



## **Gentry Pediatric Behavioral Services, PLLC Evaluation and Treatment Process**

### **IMPORTANT INSTRUCTIONS**

1. Download, print, read and fill out ALL of the forms, including:
  - Reason for Referral
  - Consent
  - Developmental History
  - Authorization to Release Information –  
Informed Consent (for therapy clients only)
2. *\*\*Fill out the Authorization to Release/Exchange information form for your child's school district if he/she is being evaluated as an Independent Educational Evaluation (IEE)*
3. Fax or Mail ALL forms back to: Gentry PBS (Intake)  
7600 N. 16<sup>th</sup> Street, Suite 110  
Phoenix, AZ 85020  
Fax- (602) 314-4175
4. Upon receiving these forms, you will receive a phone call and/or e-mail to schedule an intake/assessment appointment with our team at Gentry PBS.

During the intake portion of our meeting, we will go over all of the forms and collect important information from you regarding your child. Therefore, it is important that you bring copies of important documents, such as:

- A picture of your child
- Current IEP's
- Past Evaluation Reports
- Current/Past Behavior Plans

Thank you, if you have any questions please do not hesitate to call us at 602-368-3282.

## INITIAL INTAKE QUESTIONNAIRE

**Please print clearly and complete all items.** Write N/A for items that do not apply to you. Note any item(s) that you are unsure how to answer. Your clinician will review the form with you and answer any questions during the initial interview.

First and last name of person completing form: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Date of completion: \_\_\_\_\_

### REASON FOR REFERRAL

**How did you hear about Gentry PBS?** \_\_\_\_\_

**Provider Preference, if any:** \_\_\_\_\_

**What services are you interested in receiving from Gentry PBS?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Independent Educational Evaluation (IEE-School Pay) | <input type="checkbox"/> Counseling              | <input type="checkbox"/> Speech Therapy         |
| <input type="checkbox"/> Educational Evaluation/Learning Disability/Gifted   | <input type="checkbox"/> Parent Training         | <input type="checkbox"/> Speech/Lang Evaluation |
| <input type="checkbox"/> Diagnostic Evaluation/Anxiety/ADHD/Behavior         | <input type="checkbox"/> Behavioral Consultation |   |
| <input type="checkbox"/> Functional Behavioral Assessment (FBA)              | <input type="checkbox"/> Autism Evaluation       |   |

**Please describe why you want your child to be seen at this time?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are your goals for evaluation/treatment/consultation?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### CLIENT/CHILD INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Nickname: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender:  Male  Female

Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Language spoken at home: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_  
month / day / year city / state

Address: \_\_\_\_\_  
street / city / state / zip code

County of Residence: \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Who does the client live with?

Both parents  Mother  Father  Other (specify): \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_  
street / city / state / zip code

**PARENT/GUARDIAN INFORMATION**

**Mother/Guardian:**  Birth mother  Adoptive  Stepmother  Guardian  Other

Mother's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

check here if contact information is the same as client's, and if so, skip directly to e-mail

Address: \_\_\_\_\_

street / city / state / zip code

County of Residence: \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Occupation (if applicable): \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_

**Father/Guardian:**  Birth father  Adoptive  Stepfather  Guardian  Other

Father's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

check here if contact information is the same as client's, and if so, skip directly to e-mail

Address: \_\_\_\_\_

street / city / state / zip code

County of Residence: \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Occupation (if applicable): \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_

Parents' Marital status:

Married  Divorced  Separated  Widowed  Never married  Unknown

Please indicate date married/divorced/separated/widowed: \_\_\_\_\_

**If parents are separated/divorced, who has custody:** \_\_\_\_\_

**(please attach legal documentation)**

**Siblings:** List all full, half, stepbrothers and sisters of child, living or deceased, in birth order.

Name	Sex	Age	Relationship to Child/Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Other members living in the household:**  Yes  No

If yes, list names and relationship to the child: \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

Has anyone in your immediate family experienced any of the following in the last two years (please explain):

Moved \_\_\_\_\_  Divorce \_\_\_\_\_

Marriage \_\_\_\_\_  Separation \_\_\_\_\_

Serious illness \_\_\_\_\_  Accident \_\_\_\_\_

Death \_\_\_\_\_  Arrests \_\_\_\_\_

Any other significant events: \_\_\_\_\_

Describe any major medical or mental illness(es) in family members: \_\_\_\_\_

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### DEVELOPMENTAL HISTORY

Did mother use any of the following during pregnancy? Tobacco:  Yes  No  
Alcohol:  Yes  No  
Drugs:  Yes  No

Describe any difficulties or complications during pregnancy: \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Type of birth:  Vaginal  Caesarian Section

Please state the age at which your child did the following. If you do not remember the exact age, give the approximate age.

