the newborn phase?

Yes___No___ Please specify: _____

_____

INFANCY (0 to 12 months)

Check if applicable, any significant problems, delays, and/or difficulties your child had in the 1st year:

_____feeding _____sleeping _____breathing _____colic _____bowel/urinary habits _____crawling

_____sitting unassisted _____intolerance of affection _____inability to be consoled _____emotional responsiveness

Please specify any other significant problems during this period: _____

_____

_____

Who cared for child during the first year?_____

_____

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TODDLERHOOD (12 to 36 months)
Check if applicable, any significant problems, delays, and/or difficulties:

_____walking unassisted _____feeding self _____first words _____using sentences

_____entertaining self _____stranger anxiety _____severe temper tantrums

_____self destructive behavior _____toilet training _____overactivity

Please specify any other significant problems:_____

_____

Did your child attend daycare?___yes ___no. If so, at what ages? _____

Did your child attend preschool?___yes___no. If so, at what ages?_____

CHILDHOOD (3 to 11 years old)
Check if applicable, any significant problems, delays, and/or difficulties:

_____reading skills _____impulsive _____writing skills _____nervous/fearful

_____math skills _____severe temper tantrums _____school failure _____destroying property

_____completing tasks _____self-destructive habits _____cooperating in group activities

_____overactivity _____obeying _____bowel/urinary habits

_____aggressive _____very shy _____prolonged sadness or irritability

Please specify any other significant problems:_____

_____

ADOLESCENCE (12 to 18 years old)
Check if applicable, any significant problems, delays, and/or difficulties:

_____truancy _____delinquency _____prolonged sadness or irritability

_____aggressive _____social isolation _____gang membership _____academic failure

_____impulsive _____pregnancy _____sexually active _____running away

_____drug and alcohol use _____temper outbursts _____fighting

Please specify any other significant problems:_____

_____

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MEDICAL/HEALTH HISTORY

Check if applicable any of the following health problems your child has had:

_____ear infections	_____rashes or skin problems	_____meningitis	_____seizures
_____pneumonia	_____trouble with eyes/vision	_____anemia	_____asthma
_____high fevers	_____slow weight gain	_____headaches	_____bowel problems
_____lead poisoning	_____heart problems	_____kidney problems	_____suicide attempt
_____drug overdose	_____surgeries*	_____hospitalization*	
____serious injuries*	_____allergies*	_____child physical or sexual abuse	

*Please give details:_____

_____

List medications used over several months/years:_____

_____

Primary Care Physician or Pediatrician and other treating medical doctors (e.g., psychiatrists): _____

_____

SOCIAL HISTORY

Were/are both parents involved in the child's care? _____

_____

Who stays with the child when the child is ill? _____

Does your child require much scolding or discipline? _____ Please explain._____

_____

_____

What forms of discipline/guidance do you use?_____

_____

_____

What is your child's reaction to discipline/guidance?_____

_____

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Do parents usually agree on discipline/guidance? If no, please explain._____

_____

_____

Do you have extended family or friends in the community to help with the child? Describe._____

_____

Does the child have a close relationship with an adult not presently living at home?_____

_____

Have brothers or sisters of the child experienced any learning or behavioral problems?_____

If so, explain: _____

_____

Have other family members, including parents, experienced any learning, behavioral, or emotional problems?

If so, please explain:_____

_____

Are you satisfied with your child's progress in school?_____

_____

What does your child say about school?_____

_____

What activities does the child do when not in school?_____

_____

What activities does the family do together?_____

_____

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Have there been any important changes in the family during the last year (examples: job changes, moves, births, deaths, separation or divorce)?_____

_____

How does the child get along with others (family, neighbors, peers)? _____

_____

Does your child have any habits that concern you (nail-biting, bedwetting, drugs, truancy, etc.)?

_____

Who watches your child after school hours? _____

Does the child play outside in the neighborhood? _____

What kinds of jobs or household responsibilities does your child have? _____

_____

Does he/she do them willingly? _____Without prompting? _____

Has your child ever received special services and/or Special Education or been hospitalized for behavioral or emotional reasons?_____ Please explain and provide records_____

_____

Please list the names and addresses of any doctors, psychologists, speech therapists, or other professionals who have evaluated your child. Please note if your child receives Special Education.

_____

_____

_____

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At this stage of your child's development, please discuss those aspects of your child's development (mental, social, physical, or emotional) about which you feel pleased -- areas of the child's strengths.

If you would care to, please discuss your aspirations for this child -- what you hope or expect him/her to become as an adult.

Please feel free to add any information you feel will add to my understanding of your child.

