NOTICE OF PRIVACY PRACTICES

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

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all records of your care generated by a provider of Psychological Health-Roanoke.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe examples of the way we use and disclose health information:

For Treatment:

We may use health information about you to provide treatment or services and continuity of care with other healthcare providers.

For Payment:

We may use and disclose health information about your treatment and services to bill and collect payment from you, or a third party payer. We may also tell your health plan about treatment you are going to receive to determine whether your plan will pay.

For Health Care Operations:

- To remind you that you have an appointment for medical care
- To tell you about health-related benefits or services

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Future Communications:

We may communicate to you via newsletters, mail outs or other means regarding treatment options and health related information.

Law Enforcement/Legal Proceedings:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Psychological Health- Roanoke you have the **RIGHT TO**:

Inspect and Copy:

You have the right to inspect and obtain a copy of the health information used to make decisions about your care. We may deny your request to inspect and copy in certain circumstances. If you are denied access you may request that the denial be reviewed. Another licensed health care professional chosen by Psychological Health-Roanoke will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Please turn over

Amend:
If you feel that your health information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Psychological Health-Roanoke. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures:
You have the right to request an accounting of disclosures. This pertains to disclosures we make of your health information for purposes other than treatment where an authorization was not required.

Request Restrictions:
You have the right to request a restriction or limitation on the health information we use or disclose about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. **We are not required to agree to your request**. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment.

Request Confidential Communications:
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. Psychological Health-Roanoke will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services and related correspondence. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of This Notice:
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE
We reserve the right to change this notice at any time.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with Psychological Health-Roanoke. You may also file a complaint with the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that provided to you.

Psychological Health-Roanoke-MINOR REGISTRATION

Date: _____ Home Phone: _____
Cell Phone: _____
Email:_____

Patient: _____
First Middle Last
Address _____
Street and PO Box
_____
City State Zip Code

Age _____ Birth Date _____ Social Security # _____

Responsible Party _____ DOB:_____
Social Security #_____ Relation to patient:_____
Employer/Address _____
Occupation: _____ Employer Phone _____

If custody is shared both responsible parties need to be listed:
Responsible Party _____ DOB:_____
Home Address (if different from above):_____
Home #:_____Cell#:_____(if different than above)
Social Security #_____ Relation to patient: _____
Employer/Address _____
Occupation: _____ Employer Phone _____

Do you have Medical Insurance? **Yes, please provide a copy to the receptionist at time of check-in.**
If No, then payment is due in full date of service.

REQUIRED INFORMATION:
In case of emergency, who should be notified? _____ Phone: _____
Relation to patient:_____

I authorize treatment deemed necessary by the health care providers of Psychological Health- Roanoke.

A law enacted in Virginia in 1989, authorizes health care providers to test their patients for HIV antibodies and other blood borne pathogens when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV) and other blood borne pathogens. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies and other blood borne pathogens and the testing would be explained. You could ask any questions you might have at that time.

I authorize Psychological Health-Roanoke to release to my health plan any and all information which it deems necessary regarding my care and treatment to insure prompt payment of all charges for services provided. I herby assign the payment of all insurance benefits to Psychological Health- Roanoke for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Psychological Health-Roanoke for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicare or Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due within thirty days of receipt of a statement.

In consideration of the services rendered and to be rendered pursuant to my request for medical services from Psychological Health- Roanoke, I hereby waive any right to a jury trial should Psychological Health-Roanoke have to file suit to collect my account.

METHODS OF PAYMENT:

Our office accepts the following payment methods:

Cash, Personal Check and Credit Cards.

For returned checks we assess a $50.00 NSF charge, and report to the local Commonwealth attorney's office checks that are not paid within 2 weeks of being returned to our office.

If fees are not paid, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The parties agree that all claims, disputes and other matters of action shall be brought within and decided in the Commonwealth of Virginia.

You agree, in order for us to service our account or to collect any amounts you may owe, that we may contact you by telephone at any telephone number associated with you account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THIS INFORMATION.

_____ _____

Responsible Party for Minor Date

Psychological Health- Roanoke
Informed Consent for Treatment

Confidentiality

Clinicians and staff in Psychological Health-Roanoke value the patient-therapist and patient-physician relationships and strive to keep all information confidential. We only release information to others with your written permission.

