General Information

Child's Name: _____ DOB: _____ SSN: _____

Age: _____ Sex: _____ Parent to call about appointment changes: _____ #:_____

With whom does this child live? _____

Father's Name: _____ Address: _____

Father's Cell Phone: _____ Work Phone: _____ Email: _____

Mother's Name: _____ Address: _____

Mother's Cell Phone: _____ Work Phone: _____ Email: _____

Financially Responsible Party

Name: _____ SSN: _____ Date of Birth: _____

Relationship to Patient: _____ Email: _____

Address (if different from above): _____

Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information

Primary Insurance: _____ Group: _____ Group No: _____ ID No:_____

Policy Holder's Name: _____ DOB: _____ Employer: _____

Relationship to Patient: _____

Secondary Insurance: _____ Group: _____ Group No: _____ ID No:_____

Policy Holder's Name: _____ DOB: _____ Employer: _____

Relationship to Patient: _____

Emergency Contact Information

Contact Person: _____ Relationship to Patient: _____

Address: _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email:_____

Contact Person not living in your home: _____ Relationship_____

Address: _____ Home Phone_____

Work Phone: _____ Cell Phone: _____ Email: _____

INFORMATION AND AGREEMENT
Bruce R. Johns, Ph.D.

This document contains important information about my professional services and business policies. Please read it carefully and discuss with me any questions you might. Your signature certifies this document as a legally binding agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy can result in very positive outcomes for both children and parents. However, it may involve discussing difficult subjects and some sessions may be uncomfortable. Because many factors can affect the outcome of therapy, success cannot be guaranteed. What I offer is my best effort to help you and your child achieve good results.

Therapy frequently involves a significant commitment of time, money and energy. Within the first session or two, I'll be able to offer my view of the problems and how those might best be addressed. If you have questions about treatment goals or procedures, please discuss them with me whenever they arise. If, after talking about your concerns, you're unsure of whether you want to proceed, I can help you set up an appointment with another therapist for a second opinion.

CONFIDENTIALITY

Parents are welcome to attend at least part of each therapy session with their child, which usually gives therapy increased direction and makes our time more efficient and effective. However, for children to be able to speak openly with a therapist, parents must surrender some of their rights to information obtained from their child in therapy. This allows your child to have confidence that whatever he or she wants kept private will be kept private. Parents continue to have rights to general information about their child's therapy (is the child being open, treatment goals, is he/she making progress, is there anything the parents can do to improve the relationship). Most of the time, your child and I will have previously talked about any issues that I might bring up with you.

Confidentiality for children does not preclude parents from providing me regular updates and information they consider pertinent by email. In fact, I encourage this. I am also willing to provide parents a general summary of treatment when it is complete.

Having talked about how confidentiality applies to children, let me explain a few exceptions, as outlined below:

1. When another family member, friend, or adult is invited to attend therapy, the lines of confidentiality are redrawn to include that person in the inner circle where information can be shared.
2. If I believe there is a high risk that your son or daughter is about to seriously harm someone or himself/herself, I will notify a parent of my concern so he/she can take appropriate preventive actions.
3. There are some situations in which I am legally obligated to act to protect others from harm (such as reporting to appropriate agencies when someone has threatened serious bodily harm, a life is at risk, or when abuse or neglect is suspected). These actions may include notifying the potential victim, contacting family members or others who may help provide protection, contacting the police or seeking hospitalization for the patient. Such situations often require that I reveal some information about a patient's treatment.

4. If your son's or daughter's welfare or emotional condition becomes a critically important legal issue, a judge may order my testimony, if he/she determines that the situation warrants it, and I would have to comply. Such an order has been exceptionally rare in my experience.
5. I associate with and collaborate with other behavioral health providers, all of whom are members of Mt. Logan Clinic, LLC. We are each independent of one another, yet we share office space, certain expenses, and administrative functions. I am completely independent in providing you with clinical services and I alone am responsible for those services. My professional records are separately maintained and no member of the group has access to them without your specific permission. My support staff may have access to your medical chart and may have occasion to send or receive privileged information such as psychotherapy notes, evaluations, and other written and/or verbal communications. They are the only ones, beside myself, who will have access to your records and they are under the same limits of confidentiality I am.
6. Most insurance companies require you to authorize me to provide them with clinical information such as symptoms, clinical history, diagnoses, treatment plans, and clinical progress. I have no control over what your insurance company may do with information submitted to them. I will provide you with a copy of any report I submit, upon request. If you prefer, you always have the right to pay for services yourself to avoid insurance complexities.

I am willing to discuss any questions you may have about confidentiality. You may also want to obtain formal legal advice because the laws governing confidentiality are quite complex and I'm not an attorney.

CHILD CARE

Effective therapy requires your and your child's full attention. Please make arrangements for any needed childcare because we cannot provide it. Young children should not be left in the waiting room unsupervised. Should a problem arise due to inadequate supervision, the therapy session would be cut short that day.

APPOINTMENTS

Therapy sessions are typically 45 minutes long. This time is reserved for you. Because your child's therapy session is a substantial portion of my day, it is important that you keep track of your child's appointments. If my patient fails to show for an appointment, the guarantor is charged full fee for the session. Your insurance will not pay for missed appointment fees.

