Thank you for contacting me to address some of the issues that are concerning you.

Before our first session, it is necessary to read over and complete the initial paperwork. In this packet, you will find important information regarding the scope of services, as well as information about confidentiality and payment.

Please take the time to fill out this information and bring it with you to your first visit.

The following forms are enclosed:

- **Client Information and History Form:** This provides information about you, your current concerns, and history.
- **Consent and Psychological Services Agreement:** This form indicates that you are voluntarily seeking services and what therapy entails. Please review and initial each point and sign at the bottom.
- **Health Insurance & Consent Form (for clients using insurance):** Please complete as much information as possible
- **Payment Contract for Services:** This form can be completed during our first session. It covers what the rate of each session (if you are paying out of pocket) or your portion of out of pocket payment if you are utilizing insurance (as well as benefits from your insurance company)
- **The Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information (HIPAA):** This form is standard for any healthcare provider and is required by HIPAA law. It discusses your protected health information (PHI). Please keep the three pages of the HIPAA policy for your records (pages 7-10 in this packet).

Please bring your Driver's License and Insurance Card to our first appointment so a copy can be made for your record.

I will be happy to discuss any questions that you may have during our first session.

Thank you,

Tina DiCicco Reynolds, Psy.D.
Licensed Clinical Psychologist
PY 7384

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CHILD INFORMATION & HISTORY FORM Today's Date: ____________

Child's Name: ____________________________________ Date of Birth: ________ Gender:__________________

Address: ____ Age:__________ Grade:___________________

____ Email address: ____________________________________

Parent 1 Name: __________________________________ Name of School:___________________________________

Parent 1Preferred Phone Number: ___________________ Teacher's Name:__________________________________

Parent 2 Name: ___________________________________ Who is child's legal guardian: ________________________

Parent 2 Preferred Phone Number: ___________________ Guardian Driver's License#:__________________________

Emergency Contact other than parents/guardians:

Name: ______________________________________ Relationship:____________________________________

Address: ______________________________________ Phone Number: _________________________________

____

I consent and authorize Dr. Tina DiCicco Reynolds to contact the above-designated person in the event of an emergency.

Signature: ____ Date:____________________________

Reason that you are seeking treatment for your child at this time

____

____

List any recent stress/challenges/life events ____

____

Has your child experienced any of the following in the past year?

Inattention	_____	Behavioral Problems	_____	Oppositional Behaviors	_____
Impulsivity	_____	Anxiety	_____	Aggressiveness	_____
Depression	_____	Difficulty with Peers	_____	Substance Abuse	_____
Mood Swings	_____	Weight Loss/Gain	_____	Academic Difficulties	_____
Low Self Esteem	_____	Tantrums/outbursts	_____	Other___________________________	

Medical History

Pediatrician:_______________________________________ Phone Number:___________________________

Current Medications & Dosages: ____

Allergies or other significant medical information: ____

____

Previous Therapy/Psychiatric Medications (date/reason/name)____

____

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Developmental History

Any complications or problems during pregnancy or birth:____

____

Any developmental delays? ☐ No ☐ Yes If yes, please describe: ____

____

Any current bedwetting concerns: ☐ No ☐ Yes If yes, please describe: ____

____

Any speech, hearing, or language difficulties ☐ No ☐ Yes If yes, please describe: ______________________________

____

Family History

Describe current living situation:____

____

If parents are divorced, what is custody arrangement? ____

Siblings (Names/ages):____

Briefly describe child's relationship with parents/siblings: ____

____

History of physical or sexual abuse, violence, or neglect? ☐ No ☐ Yes If yes, please describe: _____________________

____

History of psychiatric/psychological disorders on family: ☐ No ☐ Yes If yes, please describe: ______________________