Here are some important exceptions to this confidentiality of which we want you to be aware. These include:

- Suspected child abuse or neglect
- Suspected abuse or neglect of an elderly or incapacitated adult
- Patient is thought to be an immediate threat to self or others
- Court-ordered releases with regard to legal actions
- Misconduct by a health care provider
- Workers Compensation
- If you are licensed or certified by a health regulatory board or hold a multistate license, and your condition places you or the public at risk

Other Matters Related to Confidentiality

- It may occasionally be helpful or necessary to consult about a patient with another professional. In these consultations, the physician/therapist makes every effort to avoid revealing the identity of the patient. The consultant is, of course, also legally bound to maintain confidentiality.
- If insurance reimbursement is requested, we are required to provide the insurer relevant information such as diagnosis and/or treatment plan.
- If the patient is under eighteen years of age, please be aware that while the specific content of therapy is confidential, parents have a right to receive general information on the progress of the treatment and have legal access to the record.

I understand that my therapist will discuss my diagnosis as well as the method of treatment. The nature of the treatment has been described to me as well as possible side effects and alternative forms of treatment. I understand I may withdraw from treatment at any time, but if I decide to do this, I will discuss my plan with this physician/therapist before acting on it.

The physician/therapist has further discussed with me scheduling policies, fees to be charged, and matters relating to insurance, and if applicable, preauthorization and utilization review issues.

If you need to change an appointment, please give us a minimum 24 hours notice. We reserve the right to assess service charge to patients who break or fail to attend their appointment commitments with us and who fail to give us at least 24 hours notice of their intention to do so. Follow-up appointments will only be made when any outstanding co-payment balance is paid.

I have read the above; fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the fees, and the limits of confidentiality and give consent for treatment.

I acknowledge that I have been given the Psychological Health-Roanoke Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

Patient: _____ Date: _____

Provider: _____ Date: _____

PATIENT'S RIGHTS AND RESPONSIBILITIES

Statement of Patient Rights

*Patients have the right to be treated with dignity and respect.
*Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability or source of payment.
*Patients have the right to have their treatment and other information kept private.
*Only in life-threatening situations or if required by law, can records be released without a signed consent from patients.
*Patients have the right to information from staff/providers in language they can understand.
*Patients have the right to an easy to understand explanation of their condition and treatment.
*Patients have the right to know all about their treatment choices regardless of cost coverage.
*Patients have the right to get information about services offered by their providers and patient role in the treatment process.
*Patients have the right to request professional information about their provider.
*Patients have the right to know the clinical guidelines used in providing and/or managing their care.
*Patients have the right to provide suggestions on office policies and procedures.
*Patients have the right to complain and to know about their complaint, grievance and appeals process.
*Patients have the right to know State and Federal laws governing their rights and responsibilities.
*Patients have the right to participate in the formation of their plan of care.

Statement of Patient Responsibilities

*Patients are responsible for providing their medical provider with information needed to deliver quality care.
*Patients are responsible for informing their provider when/if their treatment plan is no longer effective.
*Patients are responsible to follow their treatment plans and to inform their provider of any changes to the treatment plan made by other providers including any changes in their medications.
*Patients are responsible for reviewing their care and treatment plans continuously and reporting effectiveness or ineffectiveness of the care plan to their provider.
*Patients are responsible for treating those giving them care with dignity and respect.
*Patients should not be involved in any conscious behavior that could endanger the safety of their provider, office staff or other patients.
*Patients are responsible for keeping their appointments, arriving on time and notifying the office of any cancellation at least 24 hours prior to the appointment.
*Patients are responsible for addressing questions about their care to their provider and ensure understanding of their care and their role in the treatment process.
*Patients are responsible for notifying their provider of any concerns regarding payment or insurance coverage.

I understand my rights and responsibilities as stated above.

_____

Patient Signature ***Date***

Psychological Health Roanoke
Financial Policies

Name _____

Failed Appointment and Late Cancellation Policy

WE ASK THAT YOU GIVE 24 HOURS NOTICE IF YOU INTEND TO CANCEL AN APPOINTMENT.