Should it be necessary to cancel an appointment, please notify the receptionist at least one full working day in advance so she can offer that appointment time to other patients. Appointments canceled with less than a full working day's notice will be charged full fee. Mt. Logan Clinic is open Monday through Thursday. As such, Monday appointments cannot be cancelled any later than the previous Thursday by 5:00 p.m. Your insurance will not pay for late cancellation fees.

If a child misses two consecutive appointments, we will attempt to contact a parent to determine whether he/she wants to continue therapy. To protect parents from continued missed appointment fees, if no response is received within 3 business days, future appointments will be cancelled, until we hear from a parent. Additional appointments can only be rescheduled after any missed appointment fees have been paid in full.

APPOINTMENT REMINDERS

Parents can now receive appointment reminders via email, text message, or telephone voice message. Please note that appointment reminders are sent as a courtesy only. Missed appointment fees still apply if, for any reason, the reminders cannot be delivered.

How would you like to receive appointment reminders? (check one)
_____ via secure text message to this cell phone number: _____
_____ via secure email to this email address: _____
_____ via automated voice message to my home phone number: _____
_____ Do not send reminders. I'll remember my appointments on my own.

STATEMENTS

Monthly electronic statements will be delivered via secure email unless you elect to receive paper statements via U.S. Mail (Note: a $2 paper statement fee will be added to cover the additional costs associated with preparing and mailing paper statements).

How would you like to receive monthly statements? (check one)
_____ Send secure electronic statements to this email: _____
_____ Send paper statements to my home address. I accept the monthly $2 charge.

Appointment information may be classified as "Protected Health Information." By my signature, I am requesting that appointment reminders and statement be handled as I have noted above.

Parent's signature _____ Date: _____

YOUR PATIENT PORTAL

Parents can also view scheduled appointments, request additional appointments, request cancellations, view account balances, make payments, and send secure messages to myself or my staff in our secure patient portal. If you have no interest being able to do these things online, please skip to Billing and Payment.

To access your patient portal, go to **www.therapyappointment.com** and click on "find your therapist" at the top of the page. That will direct you to a screen where you can look up Bruce Johns, Ph.D. by name. Once you do, it will ask you for your temporary user name and password, which you will create below. To get started, please fill in the information below so we can set your temporary user name and password.

Child's name: _____ DOB: _____
Parent's requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| (letters and/or numbers only)
Temporary password: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| (must be at least 8 characters and contain both letters and numbers)

After you log in with your temporary user name and password, you'll be asked to change your temporary password to a permanent password**.** Please write down your user name and permanent password. Once established, you can access your patient portal by going directly to **www.schedule.care** at any time.

BILLING AND PAYMENT

1. **Co-pays:**
   If I am a paneled provider for your insurance company, I will accept the contracted maximum allowable fee (MAF) as payment in full for services. The MAF is comprised of a co-pay (a per-session fixed amount or percentage of the MAF for which the parent is responsible) plus an amount or percentage the insurance company agrees to pay on behalf of the patient. For example, a parent may pay a $25 co-pay at the time of a session and then insurance is billed for the remaining portion of the MAF. Or, a parent may pay a 20% co-pay at the time of service and the insurance is billed for the remaining 80% portion.

Payment for services is ultimately the responsibility of the guarantor. If an insurance claim is not responded to or is denied, guarantors remain responsible for the cost of the service.

Insurance company policies and my policy require that co-pays be submitted at the time of service (upon check-in). **There is a $10 service fee charge for non-payment of co-pay at the time of service**. Lack of co-pay for two successive sessions will prevent future appointments being made until the balance owed is paid. Future scheduled appointments may also be cancelled, if co-payments or co-insurance payments are not made within 30 days.

2. **Deductibles:**
Most insurance plans have "deductibles" which renew at the beginning of the insurance contract year (usually January 1st or July 1st). A "deductible" is an amount that you are required to pay out of your own pocket before your insurance will begin paying its portion of the maximum allowable fee (MAF). The deductible is "met" by you paying for any covered health services out of pocket until your required deductible amount has been reached (e.g., a $500 deductible may be met by paying $150 to a psychologist and $350 to a family physician). After the deductible has been met, you are only responsible for your co-pay for any qualified services, until the beginning of your next contract year. Consequently, at the beginning of your contract year, you will be responsible to pay the entire contracted MAF, at the time of service, until you have met your deductible.

3. **Qualified services:**
Insurance companies vary in what they consider qualified services. Some insurance companies exclude certain diagnoses or procedures. They may or may not pay for family sessions without the patient, 60-minute sessions, psychological testing, crisis intervention, and consultations. Miscellaneous services, such as writing letters on behalf of patients, telephone calls, travel time, time spent responding to insurance requests, or services for legal proceedings, are unlikely to be covered. If you have a question about whether a service or diagnosis is likely to be covered please ask me. Please note that you remain responsible to pay for my services, even if your insurance company does not qualify them.

