PATRICIA KOCH, Ph.D., LICENSED PSYCHOLOGIST
3103 Bee Cave Road, Suite 101, Austin, TX 78746
(512) 371-7221 (office/fax) (512) 773-3923 (cell) wellbeing@drpatkoch.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_____Today's Date_____

Sex_____ Date of Birth_____ Age_____ Race _____

School attendending_____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?_____ Age of child when adopted_____

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 step-parents:

Name_____Relationship_____
_

Name_____Relationship_____
_

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 (either in person or by mail and 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._____

_____

_____

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

Birthweight:_____. 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 lst year:

_____feeding	_____sleeping	_____breathing
_____colic	_____bowel/urinary habits	_____intolerance of affection
_____crawling	_____inability to be consoled	_____sitting unassisted
	_____emotional responsiveness	

Please specify any other significant problems during this period: _____

_____

_____

Who cared for child during the first year?_____

_____

TODDLERHOOD (12 to 36 months)

Check if applicable, any significant problems, delays, and/or difficulties:

_____walking unassisted	_____feeding self	_____first words
_____severe temper tantrums	_____using sentences	_____entertaining self

_____self destructive behavior _____toilet training _____overactivity
_____stranger anxiety

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:

_____impulsive
_____nervous/fearful
_____severe temper tantrums
_____destroying property
_____self-destructive habits
_____overactivity
_____obeying
_____bowel/urinary habits
_____prolonged sadness or irritability
_____reading skills
_____writing skills
_____math skills
_____school failure
_____completing tasks
_____cooperating in group activities
_____very shy
_____aggressive

Please specify any other significant problems:_____
_____

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

_____prolonged sadness or irritability
_____gang membership
_____academic failure
_____drug and alcohol use
_____temper outbursts
_____truancy
_____aggressive
_____impulsive
_____sexually active
_____fighting
_____delinquency
_____social isolation
_____pregnancy
_____running away

Please specify any other significant problems:_____

_____

MEDICAL/HEALTH HISTORY
Check if applicable any of the following health problems your child has had:

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

*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?
_____

_____

_____

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? _____

_____

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 which concern you (nail-biting, bedwetting, drugs, truancy, etc.)?

_____

Who watches your child after school hours?
_____

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.

_____

_____

_____

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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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 comfort and safe. Please let me know if there is anything I can do to help you feel more comfortable.**

· The first appointment is generally an **Initial Evaluation** and lasts approximately one to one and a quarter hours. Prior to the first visit, please complete the appropriate forms as they provide information for the first meeting. You can send those forms back or bring them with you on your first visit.

· The information you share with me is confidential and this information 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 the psychologist for purposes of "covering" for me when I am unavailable or 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.

· 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 full fee. This fee is payable before or at the time of the next appointment. The client, not the insurance carrier, is responsible for this charge. Payment is expected at the time of service. I accept cash, checks, and Visa and Mastercard credit cards.

· 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. Managed care/insurance plans are often complicated, and I share what I know to help guide you in understanding what services and costs your plan accepts. Ultimately, it is your responsibility to know and manage your benefits. 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) 773-3923. In 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. The ethical guidelines and practice standards published by the American Psychological Association and the American Association of Marriage and Family Therapists are adhered to in my practice. Questions about consumers' rights may be addressed to the Texas State Board of Examiners of Psychology (512/305-7700) and The Texas State Board of Examiners for Marriage and Family Therapists (512/834-6657)..

Keep a copy of this for your records

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Fee Information

The following is a list of my fees for psychological services:

Diagnostic Assessment/Intake Assessment	(90791)	$170
Individual Therapy 45 minutes	(90834)	$130
Family/Couples Therapy 50 minutes	(90847)	$150
Individual Therapy 30 minutes	(90832)	$ 75
Individual Therapy 60 minutes	(90808)	$150
Individual/Family Therapy 90 minutes		$200
Group Therapy 90 minutes	(90853)	$ 50
Neurofeedback in 10 session packets		$1200
Coaching 60 minutes		$130
Reports, letters up to 20 minutes		$ 50
Reports, letters up to 45 minutes		$100
Telephone Contact < 15 minutes		$ 35
Telephone Contact < 30 minutes		$ 60
Telephone Contact < 45 minutes		$ 85
Court or Deposition Services (per hour)		$250
No Call/No Show w/out 24 hour notice		75 % of full fee
(Insurance does not cover this cost)		

These fees do not reflect any contracted discounts with managed care plans or individuals. The total fee, or the agreed upon co-payments are due at the time of service unless alternative arrangements have been made.
****

My signature attests to the following: 1) I have read the Office Information and Fee Information forms, and I consent to engage in psychological services; 2) I authorize Patricia Koch, Ph.D. to release any pertinent information acquired in the course of my evaluation and treatment to my insurance company; 3) If pertinent, I authorize my insurance benefits to be paid directly to Patricia Koch, Ph.D., and I understand I am financially responsible for non-covered services; 4) I understand that Patricia Koch, Ph.D. is not "on-call" after office hours or on weekends; 5) I understand that Dr. Koch 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.

REGISTRATION INFORMATION

Please Print Date_____

Last Name First Name MI

Street Address Apt. No City State Zip

Social Security No. Sex Date of Birth Home Phone Cell Phone

Employer Occupation Work Phone E-mail

PRIMARY INSURANCE INFORMATION

Insurance Company/Plan Group No. Member Identification Number

Insurance Claim Address Insurance Phone No. Effective Dates
Self Spouse Dependent Other

Policyholder Last Name First Name MI Relationship to Policyholder

Policy holder Street. Address Apt. No. City State Zip

Policyholder Employer Occupation Date of Birth Sex

Policyholder Home Phone Policyholder Work Phone Other Phone

SECONDARY INSURANCE INFORMATION

Insurance Company/Plan Group No. Member Identification Number

Insurance Claim Address Insurance Phone No. Effective Dates
Self Spouse Dependent Other

Policyholder Last Name First Name MI Relationship to Policyholder

Policy holder Street. Address Apt. No. City State Zip

Policyholder Employer Occupation Date of Birth Sex

Policyholder Home Phone Policyholder Work Phone Other Phone

EMERGENCY CONTACT

Last Name First Name Home Phone No. Work Phone No. Other Phone

Street Address Apt. No. City State Zip

Patricia Koch, Ph.D. Licensed Psychologist
HIPAA Notice of Privacy

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, including,

1. **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.**
2. **The right to request information of any party that has requested information pertaining to your private health information.**
3. **The right to receive confidential information regarding your private health information.**
4. **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:

1. **Make each patient aware of the Privacy Notice.**
2. **At any time make the necessary changes to 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 Patricia Koch, Ph.D. to release private health information on my behalf to the following person(s): _____

_____ _____

Patient/Legal Guardian/Signature **Date**

_____ _____

Witness **Date**

Patricia K. Koch, Ph.D.
Licensed Psychologist

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, & OPERATION

I understand that as part of my healthcare, Patricia Koch, Ph.D. 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 Patricia Koch, Ph.D. 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 Patricia Koch, Ph.D. 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

_____ _____

Witness Date

Patricia K. Koch, Ph.D.
Licensed Psychologist

Consent to E-Mail

In order to comply with HIPAA law, I am required to inform you that while my computer is password protected, my E-mail is not considered to be secure.
If you would like to communicate with me via my E-mail, you are required to provide informed consent.

I understand that my E-mail communications with Patricia Koch, Ph.D. are not considered secure. However I would like to communicate with her via E-mail.

_____ _____
Patient/Legal Guardian Date

_____ _____
Witness Date