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Registration Information

Date_____

Parent's Name_____
Last First MI Preferred Contact #

Home Address City State Zip

Employer Occupation Work # Email

Social Security # Sex DOB

Home tel # Cell phone #

EMERGENCY CONTACT*

Name Relationship

Street Address City State Zip

Cell phone # Work # Home # Other #

*I AGREE THE EMERGENCY CONTACT MAY BE CONTACTED IN THE CASE OF A PERCEIVED EMERGENCY.
INITIAL _____

Parent's Name_____
Last First MI Preferred Contact #

Home Address City State Zip

Employer Occupation Work # Email

Social Security # Sex DOB

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EMERGENCY CONTACT*

Name Relationship

Street Address City State Zip

Cell phone # Work # Home # Other #

***I AGREE THE EMERGENCY CONTACT MAY BE CONTACTED IN THE CASE OF A PERCEIVED EMERGENCY.**
INITIAL _____

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Office Information

I appreciate the opportunity to work together with you. My goal is to provide effective and efficient help for the problems you are experiencing. Below is information about my office policies.

My intention is for my office to feel comfortable and safe. Please let me know if there is anything I can do to help you achieve that goal.

Prior to the first visit, please complete the appropriate forms as they provide information for the first meeting. You can send them back or bring them with you on your first visit.

The information you share with me is confidential and will not be discussed with anyone without written consent, except in the following situations: 1) If you share information that indicates that you are a danger to yourself or others; 2) If abuse of a minor, elderly, or disabled person is suspected, or if you provide information about such abuse; 3) To insurers for claims payment; 4) To mental health professionals who are in association with me (i.e., for purposes of case supervision, for purposes of "covering" for me when I am unavailable, for purposes of hospitalization or for emergency psychiatric services); 5) As required by state law; 6) If I were appointed by the court to evaluate/provide service to you; 7) If you were to file a suit against me for breach of duty.

Payment is expected at the time of service, and is appreciated at the beginning of the session as it allows us to spend our time on you. I accept cash, checks and MC/Visa. Please notify me as soon as possible and within 24 hours when canceling or rescheduling an appointment. The reason for doing this is that we have agreed to meet at a specific time and this time slot is reserved for you. Missed appointments or those canceled with less than 24-hour notice carry a charge of 75% of your regular fee. This fee is payable before or at the time of the next appointment. You, not an insurance carrier, are responsible for this charge.

I do not accept insurance, but will be glad to provide paperwork you can submit. You are responsible for knowing your insurance benefits, including knowing whether a mental health provider is on your plan, and the type of services covered by your plan. The services you receive may exceed the benefits provided in your insurance or managed care benefits package. Accounts due for over 30 days are considered overdue. Delinquent accounts may be turned over to a collection agency and a surcharge will be added.

I check my voice mail throughout the day and return calls as soon as possible, usually within a couple of hours or at the end of my work day. For urgent matters feel free to contact me on my business cell phone (512) 567.6944. If you are in crisis or a life-threatening situation contact your doctor, psychiatrist, the Mental Health Hotline (472-4357) or go to the nearest emergency room.

Please let me know if you have any questions or problem with my services. It is most productive to work out concerns at the time they occur. I adhere to the ethical guidelines and practice standards published by the American Association for Marriage and Family Therapists in the AAMFT Code of Ethics. I am an LMFTA, Licensed Marriage and Family Therapy Associate (license #201226) and am supervised by Patricia Koch, Ph.D., LMFT. Questions about consumers' rights or complaints may be addressed to the Texas State Board of Examiners for Marriage and Family Therapists by telephone (512/834-6657) or by mail (1100 W. 49th St, Austin, TX 78756).

Keep a copy of Office Information for your records

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Fee Information

Policy
I have not chosen to work as a provider for insurance companies, but will furnish paperwork you may submit. You may want to contact your insurance provider and ask what your out-of-network mental health benefits are for more information about reimbursement. Please be aware that insurance companies require a diagnosis that becomes part of your insurance record.

Payment
Payment is greatly appreciated at the beginning of the appointment so that we may focus meeting time on you. I accept payment by check, cash or credit card (MC/Visa).

Initial phone consult	15 minutes	No charge
Individual Therapy	50 minutes	$85
Individual	90 minutes	$120
Couple/Family	50 minutes	$95
Couple/Family	90 minutes	$130
Telephone Contact	< 20 minutes	$20
Telephone Contact	< 30 minutes	$50
Telephone Contact	< 45 minutes	$75
Reports/Letters	< 20 minutes	$45
Reports/Letters	< 45 minutes	$80
Short Notice Cancel/No Show *		75% of regular fee

(< 24 hrs prior to appointment.
**Not covered by insurance.)*

Fees are subject to periodic adjustment.