4. **Service fees**
Unless I've agreed with your insurance company to accept their maximum allowable fees (MAF), the current cost of an initial assessment is $200. Subsequent 45-minute sessions are $131 and 60-minute sessions are $175. Other professional services you may need are $175 per hour or $43.75 per quarter hour for crisis intervention, psychological test administration, scoring and interpretation, report writing, telephone conversations lasting more than 10 minutes, consultations with doctors, hospital staff, school personnel, other providers, agencies, attorneys, or court officials, preparing for depositions, office visits lasting longer than 10 minutes, reading documents submitted regarding your case, preparation of treatment summaries or insurance reports, required travel, or time spent performing any other service relative to your case. Billing is typically in 15-minute increments.

Fee increases do occur occasionally, to keep up with cost of living increases. Fee increases may occur without prior notice. You would be notified, at the time of service, of any fee increase.

Due to the additional costs associated with working with insurance companies, parents who do not use insurance will be offered a 25% discount for psychotherapy services (initial assessment $150, 45-minute appointment $98, psychological assessment $131/hour). Services typically not covered by insurance will be charged full fee ($175 per hour, $43.75 per quarter hour).

Miscellaneous services requiring less than 10 min. are typically provided, without cost, as a courtesy.

Should you require special financial consideration, please talk with me about your situation. Any deviation to the fee schedule must be in writing and signed by me.

5. **Outstanding balances and returned checks:**
It is expected that you will pay any deductible and co-pay at the time of service. If, for some reason, there is a balance owed (other than a pending insurance payment), you are expected to pay off the balance at your next visit. Parents will be informed of their balance at each scheduled session.

Parents owing a balance will be sent monthly statements showing charges, your payments and insurance company payments. Insurance companies usually make payments within 30 - 60 days. Any insurance charges left unpaid after 60 days will become your responsibility to pay. You may then settle with your insurance company. Payment is due within ten days of receipt of your statement. A finance charge of 1.5% per month (18% per annum, $5.00 minimum charge) is assessed on any unpaid balance over 60 days old. Returned checks result in a $20 service charge in addition to any bank service charges.

If your balance (excluding pending insurance payments) exceeds $300, you would be required to bring the balance under $300 prior to any future appointments being made, unless other arrangements are made, by written agreement, with me. Lack of doing so, within 30 days, could risk the loss of existing appointments.

6. **Statements**
Statements can be confusing. For example, our billing software system automatically applies payments to the oldest outstanding charge in order to reduce interest charges. It may therefore appear that a co-pay wasn't credited when it really was, but it was applied to an older charge. If there is an error on your statement, please bring it to our attention so we can promptly resolve the problem. If you have questions about your statement or balance owed, please contact my billing specialist at 435-750-6300 ext. 207.

7. **Changing Insurance:**
You are responsible for informing me, or my billing specialist, of any changes in your insurance coverage. I may consider applying for panel membership if your new insurance company's policies, procedures and maximum allowable fees (MAF) are acceptable. If you switch insurance coverage to a company with whom I am not paneled, you may want to contact your insurance company and request a single-case agreement (which might allow continued insurance coverage of my services) or you may elect to use the self-pay schedule (see "Service Fees" above). If necessary, I am also willing to facilitate a transfer to a therapist who is either paneled with your new insurance or who provides services on a sliding-fee scale.

Due to the recent instability of insurance fee schedules, I reserve the right to evaluate whether to maintain my relationship with insurance companies at my sole discretion. Such decisions may be determined by the insurance company's fee schedules, paperwork demands, or willingness to support what I consider quality treatment.

8. Outstanding Payment Authorization
To keep our therapeutic relationship free of any financial strains and to avoid the possibility of needing to turn an account over to a collection service (which is expensive and hurts clients' credit ratings), I

require each financial guarantor to consent to an outstanding payment authorization agreement. Essentially, the guarantor assures payment for my professional services by authorizing us to charge a credit/debit card (identified below) for the total amount of any unpaid balance owed, after it is 60 days past due. At least two separate notices of any balance 60 days overdue would be attempted, prior to the card being charged. If there is a dispute regarding any charges billed, a written notice of the issue must be submitted a minimum of five business days prior to the 60-day limit. All reasonable and appropriate efforts will then be made to resolve the identified dispute before charging the card on file. However, I reserve the right to submit charges to the card for any services I've rendered consistent with the contracted rates and charges identified in this agreement, provided sufficient reasonable evidence exists that services were rendered for each applicable charge (e.g., patient signature on applied date of service). No other charges will be placed upon the card without your express consent. All credit card information will be stored using encryption consistent with both HIPPA and Payment Card Industry Data Security Standards (PCI-DSS). If repeated attempts to charge the card/account on file are unsuccessful or denied for any reason, the financial guarantor will be assessed a service fee of $100 in addition to all other outstanding charges and the account may be submitted to collections as detailed in the signed contract.

With your signature below, you certify that you are an authorized user of the identified credit card/account and authorize use of the card by Bruce R. Johns, Ph.D., P.C., as detailed above. You also agree that you will not dispute these transactions with your bank or credit card company, so long as the transactions correspond to the terms indicated in this document. You further agree that if, at any time, you terminate the card on file, you will provide Bruce R. Johns, Ph.D., P.C. with a replacement card.