____

History of substance abuse in family: ☐ No ☐ Yes If yes, please describe: ____

____

History of suicide in family: ☐ No ☐ Yes If yes, please describe: ____

____

Education History

What kind of grades does your child usually earn: ____

Placement in special classes? ☐ No ☐ Yes If yes, please describe:____

Grades repeated: ☐ No ☐ Yes If yes, please describe: ____

Behavioral problems at school: ☐ No ☐ Yes If yes, please describe: _______________________________________

____

Recreation/Social Activities/Social Support

Hobbies/Interests/Activities:____

____

How does your child get along with peers: ____

____

Any legal history: ☐ No ☐ Yes If yes, please describe: ____

____

Any concerns about substance use? ☐ No ☐ Yes If yes, please describe_____________________________________

____

Please describe any other relevant information: ____

____

____

____

Consent and Psychological Services Agreement

Please read and initial each section and sign on the bottom of the page:

_____ I am voluntarily choosing to seek psychological services for _________________________, a minor or person under my legal guardianship, with Tina DiCicco Reynolds, Psy.D. The rights, risks, and benefits associated with psychological services have been explained to me. I understand that at any time, I have the right to discontinue psychological services.

_____ I certify that I am the parent/guardian of ________________________, a minor or person under my legal guardianship, and that I am authorized to make medical decisions for this person. If any split or shared custody or shared guardianship agreement exists, I certify that I have notified the other party and they agree to this treatment. I will provide Dr. Tina Reynolds with a copy of the parenting plan and/or custody order.

_____Confidentiality of client records is protected by Federal and/or State laws and regulations. Current law requires clinicians to maintain complete confidentiality of information revealed in treatment as well as attendance or involvement in services, without written consent. Unless the disclosure is, 1) court ordered by a judge, 2) if Dr. Reynolds has reason to suspect potential for immediate harm to self or others, or 3) if Dr. Reynolds has reason to believe a child, elderly person, or handicapped adult, has been or is at risk for abuse or neglect. In any of the above-mentioned circumstances, normal assumptions of confidentiality will not apply and Dr. Reynolds is mandated by law to report these concerns

_____ Payments, copayments, and deductibles are due at the time of service. All fees are due at the beginning of each session. I understand that if I am using an insurance plan, payment by insurance company cannot be guaranteed therefore I accept responsibility for unpaid balances not covered by my insurance company.

____I acknowledge that since my appointment time has been reserved exclusively for me, I am required to cancel or reschedule appointments at least 24 hours in advance to avoid a $55 cancellation fee. I am aware that my insurance company will not pay for missed appointments.

____I understand that Dr. Tina DiCicco Reynolds does not provide on-call service. If I need to contact Dr. Reynolds between my sessions, I will leave a message and she will return my call in a timely manner. If an emergency arises, in which I believe that I am a danger to myself or others or my child may be a danger to him/herself or others, I must call 911, Henderson Mental Center Crisis Response Team (954) 463-0911, or go to the nearest emergency room.

____ I have received a copy of this form for my records.

My signature below indicates that I have read, understand, and agree to abide by the above stated policies and agreement.

____ ____________

Print Name Signature Date

My signature below acknowledges that I have received a copy of Notice of Mental Health Practitioner's Policies and Privacy Practices regarding the use and disclosure of my Protected Health Information. My signature authorizes Dr. Tina DiCicco Reynolds to bill my insurance carrier and to communicate with my insurance carrier under the limitations of the HIPAA notice.

____ ____________

Print Name Signature Date

Health Insurance Information and Consent

Patient's Name ____ Date of Birth _________________________
Primary Insurance Company____
Insurance Company Contact Number(s)____
Policy Number ____ Group Number________________________
Name of Insured _______________________________________ Insured's Date of Birth_________________
Insured's SS Number ____________________________________ Employer ____________________________
Patient's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Do you have secondary insurance? If so, please complete the following:
Secondary Insurance Company____
Insurance Company Contact Number(s) ____
Policy Number ____ Group Number________________________
Name of Insured ______________________________________ Insured's Date of Birth_________________
Insured's SS Number ___________________________________ Employer ____________________________
Patient's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