My signature attests to the following: 1) I have read the Office Information and Fee Information forms, and consent to engage in counseling/therapy services; 2) if applicable, I authorize Asha Jane, LMFTA to release any pertinent information acquired in the course of my evaluation and treatment to my insurance company; 3) I understand I am financially responsible for non-covered services; 4) I understand that Asha Jane, LMFTA is not "on-call" after office hours or on weekends; 5) I understand that Asha Jane, LMFTA is a sole practitioner in independent practice and is not part of a group practice.

Signed_____Date_____
(Client)

Signed_____Date_____
(Client)

Keep one copy of this contract for your records. Return one copy to me.

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HIPAA Notice of Privacy
April 2003

Patient Name_____ Date of Birth_____

THIS NOTICE DESCRIBES HOW YOUR PRIVATE HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Private Health Information may be used and disclosed in the following circumstances:

1. When required for public health issues such as workman's compensation.
2. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
3. When required by any state or federal law, including abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservist, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits.

You as the patient have rights to your Private Health Information (PHI), including:

6. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.
7. The right to request information of any party that has requested information pertaining to your private health information.
8. The right to receive confidential information regarding your private health information.
9. The right to revoke this consent in writing, however, this will not affect any information already disclosed.

I, as a private practitioner have the responsibility to:

10. Make each patient aware of the Privacy Notice.
11. At any time, make the necessary changes to the Privacy Notice that are required by law.

If you as the patient feel your privacy has been violated you have the right to complain by filing a written complaint with the Secretary of Health and Human Services in Washington, D.C.

I, _____, hereby authorize Asha Jane, LMFTA to release private health

information on my behalf to the following person(s): _____

_____ _____
Patient/Legal Guardian/Signature **Date**

_____ _____
Patient/Legal Guardian/Signature **Date**

_____ _____
Witness **Date**

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Consent to the Use and Disclosure of Health Information for Treatment, Payment & Operation

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

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

I understand and have been provided with a HIPAA Notice of Privacy that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Asha Jane, LMFTA reserves the right to change her notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that my health information will not be used for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment or payment. I understand that I may revoke this consent in writing, except to the extent that Asha Jane, LMFTA has already taken action in reliance thereon.

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

_____

_____

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Witness Date

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Authorization for Communication via Email

No information is ever sent electronically without prior written permission given by you or your legally authorized representative. You have the option to communicate with me via electronic mail (email) for non-urgent matters but you should be aware this is an exception to the HIPAA Privacy Rule and requires your authorization. Although my computer is password protected, I cannot and do not guarantee the privacy or security of any messages being sent over the Internet.

Please do not use email during emergencies or when in crisis: Email may be used to request general information and ask non-urgent questions. It should not be used in emergencies. If you are experiencing a crisis, please contact the Mental Health Hotline at 512.472.4357, call 911, or go to an emergency room.

Privacy and security of email: Do not use email to send or request sensitive information, particularly personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use email provided by your employer, any email sent on your employer's system might be accessible and read by your employer and possibly others at your work place.

There is the potential that email sent over the Internet can be intercepted and read by others or read by others who might have access to your computer or email account. If this is of concern to you, you should not communicate with me by email.

Authorization to use email
I have been informed of and understand the risks involved with using email and that while Asha Jane's computer is password protected, it is not to be considered secure. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of email as one form of communication with Asha Jane, LMFTA.

Name (Print)_____ **Date**_____

Signature_____

Signature_____ **Date**_____
Asha Jane, MA, LMFTA

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Release of Information Authorization

Patient Name _____ **Date of Birth** _____ **Social Security Number**_____

To/From _____ **To/From** _____

_____ _____

_____ _____

Type of Individual Identifiable Health Information

____Psychological Assessment ____Vocational Information/Assessment ____Initial Evaluation

____School Records ____School Academic and Behavioral Data ____Termination Summary

____Progress in Treatment ____Special Education Evaluation & Records ____Treatment Plan

___Legal Information ____Medical Information ____Other_____

The Purpose for this Release:

____Legal Circumstances ____Insurance Purposes ____Continuity of Care

____Disability Determination ____Coordination of Treatment ____Vocational Rehabilitation

____Other _____

- I understand that I can revoke my authorization at any time except that disclosure has already taken place, and if not previously revoked, this authorization will expire one year from the date signed.
- I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL ABUSE or MENTAL HEALTH TREATMENT.

PROHIBITION ON DISCLOSURE
This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the
information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____ _____
Patient/Legal Guardian Signature Date ID Verified

_____ _____ _____
Patient/Legal Guardian Signature Date ID Verified

_____ _____
Witness Date