Name of Patient: _____
Name of Responsible Party (if different): _____
Signature of Responsible Party: _____ Date: _____

Type of Card: Visa _____ MasterCard _____ Discover _____
Cardholder Name: _____ Card Number: _____
Expiration Date: _____
Billing Address: _____ City, State, Zip: _____
Phone: _____ Email: _____
Cardholder Signature: _____ Date: _____

9. **Collections:**
If reasonable efforts to collect your bill fail, the account is turned over to a collection agency or a claim is made in small claims court. Collection agencies typically require that an amount equal to 50% of the outstanding balance be added to the bill as a "collection fee". This charge is included in the claim. In most collection situations, the only information I release is the name of the patient and responsible party, the dates and nature of services provided, and the amounts due. Negative credit reports may be submitted to a credit reporting agency, when contracted financial obligations are unfulfilled, which can damage your credit rating.

CONTACTING ME

I am usually in my office between 8:30 AM and 5:30 PM Monday through Thursday. However, I am usually with a patient. The most reliable way to contact me is through the receptionist (435-750-6300 ext. 100) or, if you prefer, you may leave me a confidential voice mail (435-750-6300 ext. 103) or leave me a message via the patient portal. I retrieve messages and try to return calls at the end of my day, Monday through Thursday (except for holidays and vacations). I do not guarantee my availability or how quickly I will be

able to respond. **If you have an emergency, please call 911 or go directly to the emergency department of the nearest hospital.**

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I keep two sets of records–the medical record and my psychotherapy notes. The medical record includes the dates and times of sessions, the type of therapy provided, the results of any psychological testing, and any summaries of symptoms, diagnosis, treatment plan, and treatment progress. The medical record is available for your review upon request. Psychotherapy notes and my personal notes, on the other hand, are protected by HIPAA law and state law and are considered the property of the health care provider who created them.

FAMILY, AND FRIENDS

A family member, or friend may participate in and play an important part in treatment. A person participating in this way might attend only one session or might attend all of the patient's therapy sessions. In fact, the participant's relationship with the patient may be a major focus of the treatment. But a participant, that is not a parent, does not have a right to access the medical record nor does he or she have the same rights as the parent and patient regarding confidentiality. My primary responsibility and allegiance remains with my patient and his/her parents.

Occasionally I recommend that a family member, or friend obtain his/her own therapy. I may refer the person to another clinician unless my patient, the parents, and I agree that my patient and the other person might be better served if I provide the therapy. But such situations carry risks. Providing therapy for two people that have a close relationship (e.g. siblings or child and parent), can lead to complications such as one person believing that the therapist has taken sides with or shows preferential treatment toward the other person. Also, if a therapist were to see a parent and a child separately, the child might worry whether what is told the therapist in confidence will really remain confidential. This could interfere with the child's trust and reduce the effectiveness of therapy. Trust is a critical component to successful therapy.

Sometimes family therapy can be most helpful in treating an individual. Usually, in such cases, one person is the identified patient and the others become participants. When this occurs, everyone involved agrees that the normal limits of confidentiality are redrawn to include the other participants. Not all information shared with me is shared with anyone else. Rather, I will use my judgment regarding what information is shared and with whom. My intent in sharing information is to promote the welfare of those involved. If you have any concerns about what information may or may not be shared under these circumstances, please talk to me.

If a child's parents have both been involved in the child's therapy and the parents separate or divorce, any requested release of medical records would require the consent of both parents. Once a child becomes 18, medical records are within complete control of the now legal adult.

Summary

I have read and reviewed the Information and Agreement above and resolved any questions or concerns that I had. I understand and agree to the expectations and conditions as detailed above.

Specifically (please initial each paragraph below):

_____In order for my child to have confidence that what he/she says in therapy will remain confidential, I relinquish my parental rights to such information. I understand that Dr. Johns will keep information he receives confidential, but that those rights to confidentiality have limits, as explained above. I understand that, including other people in therapy redraws the lines of confidentiality to include those persons as people with whom confidential information can be shared.

_____ I understand that I am solely responsible for keeping track of my child's appointments with Dr. Johns. I understand that failure to show up for appointments, or failure to cancel an appointment with one full working day's notice (except in cases of emergency or sudden illness), will result in a missed appointment or late cancellation fee. I understand that after two no-shows, those fees must be paid in full to continue treatment.

_____I understand that I will be billed for Dr. Johns' services at the rates detailed above. I understand that insurance companies may not cover some charges or diagnoses. I accept that any charges left unpaid, by the insurance company after 60 days, will become my responsibility to pay. I agree to pay for all services provided me by Dr. Johns. I understand that fee rates may be increased without prior notice.

_____I understand that I am required to pay my co-pay at the time of service and agree to do so. I understand I will be charged a $10 fee for failure to do so. I understand that further sessions will not be held/scheduled after missing two consecutive co-pays until the co-pay balance is paid in full. I understand that insurance company refusal to pay does not relieve me of my responsibility for payment of services provided by Dr. Johns.

_____I understand that I am required to pay any deductible (out of pocket) amounts at the time of service. I also understand that unpaid deductible payments may result in an interruption of services until the deductible balance is paid in full. I understand it is my responsibility to educate myself about my insurance company's calendar year and deductible policies.

_____I understand that it is my responsibility to inform Dr. Johns and his staff of any changes to my insurance coverage or requirements. I accept financial responsibility for any denial of insurance payments that might result from my failure to inform. I accept that Dr. Johns has the right to choose to become a non-provider for my insurance.