Motor	Language
Sat alone: _____	Age of first words: _____
Stood alone: _____	Combined 2 words: _____
Walked alone: _____	Used 3-4 word sentences: _____

Please indicate any difficulties your child has had with the following:

Toileting:  In the past  Currently  Never  
Eating:  In the past  Currently  Never  
Sleeping:  In the past  Currently  Never

When did you start to worry about your child's development? \_\_\_\_\_

Has your child been diagnosed with a special need(s)?  Yes  No

If yes, indicate: \_\_\_\_\_

Is he or she receiving any special services and by whom? \_\_\_\_\_

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### MEDICAL HISTORY

(If you need more room, feel free to add your own page)

Serious illnesses or hospitalizations?  Yes  No If yes, explain: \_\_\_\_\_

Serious head injuries or accidents?  Yes  No If yes, explain: \_\_\_\_\_

Vision Problems or glasses?  Yes  No If yes, explain: \_\_\_\_\_

Hearing Problems or hearing aids?  Yes  No If yes, explain: \_\_\_\_\_

Has your child been diagnosed with a physical condition or allergies?  Yes  No If yes, explain: \_\_\_\_\_

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Has the child ever had treatment for this?  Yes  No

If yes, when and where? \_\_\_\_\_

Has your child been diagnosed with a psychological or behavioral disorder?  Yes  No If yes, explain: \_\_\_\_\_

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Has the child/client ever had treatment for this?  Yes  No

If yes, when and where? \_\_\_\_\_

Has your child had a history of any trauma, abuse, or neglect?  Yes  No If yes, explain: \_\_\_\_\_

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List any medication or supplements child/client is receiving:

Medication	Dosage	Time(s) given

Describe any odd eating habits: \_\_\_\_\_  
Does he or she have a special diet or food allergies? \_\_\_\_\_

Previous Psychological/Psychiatric Evaluations  Yes  No

If yes, list Date, Evaluator, Location, and Reason for Testing (e.g. March 2008, Dr. Smith, Good Clinic, diagnostic evaluation):

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### SOCIAL/BEHAVIORAL HISTORY

Please select any behavioral characteristics that apply to your child:

- |   |   |
|---|---|
| <input type="checkbox"/> Aggressive           | <input type="checkbox"/> Sad or depressed |
| <input type="checkbox"/> Contact with police  | <input type="checkbox"/> Cries a lot      |
| <input type="checkbox"/> Noncompliant         | <input type="checkbox"/> Happy            |
| <input type="checkbox"/> Substance abuse      | <input type="checkbox"/> Low self-esteem  |
| <input type="checkbox"/> Distractible         | <input type="checkbox"/> Worries a lot    |
| <input type="checkbox"/> Forgetful            | <input type="checkbox"/> Fearful          |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Perfectionist    |
| <input type="checkbox"/> Overly active        | <input type="checkbox"/> Shy              |
| <input type="checkbox"/> Impulsive            | <input type="checkbox"/> Withdrawn        |
| <input type="checkbox"/> Angry                | <input type="checkbox"/> Friendly         |

Any other behavioral problems: \_\_\_\_\_  
\_\_\_\_\_

Does your child play well and socialize with other children?  Yes  No

Explain: \_\_\_\_\_

Does he or she have friends?  Yes  No

Favorite toys or activities: \_\_\_\_\_

Any preoccupations/rituals/obsessions? \_\_\_\_\_

Is your child unusually frightened by:  animals  rough children  loud noises  the dark

Does your child belong to any social groups, clubs, or sports teams?  Yes  No

If yes, please indicate: \_\_\_\_\_

**STRENGTHS OF CHILD/CLIENT AND FAMILY**

What are the child's strengths? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your family's strengths? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EDUCATIONAL HISTORY**

School the child currently attends: O Preschool Name: \_\_\_\_\_  
O Public School Name: \_\_\_\_\_  
O Private School Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Address: \_\_\_\_\_  
street / city / state / zip code

School phone number: \_\_\_\_\_ School district: \_\_\_\_\_

Name of classroom teacher: \_\_\_\_\_ Teacher's email address: \_\_\_\_\_

List all schools attended, including preschool.

