CADENZA CENTER FOR PSYCHOTHERAPY & THE ARTS, INC.

CHILD INTAKE

Date:____/_____/_____

Name:_____Date of Birth:____/____/_____

Age:_____ School: _____ Grade: _____

PRIMARY LANGUAGE: □ English □ Spanish □ Other
_____

Address:_____

City/State/Zip:_____

Phone: Home: (_____)_____-_____ Work:(_____)_____-_____ Cell:(____):_____-_____

E-mail: _____Phone # for session reminder: _____

Emergency Contact: Name:_____ Phone:(____)_____-_____

Presenting Problem: _____

_____

_____

Services requested: _____

FAMILY HISTORY

Place of Birth: City _____ State _____ Country _____

If not local, date of arrival to South Florida: _____/_____/_____ Reason for move: _____

Religious/Cultural/Ethnic factors affecting patient's status: _____

_____

PARENTS: □ Married □ Never Married □ Separated □ Divorced (child's age at divorce: _____)

Father's Name:_____ Lives w/Patient? **Y N** Date of Birth: ___/_____/_____

Mother's Name:_____ Lives w/Patient? **Y N** Date of Birth: ___/_____/_____

Step Parent:_____ Lives w/Patient? **Y N** Date of Birth: ___/_____/_____

SIBLINGS Name	Age	Lives with Patient?
1.		**Y N**
2.		**Y N**
3.		**Y N**
4.		**Y N**
5.		**Y N**

History of Physical Abuse/Family Violence or Neglect: □ No □ Yes Has abuse been reported? □ Yes □ No
Charges Pending? □ Yes □ No Patient was: □ Victim □ Perpetrator

Explain:_____

_____

History of Sexual Abuse/Trauma: □ No □ Yes Has abuse been reported? □ Yes □ No
Charges Pending? □ Yes Patient was: □ Victim □ Perpetrator

Explain_____

_____

History of Violence: □ No □ Yes, toward: □ People □ Property □ Other: _____

Explain:_____

Gang Involvement: □ No □ Yes, patient was/is: □ Victim □ Participant □"Wanna Be"
Charges Pending? □ No □ Yes, explain: _____

_____

History of Cruelty to Animals and/or Fire Setting: □ No □ Yes, explain: _____

_____

History of Risk Taking Behaviors, General Behavioral Problems or Unusual/Bizarre Behaviors: □ No □ Yes
Explain (provide time frames/dates): _____

_____

Previous In/Outpatient Treatment and Response To: _____

_____

MEDICAL & DEVELOPMENTAL HISTORY

DEVELOPMENTAL HISTORY:

Pregnancy: □ Planned □ Unplanned Reaction to pregnancy: _____

Pregnancy, Labor and Delivery: □ Normal □ Complications, describe: _____

_____

Medications or drugs used during pregnancy: _____

Description of Child as a Baby/Toddler: _____

_____

Were developmental milestones met as expected (walked, talked, toileting, feeding, self-care) describe: _____

_____

Diagnosis, if any: _____

Date Diagnosed: _____ Child's Age at Diagnosis: _____ by: _____

Name of Pediatrician/Family Practitioner: _____

Address: _____

Phone: _____

Name of Psychiatrist (if applicable): _____

Address: _____

Phone: _____

Describe Disciplinary Methods, by whom, is it effective: _____

_____

Describe Sleeping Arrangements: _____

_____

Family History of significant Medical Conditions/Illnesses: _____

_____

Family History of Alcohol/Substance Abuse: _____

_____

Family History of Psychological/Learning Issues: _____

_____

Toilet Training: □ Normal □ Not Achieved Age when achieved: _____

Eating Habits: □ Normal □ Irregular, describe: _____

Sleeping Habits: □ Normal □ Irregular, describe: _____

Has your child had surgery or head injuries? □ No □ Yes, explain (include dates): _____

_____

Current medications:

1. _____ Dose:_____ For:_____

2. _____ Dose:_____ For:_____

3. _____ Dose:_____ For:_____

CURRENT THERAPY OR SERVICES:

Please list all current services your child receives on a weekly basis.

THERAPY	DATE STARTED	NUMBER OF SESSIONS EACH WEEK	TOTAL MINUTES PER WEEK	THERAPIST NAME OR AGENCY AND PHONE NUMBER
Occupational Therapy				
Speech Therapy				
Physical Therapy				
Behavior Therapy				

ACADEMIC HISTORY

Type of Program: □ Typical □ Special Needs □ Therapeutic Program

Does your child like school?

_____

History of school behavioral problems or truancy: □ No □ Yes, explain:

_____

_____

History of separation anxiety or school phobia: □ No □ Yes, explain:

_____

_____

Description of social relationships/friends:

_____

_____

Academic performance: □ Excellent □ Satisfactory □ Unsatisfactory, explain:

_____

_____

History of repeating grade(s): □ No □ Yes, explain:

_____

_____

Previous Academic Placements:

SCHOOL NAME	DATES ATTENDED	TYPE OF PROGRAM	REASON LEFT

What does your child enjoy doing during free time:

_____

_____

Does he/she participate in structured extracurricular activities? If so, what:

_____

_____

What are your child's strengths:

_____

_____

What are your child's weaknesses:

_____

_____

What other information should we know about your child to better understand your concerns?