_____ I understand I am responsible to pay any outstanding balance within 60 days of the service date. I agree to authorize Dr. Johns to charge my designated credit or debit card for any unpaid charges past the 60-day period. I understand the identified form of payment (credit or debit account) will not be used for any other purpose without my express consent.

_____I understand that I will be charged interest, on any outstanding balance, at 18% per year. I understand that there is a returned check charge. I also understand and agree that lack of payment would result in my account being sent to collections, that 50% of the outstanding balance would be added as a collection fee, and that I would be fully responsible for all collection costs.

_____My mobile phone number is. ( ) - . I authorize the use of this number to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

_____ I understand that, in case of emergency, I am to call 911 or proceed to the hospital. I understand how that I can leave messages for Dr. Johns, but there is no guarantee of his availability or how quickly he may respond.

_____I understand that I have rights to access my child's treatment record but not Dr. Johns' psychotherapy notes.

_____I understand that people whom I include in my therapy do not automatically become patients of Dr. Johns. I understand that Dr. Johns must be able to keep confidential (even from parents) what a child tells him, in order to develop a relationship of trust with that child. If it is determined advantageous that Dr. Johns see a family member or friend as an individual client, I accept the risk of possible complications that could arise from such an arrangement. I understand that following separation or divorce, a release of medical records may require a conjoint release of information.

My signature also confirms that I am authorizing Dr. Johns and his staff to contact my insurance company and release any medical or other information necessary for authorization of services, insurance payment, or processing of claims. I am authorizing payment of medical benefits directly to Dr. Johns. Additionally, I am authorizing Dr. Johns and his staff to contact me for billing or collection purposes.

Patient's Name (printed)	
Name of Parent/Guardian	Signature of Parent/Guardian
Name of Person accepting financial responsibility	Signature of Person accepting financial responsibility
	Today's Date

PARENT FORM (TO COMPLETED BY THE CHILD'S PARENT/GUARDIAN)

Today's Date: _____ Name of Person Completing this Form _____
Child's Name: _____ Age: _____ Date of Birth: _____
Race/Ethnicity: _____ Gender: __Male __Female
City of residence: _____ With whom does the child live? _____
_____
What school does he/she attend? _____Grade enrolled/completed _____
Who referred you to me? _____
What is the primary reason for bringing your child to see me? _____
_____

Please mark below any symptoms your child is **Now** experiencing with an "**N**". Then mark all the symptoms that he/she has had in the **Past**, but no longer experiences with a "**P**".

__ Sadness	__ Fatigue/exhaustion	__ Restless sleep	__ Low or reduced energy
__ Feeling empty	__ Restlessness	__ Insufficient sleep	__ Weight loss (_____ lbs.)
__ Tearfulness	__ Social withdrawal	__ Waking too early	__ Weight gain (_____ lbs.)
__ Irritability	__ Indecisiveness	__ Excessive sleep	__ General aches/pains
__ Guilt	__ Low self-esteem	__ Difficulty thinking	__ Activities aren't enjoyable
__ Headaches	__ Feeling worthless	__ Difficulty concentrating	__ Reduced interest in activities
__ Stomach aches	__ Self-blame	__ Wishes didn't exist	__ Suicidal thoughts

__ Worrying/brooding	__ Restless/on edge	__ Easily fatigued	__ Muscle tension
__ Decreased concentration	__ Mind goes blank	__ Decreased concentration	__ Irritability
__ Intense or irrational fears	__ Fear of leaving home	__ Obsessive thoughts	__ Compulsions
__ Feeling stressed out	__ Unresolved trauma	__ Avoids social situations	

__ Panic	__ Palpitations	__ Sweating	__ Trembling
__ Difficulty breathing	__ Hyperventilating	__ Choking	__ Chest pain
__ Nausea	__ Dizziness	__ Things seem unreal	__ Fear of losing control
__ Fear of dying	__ Tingling sensations	__ Chills/hot flashes	__ Other:

__ Poor attention to detail	__ Frequent careless mistakes	__ Difficulty paying attention
__ Difficulty listening	__ Difficulty following instructions	__ Difficulty finishing tasks
__ Difficulty organizing things	__ Hyperactivity	__ Impulsiveness
__ Excessive fidgeting	__ Talking excessively	__ Forgetfulness

__ Loses temper easily	__ Argumentative	__ Defiant/noncompliant	__ Blames others
__ Deliberately annoying	__ Easily annoyed	__ Excessively "touchy"	__ Aggressiveness
__ Angry	__ Spiteful/vindictive	__ Cruel to animals	__ Cruel to others
__ Bullies others	__ Initiates physical fights	__ Destroys property	__ Robs/Steals
__ Legal problems	__ Starts fires	__ Robbery	

__ Highly Inflated self-esteem	__ Decreased need for sleep	__ Excessively talkative
__ Very rapid, "pressured" talking	__ Racing thoughts	__ Excessively distractible

___ Excessive productivity ___ Risk-taking or hyper-sexuality ___ Running away from home
___ Reckless decision making ___ Excessive energy ___ Spending far too much

___ Restriction of calories ___ Excessive exercise ___ Laxative abuse ___ Intense fear of weight gain
___ Body dissatisfaction ___ Loss of menses ___ Binging ___ Other:
___ Significant weight loss ___ Food obsessions ___ Purging