School	Type of Class	Grades/Years	Dates attended (Indicate grades repeated)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child experience frequent absences from school? O Yes O No

If yes, please explain: \_\_\_\_\_

Has your child been retained? O Yes O No

If yes, please explain: \_\_\_\_\_

Ever suspended? O Yes O No

If yes, what grade(s)? \_\_\_\_\_ Why? \_\_\_\_\_

Has your child been tested at school recently? O Yes O No (If yes, please attach the report)

Has your child been identified as gifted? O Yes O No

Does your child receive special education services? O Yes O No

If yes, what is the eligibility category? \_\_\_\_\_

What services does your child receive at school? \_\_\_\_\_  
\_\_\_\_\_

Please tell us anything else you think would be helpful in understanding you or your child. Include any questions you may have.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION TO RELEASE/EXCHANGE PROTECTED HEALTH INFORMATION  
(PHI)**

\_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Print Name of Client

\_\_\_\_\_ Home Phone: \_\_\_\_\_  
Print Name of Parent/Guardian providing authorization (if applicable)

Address: \_\_\_\_\_  
Street City State Zip Code

I hereby authorize Gentry Pediatric Behavioral Services (G-PBS) to release/exchange the following confidential health information (for the purpose of continuity of care), related to the client named above via fax, phone, e-mail, or in person. With this consent, I understand that this means that confidential documents may be sent over the internet and that the internet is not always completely safeguarded and Protected Health Information could possibly be obtained by unauthorized users. I understand that this consent may be withdrawn at any time by notifying Gentry PBS, in writing, at the following address: 7600 N. 16<sup>th</sup> St., #1110, Phoenix, AZ 85020.

- Psychological  Educational  Medical  Other \_\_\_\_\_

Release/Exchange to:

\_\_\_\_\_ Phone Number \_\_\_\_\_  
Agency/School District Name and/or Professional's Name and Title

Address: \_\_\_\_\_  
Street City State Zip Code

I hereby  **authorize** the release and/or exchange, mutual use, and/or disclosure of the information indicated above, for  
 **do not authorize** these specified purpose(s), between Gentry PBS and the agencies/professionals listed above.

This authorization expires:

- on \_\_\_\_\_  
**Specify Date or Condition of Expiration**
- one year from the date signed
- upon Gentry PBS's receipt of a written request to revoke authorization (at the address below)

\_\_\_\_\_ Signature \_\_\_\_\_ Date Signed \_\_\_\_\_  
Print Name of Adult Client or Parent/Guardian

## INSURANCE INTAKE QUESTIONNAIRE

*Gentry PBS is currently in-network with Blue Cross Blue Shield and Cigna Insurance (2014)*

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_ Policy holder's DOB: \_\_\_\_\_

check box if the patient is the policy holder

Policy holder's address:

\_\_\_\_\_  
\_\_\_\_\_

Policy holder's phone number: \_\_\_\_\_

Name of insurance carrier: \_\_\_\_\_

Provider services phone number: \_\_\_\_\_

Insurance billing address: \_\_\_\_\_

ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of policy holder's employer (if applicable): \_\_\_\_\_

Group plan name: \_\_\_\_\_

Gentry PBS has permission to contact my insurance carrier named above and discuss my coverage and services provided.

\_\_\_\_\_  
Signature of patient (or legal guardian)

\_\_\_\_\_  
date

verbal consent was give over the phone \_\_\_\_\_

\_\_\_\_\_  
signature of office staff

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Office Use only:

Dx code:



# GENERAL CONSENT

I, \_\_\_\_\_, consent to  
Print Name(s) of Parent(s)/Guardian(s)/Adult Client, providing authorization  
participation in, or authorize \_\_\_\_\_ to participate in assessment\*, evaluation,  
Print Minor Client's Name  
treatment, and/or other services deemed necessary or advisable by Gentry PBS staff for those seeking to participate in Gentry  
PBS programs and/or services.

## Email Communications

\*\*I authorize the use of electronic mail for any and all correspondence with myself, including scheduling, information gathering, and for the delivery of reports and other official documents. I understand that this means that documents with protected health information may be sent over the Internet and that the Internet is not always completely safeguarded from unauthorized persons. I understand consent may be withdrawn at any time by notifying Gentry PBS, in writing, at the following address: Gentry PBS, 7600 N. 16<sup>th</sup> St, #110, Phoenix, AZ 85020.