I authorize Dr. Tina DiCicco Reynolds to obtain insurance benefits, submit claims, and receive payments of medical/mental health benefits on my behalf. By choosing to use my insurance for psychological services, my practitioner may be required to release certain information to the insurance company at their request. Information, which may be requested, includes types of services, dates/time of services, diagnosis, treatment plans, descriptions of impairment, progress of therapy, and, at times case notes and summaries. If it is the case that my insurance company utilizes a managed care company, my therapist/examiner may need to discuss my treatment with a case manager. I understand that my confidentiality may be compromised in such a case. I realize that his/her doing so is a necessity in the efforts to secure ongoing care.

____ ____________________
Patient's Name Date

____ ____
Insured's Signature (If different than patient) Date

____ ____
Parent/Guardian's Signature Date

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PAYMENT CONTRACT FOR SERVICES

Name____
Address____

Person Responsible for Payment of Services Relationship to Client:____________________________
Name____
Address____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One: - Fees For Professional Services / Self Pay Arrangements
I (we) agree to pay Dr. Tina DiCicco Reynolds, a rate of $___________, per clinical session (defined as 45-50 minutes for assessment, testing and individual or family counseling. **<u>I (we) agree to pay a fee of $55 for any appointments canceled less than 24 hours prior to the appointment.</u>**

Part Two: Fees for professional services with insurance (deductible and copay agreement)
The following amounts are only an <u>estimation</u> of benefits based on what either you or your insurance company provided. There may be changes once a claim is processed by the insurance company as outlined in the explanation of benefits.

Estimated Insurance Benefits
1) Deductible Amount (Paid by Insurance Party): ______________________
2) Co payment (intake): __________
3) Copayment (f/u) sessions: _____________
4) The number of visits: ______________ per ______________
5) Authorization after ___________________

The person responsible for payment shall make payments for services, which are not paid by insurance company, all copayments, and deductibles. Insurance companies may not pay for services that they consider non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by the insurance company). If the insurance company does not pay the estimated amount then you are responsible for the balance.

Part Three: All Clients
Payments, co-payments, and deductible amounts are due at the time of service.

I hereby certify that I have read and agree to the conditions.

____ _________________
Client Name Signature Date

____ _________________
Print Name Person Responsible for Payment Signature Date
(If different)

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Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information

This Notice Describes How Health Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review This Notice Carefully.

If you have any questions about this notice, please contact our Administrator at 954-660-3522. Written requests should be addressed to: Tina DiCicco Reynolds PA, 2625 Weston Road, Weston, FL 33331

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). Please retain these pages (inclusive of this one) for your records.

ACKOWLEDGMENT OF RECEIPT OF THIS NOTICE
You will be asked to provide a signed acknowledgment of receipt of this notice. It is our intention to advise you of the permissible uses and disclosures. The services will not be conditioned upon your signed acknowledgment.

NOTICE OF PRIVACY PRACTICES
This Notice describes the types of uses and disclosures regarding your **Protected Health Information** (hereafter referred to as "PHI"); it explains how, when and why we use and disclose PHI about you; it notifies you that we may use and disclose your PHI as described in this Notice.

WHO WILL FOLLOW THIS NOTICE
This Notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who may provide "on-call coverage" for your health care provider.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION
We are required to protect the privacy of your health information that can identify you. This information is called "PHI." We understand that mental health and other health information about you is personal. We are committed to protecting PHI about you. We must protect PHI information that we created or received about your past, present, or future health condition; the services, care and treatment provided to you; or payment for your health care.