___ Poor eye contact ___ Social difficulties ___ Speech/language delays ___ Odd behaviors
___ Minimal gestures ___ Toileting problems ___ Odd interests ___ Tics

When were these problems/symptoms first noticed? ___+++++++_____
Have they been ___getting worse ___remained unchanged ___up and down ___improving
How much do problems interfere your child's ability to function? ___ very little ___some ___a lot
Has your child previously seen a counselor or been treated for these problems? Yes ___ No___
If yes, at what age? With whom? Approximate date range? Medications? Results? _____
_____
_____
_____
_____

Has Child Protective Services ever been involved in your child's life? If yes, please explain: _____
_____
Has there been any history of trauma or abuse, of any kind, in your home? If yes, please explain___
_____
Does anyone in your family have mental health problems? If so, please explain: _____
_____
Does your child have a religious affiliation? If so, what and how satisfying is it for him/her? _____
_____

Mark any issues that have been a problem in your family (N = now, P = in the past but not now)

___ Conflicts between parents ___ Separation/divorce ___ Work-related stresses ___ Recent move
___ Parent/child conflicts ___ Peer problems ___ School problems ___ Substance abuse
___ Conflicts between siblings ___ Financial stresses ___ Employment problems ___ Legal problems
___ Extended family conflicts ___ Medical problems ___ Housing problems ___ Recent death
___ Trauma/abuse ___ Religious, or cultural conflicts ___ Other: _____

For the following substances, please:
Write "**E**" next to those substances your child has **Experimented** with, but doesn't currently use.
Write "**U**" next to those substances your child occasionally **Uses,** without getting drunk or high.
Write "**I**" next to those substances your child uses (even sometimes) to get **Intoxicated** or high.
Write "**A**" next to those substances your child has ever been **Addicted** to or dependent on.

___ Caffeine ___ PCP/Angel Dust ___ Inhalants ___ Marijuana ___ Others (specify)
___ Alcohol ___ LSD/Hallucinogens ___ Cocaine or crack ___ Opiates/Heroin
___ Tobacco ___ Prescription drugs ___ Ecstasy ___ Amphetamines

Has your child ever been treated for substance abuse? **If yes, where/when?**_____
_____

Has your child ever been arrested? If so, for what? _____

_____

Are there any current charges, fines or sentences? _____

_____

What is your child's level of physical health? __ **excellent** ___ **good** ___ **fair** ___ **poor**

Please list any significant physical problems your child has had: _____

_____

Is he/she taking any medications? If so, specify including dosages: _____

_____

Are they effective and do they cause any side effects? _____

_____

Please check any of the following that are part of your child's medical history:

__ Seizure __ Neurological disorder __ Traumatic brain injury __ Loss of consciousness
__ Stroke __ Blood pressure problems __ Thyroid problems __ High Fever

Were there any complications during the mom's pregnancy with this child? If yes, please explain: __

_____

Were there any complications with the labor or delivery of this child? If yes, please explain: ____

_____

Was your child delivered full term? If not, how early or late? _____

How much did your child weigh at birth? _____

Did your child require any unusual medical care following birth? If yes, please explain:

_____

Please describe your child's progress on developmental milestones:

Task	Typical Development	Your Child's Development		
Lifts head	1 – 3 Months	__ Delayed	__ Typical	__ Early
Smiles	1 – 3 months	__ Delayed	__ Typical	__ Early
Babbles	4 – 11 months	__ Delayed	__ Typical	__ Early
Sits alone	5 – 8 months	__ Delayed	__ Typical	__ Early
Stands	6 – 10 months	__ Delayed	__ Typical	__ Early
Walks	11 – 14 months	__ Delayed	__ Typical	__ Early
First words	11 – 15 months	__ Delayed	__ Typical	__ Early
Pretend play	12 – 24 months	__ Delayed	__ Typical	__ Early
Toilet trained	20 – 48 months	__ Delayed	__ Typical	__ Early
Speaking in sentences	2 – 3 years	__ Delayed	__ Typical	__ Early
Riding tricycle	2 – 3 years	__ Delayed	__ Typical	__ Early
Playing cooperatively	4 – 6 years	__ Delayed	__ Typical	__ Early
Writing letters/numbers	4 – 6 years	__ Delayed	__ Typical	__ Early

Please list the following information for everyone living in your home:

Name	Age	Gender	Relationship to child

Where was this child born? _____ **Where did he/she grow up?** _____

If his/her parents are divorced, how is parenting time shared? _____

Describe the child's father, his occupation, and the child's relationship with him: _____

Describe the child's mother, her occupation, and the child's relationship with her: _____

Describe the child's relationships with his/her siblings: _____

Describe the child's relationships with any step-parents, step-brothers or step-sisters:

What has this child been like growing up? _____

Mark your child's current traits with an "N" and Past traits (that are not current) with a "P".