EMAIL CONSENT	Parent 1	Parent 2
	_____	_____
	<b>Initial</b>	<b>Initial</b>

\_\_\_\_\_  
Print Name of Parent/Guardian/Adult Client

\_\_\_\_\_  
Signature of Parent/Guardian/Adult Client

Date Signed \_\_\_\_\_

**\*\*\*If Joint Decision Making, Joint Decision Making with Final Say, or if parents were never married and share custody, both parents have to sign all forms.**

\_\_\_\_\_  
Print Name of 2<sup>nd</sup> Parent/Guardian

\_\_\_\_\_  
Signature of 2<sup>nd</sup> Parent/Guardian

Date Signed \_\_\_\_\_

\* The **Intake Questionnaire**, included with this General Consent form, represents a portion of the routine assessment process.

Under the Americans with Disabilities Act, GENTRY PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, GENTRY PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that GENTRY PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: GENTRY PBS (602) 368-3282.

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Gentry PBS is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

## DISCLOSURE OF YOUR HEALTH CARE INFORMATION

### Treatment

We may disclose your health care information to other health care professionals *within* our practice for the purpose of treatment, payment or healthcare operations. On occasion, it may be necessary to seek consultation regarding your condition from other health-care providers associated with Gentry Pediatric Behavioral Services.

### Payment

We may disclose your health information to your insurance provider for the purpose of payment of health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to the Gentry Pediatric Behavioral Services for the health care services rendered. If you pay for your health care services personally, we will as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

### Workers Compensation

We may disclose your health information as necessary to comply with State Workers Compensation Laws.

### Emergencies

We may discuss your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

### Public Health

As required by law, we may disclose your health information to public health authorities for purpose related to: preventing or controlling disease, injury or disability, reporting child or elder abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

### Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

### Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

### Health Oversight Activities

We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include monitoring, audits, investigations, inspections, and licensure.

### Deceased Persons

We may disclose your health information to coroner's medical examiners.

### Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

### Research Purposes

In certain limited circumstances, we may disclose your PHI for research purposes. For example, a research project may involve the care and recovery of all enrolled persons who receive one medication for the same condition. All research projects are subject to a special approval process. We will obtain your written authorization if the researcher will use or disclose your behavioral health PHI.

### Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

#### Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

#### Marketing

We may contact you for marketing purposed or fundraising purposes, as described below:

(Example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, gifts, money, etc. During these time, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of the Gentry Pediatric Behavioral Services sponsored fund-raising events.”

#### Change of Ownership

In the event that the Gentry Pediatric Behavioral Services is sold or merged with another organization, your health information/record will become the property of the new owner.

#### Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, Gentry Pediatric Behavioral Services is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Gentry Pediatric Behavioral Services amend your protected health information. Please be advised, however, that Gentry Pediatric Behavioral Services is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of your denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Gentry Pediatric Behavioral Services.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

#### Changes to this Notice of Privacy Practices

Gentry Pediatric Behavioral Services reserves the right to amend this Notice of Privacy Practice at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Gentry Pediatric Behavioral Services is required by law to comply with this Notice.

Gentry Pediatric Behavioral Services is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact the Billing Department at 602-312-2911.

#### Complaints

Complaints about your Privacy Rights or how Gentry Pediatric Behavioral Services has handled your health information should be directed to the Billing Department by calling this office at 602-312-2911.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509HHH Building  
Washington, DC 20201

I have read Gentry Pediatric Behavioral Services - Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide Gentry Pediatric Behavioral Services with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

\_\_\_\_\_  
Print Name of Parent/Guardian/Client

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Staff Name, Title/Credentials

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

## Client Rights

A client has the following rights:

1. To be treated with dignity, respect, and consideration;
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3. To receive treatment that:
  - a. Supports and respects the client's individuality, choices, strengths, and abilities;
  - b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
  - c. Is provided in the least restrictive environment that meets the client's treatment needs;
4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;
6. To have grievances considered by a licensee in a fair, timely, and impartial manner;
7. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;
10. To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);
11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
  - a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
  - b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
  - c. For video recordings used for security purposes that are maintained only on a temporary basis; or
  - d. As provided in R9-20-602(A)(5);
12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);
13. To review the following at the agency or at the Department:
  - a. This Chapter;
  - b. The report of the most recent inspection of the premises conducted by the Department;
  - c. A plan of correction in effect as required by the Department;
  - d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and
  - e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;
14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;
15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;
16. To be offered or referred for the treatment specified in the client's treatment plan;
17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;

19. To be free from:
  - a. Abuse;
  - b. Neglect;
  - c. Exploitation;
  - d. Coercion;
  - e. Manipulation;
  - f. Retaliation for submitting a complaint to the Department or another entity;
  - g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
  - h. Treatment that involves the denial of:
    - i. Food,
    - ii. The opportunity to sleep, or
    - iii. The opportunity to use the toilet; and
    - iv. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
21. To control the client's own finances except as provided by A.R.S. § 36-507(5);
22. To participate or refuse to participate in religious activities;
23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;
24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;
25. To participate or refuse to participate in research or experimental treatment;
26. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;
27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility.