HOW MAY WE USE AND DISCLOSE PHI ABOUT YOU

For Treatment: We may use and disclose PHI about you to provide you with medical and mental health care and other related services. We may use and disclose PHI about you to provide, coordinate or manage your medical and mental health care and other related services.
− We may disclose PHI about you to doctors, nurses, technicians, or other personnel who are involved with the delivery of services provided to you.
− We may communicate with other medical, mental and other health care providers regarding your treatment, the coordination, and management of your health care with others.
− Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Health Care Operations: We may use and disclose your PHI in order to run the office and make sure that we provide quality care and reduce health care costs. Examples of the way we may use or disclose your PHI for "health care operations" include the following:
− To review and improve the quality, efficiency, treatment, services and cost of care provided to you and to evaluate the performance of staff providing services to you.
− To review and evaluate the skills, qualifications, and performance of health care providers taking care of you.

For Payment: We may use and disclose your PHI to others such as your insurance company and third party payers for purposes of receiving payment for the services rendered. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also share portions of your medical information with the following:
− Billing departments;
− Collection departments or agencies;
− Insurance companies, health plans and their agents which provide you coverage;
− Consumer reporting agencies (e.g., credit bureaus).

Appointment Reminders: We may use and disclose your PHI to contact you regarding the scheduling of an appointment, to remind you of an appointment, and to send written notification of a scheduled appointment for treatment.

Treatment Alternatives: We many use and disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services: We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you. For example, if you are diagnosed with diabetes, we may tell you about nutritional and other counseling services that may be of interest to you.

To Avert Serious Threat To Health Or Safety: We may use and disclose your PHI consistent with applicable state and federal laws and standards of ethical conduct, if we in good faith believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of a person or the public; if the disclosure is made to a person or person(s) reasonably able to prevent or lessen the threat, including the target of the threat or is necessary for law enforcement authorities to identify or apprehend an individual. Additionally, we may use and disclose your PHI when the disclosure relates to victims of abuse, neglect or domestic violence.

Child Abuse: If there is a reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that the practitioner report such knowledge or suspicion to the Florida Department of Child and Family Services.

Adult and Domestic Abuse: If there is a reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires the practitioner to report such suspicion to the Central Abuse Hotline.

Research: Under certain circumstances, we may use and disclose your PHI for research purposes, but only under contacting the Privacy Officer in writing.

Worker's Compensation: We may release your PHI for worker's compensation or similar programs as authorized by state worker's compensations laws and programs.

Public Health Activities: We may use and disclose your PHI for public health reasons in order to prevent or control disease, injury or disability; report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may use and disclose your PHI to a state or federal health oversight agency which is authorized by law to oversee our operations. These activities include audits, investigations, inspections, and licensure. These activities are required by government programs to monitor the health care system, government programs and compliance with applicable laws, including civil rights law.

Judicial Administrative Proceedings, Lawsuits And Disputes: If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. Prior to this disclosure, we must

make a good faith effort to inform you about the request or to obtain an order protecting the information requested and to follow applicable state laws.

As Required By Law: We will disclose your PHI when required to do so by federal, state or local law or other judicial or administrative proceeding.

Specialized Government Functions: If you are a member of the armed forces, we may disclose your PHI as required by military command authorities. We may use and disclose your PHI to authorized federal, foreign and other national security officials when the use and disclosure is for activities deemed necessary to assure the proper execution of the military mission or for other specialized government functions.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Examples of Other Permissible or Required Disclosures Of Health Information About You Without Your Authorization:

Business Associates: Some activities are provided on our behalf through contracts with business associates. Examples of when we may use a business associate include coding and claims submission performed by a third party billing company, consulting and quality assurance activities provided by an outside consultant, billing and coding audits performed by an outside auditor, and other legal and consulting services provided in response to billing and reimbursement issues which may arise from time to time. When we enter into contracts to obtain these services, we may need to disclose your PHI to our business associate so that the associate may perform the job which we have requested. To protect your PHI, however, we require our business associate to appropriately safeguard your information.