_____

_____

Completed By: _____
PRINT NAME

_____
SIGNATURE

_____
DATE

Relationship: □ Mother □ Father □Guardian

_____ (Initial) By completing this form and putting my signature above, I acknowledge that I am consenting for treatment, evaluation, and/or consultation for the above-mentioned individual and that I have the authority to give such consent.

Cadenza Center for Psychotherapy & the Arts, Inc.

Client Rights and Responsibilities, and Consent for Treatment

Client Name:_____ Date:_____

As a potential client of Cadenza Center for Psychotherapy & the Arts , Inc., I understand that I am assured humane and dignified treatment at all times and the following rights, and I agree to the following responsibilities.

Rights:

1. Right to refuse and/or terminate treatment at any time.
2. Right to informed consent.
3. Right to confidentiality whereby the information revealed by me during treatment will be kept strictly confidential (understanding that any pertinent information relative to my care will be documented in a Cadenza Center for Psychotherapy & the Arts, Inc. contact record) and will not be revealed to anyone without my written authorization. The law provides the following exceptions to this provision.
    a. If Cadenza Center for Psychotherapy & the Arts , Inc. has knowledge of client's intent to harm self or others.
    b. If Cadenza Center for Psychotherapy & the Arts, Inc. has knowledge of child abuse, neglect or exploitation.
    c. If Cadenza Center for Psychotherapy & the Arts, Inc. receives a court-order to the contrary.
    d. If client enters into litigation with Cadenza Center for Psychotherapy & the Arts, Inc.
    e. If medical emergency necessitates disclosure.
    f. If Cadenza Center for Psychotherapy & the Arts, Inc. has knowledge of client's intentional spreading of communicable disease.
4. Right to request second opinion.
5. Right to treatment without regard to race, color, sex, age, religion, national origin, disability or sexual orientation.

Parent/Legal Guardian/Client Responsibilities:

1. To keep predetermined appointment and to notify Cadenza Center for Psychotherapy & the Arts, Inc. at least 24 hours in advance of canceling or rescheduling an appointment.
2. To participate and follow agreed upon treatment.
3. To maintain confidentiality pertaining to group therapy, when applicable.
4. To assume responsibilities for payment of the assessed and agreed fees for services.
5. To inform Cadenza Center for Psychotherapy & the Arts, Inc. of any change in address and phone numbers.

Consent for Treatment:

I understand and voluntarily agree to the above, and I authorize evaluation and/or treatment by Cadenza Center for Psychotherapy & the Arts . I understand that this consent can be repealed in writing at any time during the treatment period.

Name of the Client/Parent/Legal Guardian: _____Date:___/___/___

Signature:_____Date:___/___/___

CADENZA CENTER FOR PSYCHOTHERAPY & THE ARTS, INC.
Consent for Release of Information

Therapist/Provider: _____

Client's Name:_____ Date of Birth: ____/____/_____

I, undersigned, voluntarily request and authorize the personnel at the Cadenza Center to exchange with/obtain from/release to the party I have indicated below the information contained in my clinical and medical record. I authorize the Cadenza Center to exchange, release or obtain information verbally/in writing/both in writing and verbally. I understand that my health information may be protected by the Federal Rules (HIPAA) for privacy of Individually Identifiable Health Information (45 CFR parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient records (42 CFR Chapter, part 2), and/or the State laws.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations.

Person/Organization receiving information from or communicating information to the Cadenza Center for Psychotherapy & the Arts, Inc. include:

Name:_____ Phone:(____)_____- _____

Agency/Organization: _____

Purpose of Release: _____

_____

Print Name: _____Date: ____/___/_____

Signature:_____Date: ____/___/_____

Relationship: □ Self □ Parent □ Guardian

_____ (initial) I choose to decline the invitation to authorize communication between my therapist and other members of my medical team (i.e., primary care physician, psychiatrist, other current and/or past therapists).

_____(Initial) This consent is valid until my written request to rescind this authorization or at the termination of active treatment at the Cadenza Center.

Notice of Privacy Acknowledgement

Cadenza Center for Psychotherapy & the Arts, Inc.

210 S. Federal Hwy, Ste 302
Hollywood, FL 33020
954-925-3191 (f) 954-925-3193

Client Name:_____Date of Birth____/____/____

Social Security Number ____-____-____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and physician/non-physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of health information. I understand that this organization has right to change it **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the **Notice of Privacy Practices**. (Do we have a more complete description of our Notice of Privacy Practices?)

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or other healthcare operations. I also understand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Parent/Legal Guardian Signature: _____Date___/___/___

HIPAA Notice of Privacy and Health Information Practices

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

Introduction
At Cadenza Center for Psychotherapy & the Arts, we are committed to treating and using health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice is effective June 1, 2005, and applies to all Protected Health Information as defined by Federal Regulations.