**Persons with developmental disabilities have the same rights as other US citizens including:**

- To be treated with dignity and respect.
- To expect that the personnel caring for him/her will be current in skills and knowledge of their field of employment.
- To be served without regard to age, race, color, creed, sex, nationality, ancestry and disability.
- Protection from physical, psychological, verbal, or sexual abuse
- Access to public education
- Equal employment opportunities & compensation
- Placement evaluations
- Individual Support Program Plan (ISP)
- Right to ISP notes, participate in ISP & placement decisions
- Own, sell, lease property, marry, petition
- Presumption of Legal Competency
- Residential Program clients: right to humane, clean environment, communication, visits, personal property, live in least restrictive environment
- Right to withdraw from service
- Right to be informed of rights upon admission to service

Under the Americans with Disabilities Act, Gentry PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, Gentry PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that Gentry PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: Gentry PBS (602) 368-3282.

# CLIENT FEES & REFUNDS

## Client Fees

1. Parents/Guardians/Clients are responsible for coordinating/obtaining authorization for the funding of requested services from each applicable government funding agency (e.g., DDD, BH, Private Insurance, etc.). If/when a client receives Gentry PBS services before the funding is authorized (or in the event a funding agency removes said client from its active roster), the client or the person(s) legally responsible for the client will reimburse Gentry PBS for all services provided that were not reimbursed by the funding agency.
2. Parents/Guardians/Clients are responsible to provide Gentry PBS with updated insurance documentation every January and whenever insurance information changes.
3. A non-refundable deposit is required for some programs.
4. Program fees payable by clients via cash, check, or credit card; debit cards are not accepted unless the card doubles as a credit card.

## Client Refunds

1. Individual refund requests should be made to our CEO, Dr. Joseph Gentry. Requests are reviewed on a case-by-case basis.
2. Once approved, refunds are issued via a Gentry PBS agency check, for payments made via cash or check or, for credit-card payments, refunds are credited to the client's credit card account.
3. The refund review process, including issuing approved refunds, is usually completed within 14 days of the request.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## FAMILY CONFIDENTIALITY AGREEMENT

The Gentry Pediatric Behavioral Services, PLLC is a psychological diagnosis and treatment organization that is in contact with many families each week. GENTRY PBS's mission is to provide treatment, support, and information to these families. Through the various programs offered by GENTRY PBS, families provide information of a personal and sensitive nature, under the assumption that such information will be kept confidential. *The GENTRY PBS Staff have an ethical and legal duty to do this.*

As a family member participating in a GENTRY PBS program, it is imperative that **you also** understand these issues and agree to protect the privacy of other families who are served at GENTRY PBS.

By signing this document, I agree to:

- Respect the privacy of other families served by GENTRY PBS.
- Respect the confidentiality of sensitive materials, by not discussing personal information relating to other individuals and their families obtained at GENTRY PBS with anyone not directly involved in the GENTRY PBS program that my child/children are participating in.
- Respect the privacy of other families by keeping their names and other identifying information confidential.
- Not discuss any aspect of a child's development or family's personal information with people other than GENTRY PBS staff.
- Not discuss any aspect of current research studies or past study results with people other than GENTRY PBS research staff unless and until such research results are officially released or published by GENTRY PBS.
- Never use information available at GENTRY PBS for personal purposes.

\_\_\_\_\_  
Print Child/Client Name

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian/Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of GENTRY PBS Staff

\_\_\_\_\_  
Date

Under the Americans with Disabilities Act, GENTRY PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, GENTRY PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that GENTRY PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: GENTRY PBS (602) 368-3282.



# GRIEVANCE POLICY

Should an individual(s) wish to express dissatisfaction or file a complaint with regard to Gentry PBS services or personnel a grievance may be filed in the form of a phone call, letter, or personal contact. Gentry PBS will acknowledge the receipt of each grievance. This acknowledgement may be made verbally or in writing. If the grievance is filed verbally, acknowledgement is understood. If Gentry PBS chooses to acknowledge the grievance in writing, the acknowledgement will be made within five (5) working days.