Appointments cancelled with less than 24 hours notice and appointments not kept will result in a mandatory $25 scheduling charge unless there is illness or an emergency. Your therapist may also bill you for your missed or cancelled appointment. Your insurance will not pay for missed or cancelled appointments. Please discuss this policy with your therapist.

Co-Payment Policy

Insurance companies **require** us to collect applicable co-payments at **every** visit. If a co-payment is missed, it is to be paid at your next visit. **Failure to pay two consecutive co-payments will result in your not being able to schedule future appointments until paid.**

Collection Policy

Please note that all accounts 90 days in arrears are subject to be submitted to a collection agency. The amount will include the balance owed plus all collection agency fees.

I understand the Policies described above.

_____ _____

Signature Date

PSYCHOLOGICAL HEALTH ROANOKE, PC
2840 Electric Road, Suite 200
Roanoke, VA 24018
Tel: 540-772-5140 Fax: 540-772-5157

PARENT/GUARDIAN CONTRACT

_____ _____
Client's Name Date of Birth

I/We have requested that Psychological Health Roanoke provide evaluation and treatment for my child, named above.

I/We have read the Office Policy Statement and the handout on Confidentiality and agree to adhere to the policies explained in these handouts.

I agree that to protect the confidential nature of my child's psychotherapy I will not call the treating therapist as a witness in any custody, visitation, support or other subsequent court proceedings. I have been advised that evaluations pertaining to custody issues should be done by neutral evaluators who assess all parties involved and that the child's therapist precludes acting as custody evaluator.

I understand that the charge will be $135 for the initial session and $101 for subsequent 45 minute sessions. This may differ as determined by your insurance company. Psychological Testing is billed at $143 per hour including time for scoring and interpretation. There will be a charge of $101 per hour for other professional services not covered by insurance. This includes report writing, telephone conversations lasting longer than 10 minutes, consultations and any other service you request. I understand that payment is due when the services are rendered. I have been informed that if for any reason there is an outstanding balance over 90 days, PHR will take action to collect this balance and I will be responsible for any additional collection fees and costs. By my signature below I attest that I will be responsible for these charges.

If at any time I/we decide that therapy is not benefitting my/our son/daughter, I/we agree to notify Psychological Health Roanoke in writing that the therapy is to be terminated. I/We agree to assume financial responsibility for all charges incurred. I/We also agree to discuss termination of therapy and termination of my/our financial responsibility for it with my/our son/daughter so that he/she will understand the reason(s) for these decisions.

_____ _____
Date Relationship & Signature of Parent/Guardian

If parents have joint legal custody, both parents need to sign permissions for their child to be seen here. A copy of this contract and the applicable handouts can be provided for the other parent.

Non-Subpoena Contract for Clients in Couple, Family, or Child/Parent Therapy

ALL PARTIES ACKNOWLEDGE THAT THE GOAL OF PSYCHOTHERAPY IS THE AMELIORATION OF PSYCHOLOGICAL DISTRESS AND INTERPERSONAL CONFLICT, AND THAT THE PROCESS OF PSYCHOTHERAPY DEPENDS ON TRUST AND OPENNESS DURING THE THERAPY SESSIONS.

It is understood that no party shall attempt to subpoena PHR or the treating therapist's records for a deposition or court hearing of any kind for any reason.

Therefore, it is understood by all parties that if they request services from PHR, they are expected not to use information given to during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind.

Further, any testimony that interested parties may request will be met with "I respectfully choose not to answer on the basis of therapist-client privileged communication," pursuant to:

> **Virginia State Law Sec. 8.01-399. Communications between physicians and patients (Supreme Court Rule 2:505).**
>
> **A. Except at the request or with the consent of the patient, or as provided in this section, no duly licensed practitioner of any branch of the healing arts shall be permitted to testify in any civil action, respecting any information that he may have acquired in attending, examining or treating the patient in a professional capacity.**

Any action to be taken to uphold this agreement and the integrity of the client/therapist relationship will result in all applicable fees and expenses. These fees and expenses include, but are not limited, to legal fees, fees for PHR staff time, phone calls, face to face meetings, and time away from the office. Any additional applicable fees and expenses incurred by any PRH staff member will also be assessed and charged.