Understanding Your Health Record/Information
Each time you visit Cadenza Center for Psychotherapy & the Arts a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:
• Basis for planning your care and treatment,
• Means of communicating among the many health professionals who contribute to your care,
• Legal document describing the care you received,
• Means by which you or a third-party payer (i.e., insurance company) can verify that services billed were actually provided,
• Source of information for public health officials charged with improving the health of the State and the Nation, as required by law (i.e., reporting child abuse and neglect or reporting domestic violence),
• Basis for disclosing your child's health information to a law enforcement official, for purposes such as identifying or locating an individual, in complying with a court order or subpoena, and other law enforcement purposes,
• Source for public safety. We may disclose your child's health information to appropriate persons in order to prevent or lessen a serious threat to health or safety of a particular person, or the general public, and
• Tool in educating health professionals, source of data for medical research, and tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Cadenza Center for Psychotherapy & the Arts, the information belongs to you. You have the right to:
- Obtain a paper copy of this Notice of Health Information Practices upon request,
- Inspect and copy your health record, as provided for in 45 CFR 164.524,
- Amend your health record, as provided for in CFR 164.528,
- Obtain an accounting of disclosures of your health information, as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information, as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken.

Our Responsibilities
Cadenza Center for Psychotherapy & the Arts is required to:
- Maintain the privacy of your health information,
- Provide you with a copy of this Notice as to your legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this Notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice, provided those changes affect your health information, to you at the address you have supplied us, or if you agree, we will e-mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization, according to the procedures included in the Authorization.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact Cadenza Center for Psychotherapy & the Arts at 954-925-3191. If you believe your privacy rights have been violated, complaints should also be directed to Michelle Reitman, PsyD, LMHC, MT-BC. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint with either Cadenza Music Therapy, Inc. or the Office of Civil Rights. Please take this copy for your records

CADENZA CENTER FOR PSYCHOTHERAPY & THE ARTS, INC.

Financial Responsibility Agreement

Client Name: _____

The following is a statement of our financial policy, which we require you to read and sign prior to receiving non-emergent care.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we accept Visa, Mastercard, cash, money orders or checks. Non-payment of fees may result in the interruption of your services.

I understand that I am responsible to meet my insurance deductible and make co-payments as required by my plan in addition to any services provided that are not covered by my insurance carrier. This will be explained to me prior to my first appointment if possible. The staff at the Cadenza Center strive to obtain the most accurate insurance information from insurance companies, however from time to time, the information provided may be inaccurate. I also understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed even when benefits have been discussed with my carrier in advance of my first appointment. Therefore, in the event that my insurance carrier refuses to make payment against claims made for services rendered to myself and/or my family (regardless of reason – i.e., deductible, inaccurate copay information, inaccurate number of sessions approved), I understand that I am responsible for prompt payment (within 2 weeks of written notice) for these services received. I understand that I am entitled to a detailed description of the charges in dispute. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed on my behalf, I will immediately pay over such payments to the Cadenza Center for Psychotherapy and the Arts, Inc.

I understand that in order to receive the best clinical services, my therapist may be available for brief phone sessions to speak with me or other professionals involved in my care when necessary. In addition, my therapist may prepare letters, treatment summaries, preparation of records, or other services I request. I understand that these services and time are not billable to my insurance carrier and therefore I am responsible for payment for services lasting more than 15 minutes. My therapist or office staff will advise me of any fees applied to my account. I understand that I will be billed a pro-rated fee for these services based upon my therapist's customary session fee.

Because scheduled sessions are reserved specifically and exclusively for me and/or my family, I understand that *unless my session is canceled with at least 24 hours in advance, I may be charged a fee for missed appointments*. Only my therapist may make exceptions and waive the fee, at his/her discretion, for emergency or unusual circumstances. I am aware that insurance carriers do not provide reimbursement for cancelled or missed sessions. Additionally, repeated missed appointments may result in termination of therapy. I understand that my therapist and the staff at the Cadenza Center will always make every effort to notify me and reschedule any appointments that need to cancelled in case of an emergency.

The Cadenza Center reserves the right to refer any unpaid balance to an outside collection agency and to take appropriate legal action to collect unpaid balances. I know that I will be responsible for payment of all fees and costs associated with these collection efforts, including payment of any court costs and attorney's fees. I understand that unpaid balances greater than 30 days may be subject to a late fee of the greater of $25 or 2% of the outstanding balance.

A photocopy of this authorization is as valid as if it were an original executed document. I authorize the release of payments and medical information necessary to process my and/or my family members' insurance claims and related claims. I hereby authorize payment directly to my therapist or to Cadenza Center for Psychotherapy and the Arts, Inc. of the insurance benefits otherwise payable to me for all professional services received.

I have read the financial policy and had an opportunity to have question answered. I understand and voluntarily agree to this financial policy.

Name of Client/Guardian: _____ Date: ___/___/___

Signature: _____ Date: ___/___/___