___ Easy going	___ Perfectionistic	___ Disorganized	___ Irritable
___ Organized	___ Shy	___ Confused	___ Impulsive
___ Confident	___ Sensitive	___ Moody	___ Rebellious
___ Talkative	___ Insecure	___ Withdrawn	___ Reckless
___ Adventurous	___ Submissive	___ Distrustful	Other

Please mark below any problems you would say have ever been significant in your child's life:

___ Pre-natal problems	___ Enuresis/Encopresis	___ Learning disabilities	___ Fights/aggressive
___ Birth complications	___ Nail biting/hair pulling	___ Focus problems	___ Destructiveness
___ Infant illness/injury	___ Nightmares/Night terrors	___ Hyperactivity	___ Swearing
___ Delays in development	___ Stuttering	___ Difficulties with peers	___ Running away
___ Separation anxiety	___ Tantrums	___ Lying/stealing	Other

How easily has your child made/maintained friends? _____

Has your child been bullied or bullied others regularly? If yes, please explain: _____

How comfortable is your child with children of the same sex? _____

With the opposite sex? _____

What has been his/her experience with dating? _____
_____

If your child is currently dating, how do you feel that is going? _____
_____
What is your child's attitude toward school? _____
_____
How much motivation does he/she have to achieve in school? _____
_____
How much effort do you see regarding homework? _____
_____
How much parental supervision/follow-up is required? _____
_____
Has he/she ever skipped a grade? _____ **Has he/she ever been held back?** _____
What is your child's typical grade range in school? _____
Are there any subjects he/she tend to struggle with? _____
_____
Has he/she ever been suspended or expelled? If so, please explain: _____
_____
What would you like your child to accomplish through therapy? _____
_____
_____
_____
_____

Is there anything else you would like me to be aware of? _____
_____
_____
_____
_____

THANK YOU

PATIENT E-MAIL CONSENT FORM

I, _____ (Parent name) would like to be able to use e-mail to communicate with Dr. Johns and his staff. I understand that e-mail is to be used *solely* for ***non*-emergency** questions and requests in the ordinary course of business. I understand that, if necessary, Dr. Johns' staff may have access to some e-mails related to their work as follows:

Name/Position	Purpose
Dr. Bruce Johns	Treatment
Receptionist	Scheduling /dispersal of information
Billing Secretary	Billing and Collections

I understand that confidential and sensitive information will never be shared with a third party without my written authorization. I also understand that there are certain situations in which Dr. Johns and his staff may share my e-mail messages without written authorization (e.g., disclosures required by state or federal law). I understand that if law requires a disclosure, Dr. Johns will attempt to provide only the amount of information he judges necessary to achieve the purpose of the request and I will receive notice that the disclosure was made.

RESPONSE TIME

I understand Dr. Johns will try to respond to my e-mail within 2-3 business days, unless he considers it counter-therapeutic to do so. If, for any reason (such as vacation, illness, emergency), Dr. Johns is unavailable to answer my e-mail request within that time frame, I understand he will respond as soon as he is available.

PERMISSIBLE USES

Permissible email use includes:

1. Communication about client status.
2. Communication about third-party involvement (meetings with other providers, school professionals, etc.).
3. Confirmation of currently scheduled appointments.
4. Request to schedule additional appointments; this request will be followed up by a phone call to schedule for specific dates and times.

NON-PERMISSIBLE USES

Prohibited uses of e-mail include but are not limited to:

1. Urgent or time-sensitive communications
2. Appointment scheduling, cancelling, or changing.
3. Highly sensitive or sensitive information. Email is *not* compliant with HIPPA standards; therefore, the privacy of the information you provide and/or receive cannot be guaranteed or maintained. Highly confidential or sensitive information (e.g., discussion of HIV status, mental illness, chemical dependency and workers' compensation claims) should not be transmitted.
4. Using e-mail to attach large database files or files containing inappropriate materials unrelated to the permissible uses defined above.
5. If Dr. Johns feels the content or subject matter of an e-mail is inappropriate for an electronic response, I understand he has the right to refuse communication via e-mail and may suggest an alternate means to discuss the question or request. I understand that at no time should I expect a diagnosis, a recommendation of treatment or a prognosis via e-mail regarding a complaint or

symptom for which the doctor did not see me personally, regardless of whether the doctor has seen me personally on prior occasions.

6. I understand that at any time Dr. Johns may terminate e-mail communications with me and that I will be notified of such termination in writing. I understand that termination of online communication does not necessarily mean termination of the patient-doctor relationship.

PARENTAL RESPONSIBILITIES

I understand that e-mail should be used only for appropriate messages and non-urgent situations. I agree to call the practice immediately if the situation escalates to a point where a phone call or visit is necessary. I also agree to do the following when making an e-mail request:

1. Clarify the nature of the information or service requested.
2. Place my full name in the first line of the body of the message.
3. Configure automatic reply to acknowledge receipt of the message, if possible.

I also understand that all messages, will become part of my medical record. I understand it is my duty to maintain my own copies of e-mail communications.

SECURITY

Dr. Johns has the following security mechanisms in place to secure confidential and sensitive information:

1. I understand that after receipt, emails will be deleted from email account and will be placed into my file. I understand, the transmission of email cannot be secured and is not, therefore, compliant with HIPPA.
2. Back-ups of data will be performed *weekly, into long-term storage*.
3. Password protection allows access only staff authorized to access and handle office e-mail communications.
4. Password protected screen savers will be used on computers, including keeping all screens out of public view.
5. Information sent in a group mailing will maintain the confidentiality of the patient by using a blind copy to keep recipients invisible to each other.