Signed and Dated _____

Signed and Dated_____

Signed and Dated_____

Signed and Dated_____

Psychological Health Roanoke PC

Patient Name_____

Date _____ DOB _____

Release for Coordination With Primary Care Physician:

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time. **Name of Primary Care Physician**

_____

☐ **I do not have a Primary Care Physician.**

(Check One) I do ☐ I do NOT ☐ give permission to the practitioner named above to exchange information about my current treatment with my primary care physician.

SIGNATURE IS REQUIRED

Patient (Guardian) Signature_____ Date _____

Signature of Witness _____ Date _____

Below this line is to be completed by
Psychological Health Roanoke Clinician

To:_____
_____
_____

Dear Dr. _____:
In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on _____ for treatment of _____.

Current recommendations for the type and setting of treatment include:

( ) Individual Psychotherapy **( ) Evaluation**
( ) Family Psychotherapy **( ) Intensive Outpatient Program**
( ) Group Psychotherapy **( ) Partial Hospitalization Program**
( ) Inpatient Unit

Comments:_____
_____

If you need any further information, please contact me at 540-772-5140 or fax at 540-772-5157.

Sincerely,
Clinician: _____

Psychological Health Roanoke PC

Patient Name_____

Date _____ DOB _____

Release for Coordination With Psychiatrist:

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my psychiatrist. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time.

Name of Psychiatrist

_____

☐ **I do not have a psychiatrist.**

(Check One) I do ☐ I do NOT ☐ give permission to the practitioner named above to exchange information about my current treatment with my Psychiatrist.

SIGNATURE IS REQUIRED

Patient (Guardian) Signature_____ Date _____

Signature of Witness _____ Date _____

Below this line is to be completed by Psychological Health Roanoke Clinician

To:_____

_____

_____

Dear Dr. _____:

In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on _____ for treatment of _____.

Current recommendations for the type and setting of treatment include:

( ) Individual Psychotherapy **( ) Evaluation**

( ) Family Psychotherapy **( ) Intensive Outpatient Program**

( ) Group Psychotherapy **( ) Partial Hospitalization Program**

( ) Inpatient Unit

Comments:_____

_____If you need any further information, please contact me at 540-772-5140 or fax at 540-772-5157.

Sincerely,

Clinician: _____

Patient #_____

Psychological Health-Roanoke
Child Intake

Child's Name _____ Date of Birth _____ Age _____

Address _____ Sex ____ Race _____

Street

_____

City State Zip Code County

Parent (s) or Guardian (s) _____

Home Telephone # _____ Message # _____

Work- Mother _____ Father_____ _____

Who referred you here? Name, Address & Relationship to Child

_____

Has the child been seen at Lewis-Gale Psychological Health or Psychological Health-Roanoke?

_____ If yes, when? _____

Signature of person completing this form- _____

Relationship to child _____ Date _____

I. FAMILY HISTORY

Father's Name _____ Date of Birth _____

First Middle Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other vocational training _____

Mother's Name _____ Date of Birth _____

First Middle Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other vocational training _____

Marital status of parents _____ Marriage date _____

Date divorced, if applicable _____ Death of parent, if applicable _____

How long has the family lived at the current address? _____

Where else has the family lived during the child's life?

_____

_____

List all persons living in the home:

Name Age Relationship to child

_____

_____

_____

_____

II. PARENTAL CONCERNS

What do you think is your child's main problem?

_____

_____

_____

What have you been told by doctors, teachers and/or others about you child's problem?

_____

_____

_____

What do you expect or hope to have happen as a result of an evaluation with this clinic?

_____

_____

What have you done to resolve the current problem?

_____

_____

III. PREGNANCY HISTORY

Did the mother:	Yes	No	What Month	Complications/Medications
Drink alcoholic beverages (Indicate how much)	___	___	_____	_____
Smoke (Indicate how much)	___	___	_____	_____
Take medications or drugs (Other than vitamins/iron)	___	___	_____	_____
Have other illnesses or medical problems	___	___	_____	_____

IV. BIRTH INFORMATION

Length of pregnancy _____ Length of labor _____ Was labor induced? _____

Birth was: Normal _____ Cesarean _____ Breech _____ Twins or more _____

Were forceps used? _____ Did mother have complications? _____

If yes, please specify:

_____

Birth weight _____ How long did baby stay in the hospital after birth? _____

Did baby need medical assistance in starting to breathe? _____ _____

Other complications? _____ If yes, please specify:

_____

V. CHILD'S GROWTH AND DEVELOPMENT

1. Motor Skills: (Write "not yet" where appropriate)

At what age did your child:

Smile _____ Roll over _____ Sit without support _____ Crawl _____

Pull to standing _____ Walk alone _____ Pedal a tricycle _____

What concerns, if any, do you have about your child's motor development?