Gentry PBS staff will attempt to resolve grievances within their purview, upon receipt. If the grievance is resolved to the complainant's satisfaction, at the time of the call or personal contact, the resolution is logged and the grievance is closed.

Grievances requiring the involvement of additional time and/or Gentry PBS staff are assigned and forwarded to the appropriate staff member for further review. Gentry PBS ensures staff that make decisions on grievances are not involved in any previous level of review or decision-making. When a resolution is reached, the appropriate staff member contacts the complainant or the designated representative with the decision.

Date & Time: \_\_\_\_\_ Staff Member Receiving the Grievance: \_\_\_\_\_

Complainant: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Name of Client(s) involved: \_\_\_\_\_

Complainant's relationship to client(s) or involvement in situation: \_\_\_\_\_

Name and title of any staff members involved: \_\_\_\_\_

Describe the situation (include events leading up to and after the event/situation): *Continue on the back of this form, if necessary.*

What does complainant want to happen? \_\_\_\_\_

If grievance was not resolved, grievance was referred to: \_\_\_\_\_

Staff Comments: \_\_\_\_\_

Resolution: \_\_\_\_\_

Resolved by: \_\_\_\_\_ Date: \_\_\_\_\_

Date complainant was notified: \_\_\_\_\_  Telephone  Writing  Other: \_\_\_\_\_

Comments: \_\_\_\_\_

Under the Americans with Disabilities Act, GENTRY PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, GENTRY PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that GENTRY PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: GENTRY PBS (602) 368-3282

# **DISCHARGING A CLIENT INCLUDING AN INVOLUNTARY DISCHARGE**

Gentry PBS discharges clients from time-limited programs upon completion (graduation) of the program. A client is discharged from an open-ended service (e.g., Multidisciplinary Team for Children with Autism and other Childhood Disorders/Disabilities) when treatment goals are satisfactorily met, according to the client's treatment plan, or when the client's behavioral health issues or treatment needs are not consistent with the scope of behavioral health services that Gentry PBS is authorized or able to provide.

Gentry PBS shall ensure, at the time of discharge, that a client/family is provided a referral for treatment or ancillary services the client may need after discharge. Gentry PBS understands that most children/youth with autism spectrum disorders (ASD) and other childhood disabilities and disorders have complex medical, behavioral health, social, language, and educational needs. Programs are designed with this understanding in mind. However, on occasion, it may be necessary for Gentry PBS to involuntarily discharge a client who:

- has displayed uncontrolled aggressive outbursts,
- has displayed behavior that has been harmful to self or others,
- has displayed inappropriate sexual behaviors,
- has an active communicable disease (e.g., Tuberculosis),
- is not appropriate for, or unlikely to benefit from, the program due to age or other developmental issue,
- is excessively non-compliant with scheduled appointments
  - For Gentry PBS Programs, this includes families who are no-call/no-show for the second session in a program, or
  - For ongoing Gentry PBS services, families who have had 3 absences per quarter.

Gentry PBS shall ensure that a client/family is provided a written explanation for the involuntarily discharge, including a notification of the client/family's right to submit a grievance and a copy of Gentry PBS's grievance policy.

# MINOR - ASSENT TO TREATMENT

**Minor therapy client:** Therapy can be helpful for children and adolescents to help work through problems/concerns they or their parents/caregivers might have. It is important to be open and honest with your clinician in order to receive the most benefit from treatment.

Your clinician will make every effort to be clear about your privacy as a patient. When discussing your treatment with your parents/caregivers, your clinician will typically share general information, such as treatment goals and if you appear to be participating in treatment. Unless your clinician feels you may be at risk to harm yourself or someone else, you are engaging in very risky behavior, suspects child or elder abuse, or must break confidentiality due to another reason listed in the privacy practices above, your clinician will keep specifics of your work together private. At times, you and your clinician may agree to involve your parents/caretakers in treatment. Although your clinician will keep your information private within the limits of confidentiality, you should know it is legal in Arizona for parents/caretakers to access your treatment records.

**Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality.**

\_\_\_\_\_  
Print Name of Minor

\_\_\_\_\_  
Signature of Minor

\_\_\_\_\_  
Date Signed

**Parent/Guardian: Please initial the points below and sign your signature at the bottom to indicate your agreement to respect your child's privacy:**

\_\_\_\_\_ I will refrain from requesting detailed information about my child's individual therapy sessions. I understand however that I will be provided with updates about general progress, and/or may be asked to participate in therapy sessions as needed

\_\_\_\_\_ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the privacy of my child's treatment

\_\_\_\_\_ I understand that I will be informed about situations that could seriously endanger my child. I know this decision to breach confidentiality is up to the clinician's professional judgement

\_\_\_\_\_  
Print Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Print Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date Signed

Under the Americans with Disabilities Act, Gentry PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, Gentry PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that Gentry PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: Gentry PBS (602) 368-3282.

# **Clinician-Client Contract**

## **Informed Consent**

### **Outpatient Services Contract**

Welcome to Gentry Pediatric Behavioral Services. This document contains important information about the professional services and business policies of Gentry PBS. Please read it carefully and jot down any questions you might have so that we can discuss them at your next meeting. When you sign this document, it will represent an agreement between you and your clinician.

### **Psychotherapy**

When not covered by insurance, private pay psychotherapy services cost \$150 per hour. Psychotherapy is not easily defined in general statements. It varies depending on the personalities of the clinician and client and the particular problems you bring forward. There are many different methods your clinician might use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on the things we talked about during our session when you are on your own.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you or your child may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you or your child will experience.

Your first few sessions will usually involve an indirect assessment of you or your child's needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your intake clinician. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, this should be discussed whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

Initial \_\_\_\_\_

### **Diagnostic, Psychoeducational, and School Evaluations and FBA's**

School based evaluations, including FBA's, diagnostic, and psychoeducational evaluations are other services that can be included under this agreement. Rates for these services, if not utilizing insurance, are currently \$150 per hour, including observations, assessment and assessment scoring, teacher/parent interviews, report writing, and meeting attendance. School observations are billed at \$200 per hour due to travel time. Although the risks involved in assessment are much less than during traditional psychotherapy, the limits of confidentiality are the same, and can be read in the confidentiality section of this agreement.

Also important, it is possible that the diagnostic conclusions we make are not what you expected. Thus, while evaluation and diagnosis often opens the door for services, it may also make it more difficult to obtain services (as might be the case for a patient who does not receive a diagnosis). When completing an evaluation with a minor, their parents have a right to view the final report. Further, if their parent provides consent, the report may be shared with school personal, physicians, etc.

Initial \_\_\_\_\_

## **Meetings**

Your clinician will typically conduct an evaluation that will last the first 1-2 sessions. During this time, you and your clinician can both decide whether your clinician is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy has begun, your clinician will usually schedule one- 50 minute session per week at a time agreed on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it, unless you provide 24 hours advance notice of cancellation. If it is possible, your clinician will try to find another time to reschedule the appointment for that week.

Initial \_\_\_\_\_

## **Attendance and Scheduling**

If clients are sick (green discharge, fever, diarrhea, vomiting, etc.), please cancel your session. It is important that your clinician's stays healthy so that they don't have to cancel future sessions with you/your child and other children. If you know your child is sick, please contact your clinician as soon as possible, so other patients may be given that time slot.

Initial \_\_\_\_\_

A \$50 late cancellation fee will be charged for all sessions cancelled with less than 24 hours' notice. If this happens frequently, the clinician will meet with the family to determine what can be done to decrease the number of cancelled sessions. Termination of services may be necessary if excessive cancellations continue. \*This does not apply to cancellations due to illness. If a makeup session is scheduled and completed within one week, the late cancellation fee will be waived.

Initial \_\_\_\_\_

## **Professional Fees**

In addition to weekly appointments (fees discussed above), Gentry PBS will charge this hourly rate for other professional services you might need, though we will break down the cost if your clinician works for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 30 minutes, attendance at meetings with other professionals you have authorized (IEP meetings), preparation of records or treatment summaries, and the time spent performing any other services you request of your clinician. If you become involved in legal proceedings that require our participation, you will be expected to pay for your clinician's professional time even if they are called to testify by another party. Because of the difficulty of legal involvement, Gentry PBS charges \$300 or more per hour for preparation and attendance at legal proceedings.

Initial \_\_\_\_\_

## **Billing and Payment**

If Gentry PBS agrees to bill using an invoice, then you will receive it at the end of the month. If not, you will be expected to pay for the session at the office before you leave, unless you have insurance coverage that requires another arrangement. If you are using your insurance, be sure to pay any co-payment before leaving the office. Finally, if you are seen in your home, you will be billed using a monthly invoice that will be sent to your address. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, Gentry PBS may be willing to negotiate a fee adjustment or payment installment plan.