INDEMNIFICATION

I agree to indemnify, defend, and hold harmless **Bruce R. Johns, Ph.D., P.C.**, its officers, directors, employees, agents and independent contractors from and against any and all losses, expenses, damages and costs arising out of my use of Patient e-mail, any activity related to my patient account information and any information lost due to technical failures.

CONSENT

I have read this consent, have been given the opportunity to discuss the issues with Dr. Johns, and understand that by signing this consent I agree to the above policy and conditions. I understand that I may also withdraw consent for the use of e-mail interactions at any time without affecting my right or access to future treatment.

_____

Child's Name

_____ _____

Parent's or Guardian's Signature **Date**

BRUCE R. JOHNS, PHD, PC

SUMMARY OF PRIVACY PRACTICES

I am required by law to follow the guidelines described in this summary. All associates with whom I share on-call emergency services are also bound by the same principles and conditions. This is a summary of privacy practices, but does not replace the full—a copy of which you may also receive upon request or may review at my office at any time. This notice describes how medical information about you may be used and disclosed and how you can access that information. This notice applies to personal health information that is kept in or by the practices in Mt. Logan Clinic. Neither this summary nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Officer for the specific practice providing your treatment.

We may use your personal health information to:

- Plan your treatment and services
- Submit bills to your insurance, Medicaid, Medicare, or other third party payer.
- Obtain approval in advance from your insurance company to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.
- Perform healthcare operations such as sharing your information with business associates who need to use or disclose your information to provide a service for our medical practice (e.g., our billing company).
- Exchange information with other state agencies as required by law.
- Treat you in an emergency
- Treat you when there is something that prevents us from communicating with you.
- Send you appointment reminders.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- To agencies involved in a disaster situation
- As required by state, federal, or local law; this includes investigations, audits, inspections, and licensure.
- To law enforcement if you are a victim of a crime, if you are involved in a crime at our facility, if you have threatened to commit a crime, or if abuse of a minor is reported or suspected.
- To a parent or guardian when a minor reports a life-threatening concern (e.g., threat of suicide or homicide).
- To coroners, medical examiners, and funeral homes when necessary for them to fulfill their professional obligations.
- When ordered to do so by a court or judge.
- To federal officials involved in security activities authorized by law.
- To a correctional facility if you are an inmate within that facility.

As a patient in our clinic, you have the right:

- To ask that we communicate with you about medical matters in a certain manner or at a certain location; this request must be made in writing.

- To inspect and obtain a copy of your record; however, there are several exceptions provided by federal legislation—some of which are specific to mental health records
- To appeal our decision if we decide not to allow you to see all or some parts of your record
- To ask for the record to be changed if you believe you see a mistake or something that is incomplete; you must make this request in writing.
    - We may deny your request if: 1) we did not create the incorrect or inaccurate entry; 2) the information is not part of the file that we keep permanently; 3) the information is not part of the file that we would ordinarily permit you to see; or 4) if we believe that the record is accurate and complete.
- To require that we limit how we use or disclose information you. For example, a request that we *not* release information to a particular healthcare provider or agency; this request must be made in writing and we are not obligated to comply with this request.
- To know to whom we have sent information about you for up to the last six years. The first request in a 12-month period is free of charge, but we may charge you for additional requests.
- To have a paper copy of the Notice of Privacy Practices.
- To file a complaint if you believe that any of your rights have been violated; all complaints must be made in writing. You will *not* be penalized in any fashion for filing a complaint.
- To authorize and/or direct us to release any of your personal information (including anything not described above). You may change your mind and remove this authorization at any time in writing.
- If you wish to exercise any of these rights or to file a complaint, you should contact the Privacy Officer of the individual practice involved.

Acknowledgement of Privacy Practices

I, _____, acknowledge that I have read the Notice of Privacy Practices.

_____ _____

Signature Date

RELEASE OF INFORMATION

I,_____ (parent/guardian) authorize (check all that apply):

___ Dr. Johns to send medical/ health/ and/or psychological information to:
___ Dr. Johns to receive medical/ health/ and/or psychological information from:
___ Dr. Johns to exchange information and consult with:

Professionals/Organizations/Persons	Address	Telephone	Fax
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient name _____ Birthdate _____
Authorizing Parent/Guardian's name: _____ Phone _____
Address: _____

I specifically authorize the following information to be released:

__ initial evaluation (includes presenting problem, history of problem, previous treatment, personal & family background, diagnosis, prognosis, treatment plan)
__ treatment plan
__ treatment progress
__ diagnosis
__ medications
__ other (specify) _____

Reason for release of Information (e.g. coordinating care, transfer of care, application/insurance requirement, etc.): _____

_____ _____
Signature of Parent/Guardian Date

Important:

- You may revoke this authorization at any time by written request. Obviously, the revocation can't apply to information already released.
- There may be charges associated with the time required to fulfill this release of information.
- Your treatment is not conditional on signing this authorization.
- You are entitled to a copy of this authorization upon request.
- This authorization will expire one year from the date of your signature above.

Bruce R. Johns, Ph.D., P.C. 246 E. 1260 N. Logan, UT 84341 P.O. Box 6244,
Ph. 435-750-6300 Fax 435-753-8995