_____

2. Language and Hearing: (Write "not yet" where appropriate)

Do you feel your child hears: Well _____ Poorly _____ Not at all _____

Inconsistently _____ Uncertain _____

Does your child communicate mostly by: Gestures _____ Words _____ Crying _____

Phrases _____ Sentences _____

Has your child ever had PE tubes? _____ At what ages? _____

What age did your child: Make single sounds _____ Use words _____

Combine words to make sentences _____

Did your child begin to use words and then stop? ____ At what age? ____

What concerns do you have about your child's speech, language or hearing?

_____

_____

3. Feeding: (Write "not yet" where appropriate)

Was your child bottle fed? ___ Breast fed? _____

For his/her age, is your child: Average ____ Underweight ___ Overweight _____

Has you child had any problems with:

Feeding ___ Chewing ___ Teeth ___ Swallowing ___

What eating problems or unusual food habits does your child have?

_____

_____

4. Personal/Social: (Write “not yet” where applicable)

At what age did your child: give up the bottle _____ feed him/herself _____

Drink from a cup _____ dress him/herself _____

At what age was he/she: bladder trained _____ bowel trained _____

VI. MEDICAL HISTORY

Has your child ever been seriously ill? ___ If yes, with what_____

_____

Has your child ever been hospitalized? ___ If yes, why? _____

_____

When:_____ Where: _____

(Name and address of hospital)

List all medications your child currently takes, amounts and reason for taking:

Medicine Amount Reason

_____

_____

_____

Check any of the following which pertain to your child, indicating age and complications.

	Age	Complications		Age	Complications
___Meningitis	___	_____	___Seizure	___	_____
___Fainting spells	___	_____	___Headaches	___	_____
___Visual problems	___	_____	___Ear Infections	___	_____
___ Developmental Delay	___	_____	___ Other (Specify)	___	_____

VII. FAMILY HISTORY

Complete the following table for all of the mother's pregnancies in chronological order, including any miscarriages or stillbirths. (Please write on back if additional space is needed).

Name	Date of Birth	Birth Weight	Length of Pregnancy	Length of Labor	Problems at Birth	Any physical, emotional, behavioral, or educational problems?

Please note below if any of the child's relatives have had any of the following conditions (For example, brother, aunt, cousin, grandparent).

	Relationship To Child		Relationship To Child
Convulsions	_____	Cerebral Palsy	_____
Hearing Loss	_____	Mental Illness	_____
Mental Retardations	_____	Speech Problems	_____
School Difficulties	_____	Muscular Weakness	_____
Visual Impairment	_____	Deformities	_____
Alcoholism	_____	Emotional Problems	_____
Overactivity, attention problems	_____	Other	_____

Describe any of the above _____

_____

What stressors have impacted your family recently? (i.e. deaths, marital conflicts, etc.)

_____

_____

VIII. BEHAVIOR

What problems are you experiencing with your child's behavior?

_____

_____

Who else (i.e. school, sitter) is having problems with your child's behavior?_____

_____

_____

IX. SCHOOL HISTORY

If your child has been to school, please complete the following, beginning with nursery/day care and ending with current placement. (If more room is needed, please use the other side of this page).

School	Address	Grade or Class Placement	Dates of Attendance

Have you requested testing from the school? ___Yes ___ No

Is any testing scheduled? ___ Yes ___ No If yes, when? _____

X. PLEASE LIST THE NAMES AND ADDRESSES OF OTHER PROFESSIONALS WHO HAVE WORKED WITH YOU AND YOUR FAMILY.

	Name	Complete Address
Pediatrician	_____	
Mental Health Professional	_____	
Specialist (specify)	_____	

FOR CLINICIAN USE ONLY:

DX: _____

_____

_____

GOALS:

1. _____

2. _____

3. _____

4. _____