**If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Gentry PBS has the option of using legal means to secure the payment.** This

may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the service provided, and the amount due.

Initial \_\_\_\_\_

**Insurance Reimbursement – When and if your clinician is in contract with any companies.**

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Gentry PBS will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of your fees. It is important you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Gentry PBS will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, Gentry PBS will be willing to call the company on your behalf.

Due to the rising cost of health care, insurance benefits have increasingly become more complex. It is difficult to determine exactly how much mental health coverage is available. Managed health care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize your clinician to provide them with a clinical diagnosis. Sometimes your clinician will have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become a part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, Gentry PBS has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical databank. Your clinician will provide you with a copy of any report submitted if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember you always have the right to pay for our services yourself to avoid the problems listed above, unless it is prohibited by the contract.

Initial \_\_\_\_\_

**Contacting Us**

Gentry PBS clinician's are often not immediately available by telephone. While we are usually working between the hours of 9 A.M. and 5 P.M., we will probably not answer the phone if we are with a client. When your clinician is not available, we suggest you leave a message on their voicemail, which we all check regularly. Your clinician will make every effort to return your phone call within 24 hours with the exception of weekends and holidays. If you are difficult to reach, please inform your clinician of

times you will be available. If you are unable to reach your clinician and feel you can't wait for him/her to return your call, contact your family physician or the nearest emergency room and ask for the clinician/psychologist/psychiatrist on call. If your clinician will be unavailable for an extended holiday, they will provide you with the name of a colleague to contact, if necessary.

Initial \_\_\_\_\_

### **Professional Records**

The law and standards of our profession require that your clinician keep treatment records. You are entitled to receive a copy of your records, or your clinician can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in your clinician's presence so that the contents can be discussed. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Initial \_\_\_\_\_

### **Minors**

If you (patient) are under 18 years of age, please be aware that the law might provide your parents with the right to examine your treatment records. It is Gentry PBS's policy to request an agreement with parents that they give up access to your records. If they agree, your clinician will provide them only with general information about your work together, unless he/she feel there is a high risk that you will seriously harm yourself or someone else or you are being harmed. In this case, your clinician will notify them of their concern. They will also provide them with a summary of your treatment when it is complete. Before giving them any information, your clinician will discuss the matter with you, if possible, and do their best to handle any objections you may have about what he/she is prepared to discuss.

Initial \_\_\_\_\_

### **Confidentiality**

In general, the law protects the privacy of all communications between a client and a psychologist, and your clinician can release information to others only with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent your clinician from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your clinician's testimony if he or she determines that the issues demand it.

There are some situations in which your clinician is legally obligated to take action to protect others from harm, even if they have to reveal some information about a client's treatment.

- For example, if your clinician believes that a child, elderly person, disabled person, etc. is being abused, they must file a report with the appropriate state agency.
- If your clinician believes a client is threatening serious bodily harm to another, they are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- If the client threatens to harm himself or herself, your clinician may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection.

These situations rarely occur in our practice. If a similar situation occurs, your clinician will make every effort to fully discuss it with you before taking any action. Your clinician may occasionally find it helpful

to consult other professionals about a case. During a consultation, they make every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential. If you don't object, your clinician will not tell you about these consultations unless he/she feels it is important to your work together.

While this written of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you and your clinician discuss any questions or concerns that you may have. He/she will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and your clinician is not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during your clinician-patient professional relationship.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed  
Name \_\_\_\_\_



# Acknowledgement of Receipt of Information

I/We, \_\_\_\_\_,  
Print Name(s) of Parent(s)/Guardian(s)/Client, acknowledging receipt of information

acknowledge the receipt of the following:

- 1) Notice of Privacy Practices**
- 2) General Consent for Services**
- 3) Clinician – Client Contract and Informed Consent**
- 4) Gentry PBS’s Fees & Refunds Policy**
- 5) Family Confidentiality Agreement (if applicable)**
- 6) Consent form(s) for audio, video, photographs (if applicable)**
- 7) Minor Assent to Treatment Form (if applicable)**
- 8) An explanation of client rights
- 9) Gentry PBS’s Grievance Policy

❖ Please **complete, sign, and date** items 1-7, in **bold**, and **return** them to Gentry PBS.

\_\_\_\_\_  
Print Name of Parent/Guardian/Client

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date Signed

***If Joint Custody, second parent has to sign as well below.***

\_\_\_\_\_  
Print Name of Parent/Guardian/Client

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date Signed