Communication with family members: If you are in an emergency situation involving you or another person (e.g. your minor child) and you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, Dr. Reynolds has been unable to locate you, Dr. Reynolds may, based on professional judgment and the surrounding circumstances, determine that disclose is in the best interests of you or the other person. In these emergencies, your PHI will be disclosed, but only as it pertains to the care being provided and you will be notified of the specific disclosures as soon as possible after the care is completed.

Federal law allows for the release of your PHI to appropriate health oversight agencies, public health authorities or attorneys, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. Any use or disclosure of your PHI that is not described in this notice will be made only with your written authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You Have The Following Rights With Respect To Your Protected Health Information:

Right to Inspect and Copy: You have the right to inspect and copy all or any part of your medical or health record, as provided by federal regulations. You may request and receive an electronic copy of your protected health information, or "PHI" if we maintain your PHI in an electronic health record. To inspect and copy your PHI, you must submit your request in writing to our Administrator at the address listed on the first page of this notice. The right of access to inspect and copy must be subject to and consistent with applicable laws as set forth in the Florida Statute. In addition to the Florida law requirements, the following exceptions apply: psychotherapy notes; information compiled in reasonable anticipation of or for use in a civil, criminal or administrative proceeding; or subject to the Clinical Laboratory Improvement Amendments of 1988. Instead of providing you with a full copy of your PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. If you request a copy of your PHI we may charge a reasonable, cost-based fee in accordance with state law for the costs associated with fulfilling your request. We may deny your request to inspect and copy your PHI in certain limited circumstances.

Right to Amend: You have the right to request that we amend your PHI, clinical or billing record about you if you feel that health information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we keep the information. Your request for amendment must be in writing and you must provide the basis for the requested amendment. If we accept your requested amendment, in whole or in part, we will respond in a timely manner and forward a copy of the amendments to relevant person(s), if necessary. If we deny your request for an amendment, we will respond to you in writing, stating the basis of the denial of your request.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your PHI we have made, except for disclosures made for the purpose of treatment, payment, health care operations and certain other purposes if such disclosures were made through a paper record or other health record that is not electronic, as set forth in federal regulations. If you request an accounting of disclosures of your PHI, the accounting may include disclosures made for the purpose of treatment, payment and health care operations to the extent that disclosures are made through an electronic health record. To request an accounting of disclosures, you must submit your request in writing to our Administrator at the address listed on the first page of this notice. We will, to the extent possible, mail you a list of disclosures in paper form within 60 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; such date will not be later than a total of 90 days from the date you made the request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use and disclosure of your PHI. You also have the right to request a restriction or limitation on the disclosure of your PHI to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request for restrictions, except if you pay for a service entirely out-of-pocket. If you pay for a service entirely out-of-pocket, you may request that information regarding the service be withheld and not provided to a third party payer for purposes of payment or health care operations. We are obligated by law to abide by such restriction. To request a restriction on the use and disclosure of your PHI, you must make your request in writing to our Administrator at the address listed on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limitations to apply. We will notify you of our decision regarding the requested restriction. If we do agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures as previously addressed in this Notice.

Right to Revoke Authorization: If you execute any authorization(s) for the use and disclosure of your PHI, you have the right to revoke such authorization(s), except to the extent that action has already been taken in reliance on such authorization.

Right To Receive Confidential PHI: It is our practice to contact clients at the home number and address provided to us by the client. This contact information is documented in the client records. You have the right to request that we contact you in a different manner. This request is conditioned upon two requirements 1) you must provide us with the alternative phone and address or other method of contact 2) when appropriate, information as to how the method of payment, if any, will be handled. We must accommodate reasonable requests if you clearly state that the disclosure of all or part of the information that you are requesting could endanger you.

Right To A Copy Of This Notice: You have the right to receive a paper copy of this Notice on the date you first receive service from us. In emergency situation, we will provide the Notice to you as soon as possible. We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary of Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C., 20201. You will not be penalized for filing a complaint. We will not take any action against you or change our treatment of you in any way.