Gentry Pediatric Behavioral Services, PLLC
Evaluation and Treatment Process

IMPORTANT INSTRUCTIONS

1. Download, print, read and fill out ALL of the forms including:
    Reason for Referral
    Consent
    Developmental History
    Authorization to Release Information –
    Informed Consent (for therapy clients only)

2. ***Fill out the Authorization to Release/Exchange information form for your child's school district if he/she is being evaluated as an Independent Educational Evaluation (IEE)*

3. Fax or Mail ALL forms back to : Gentry PBS (Intake)
    7600 N. 16th Street, Suite 110
    Phoenix, AZ 85020
    Fax- (602) 314-4175

4. Upon receiving these forms, you will receive a phone call and/or e-mail to schedule an intake/assessment appointment with our team at Gentry PBS.

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

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

Thank you, if you have any questions please do not hesitate to call me at 602-312-2911.

Joseph "Dr. Joe" Gentry, Ph.D., BCBA-D

INITIAL INTAKE QUESTIONNAIRE

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

First and last name of person completing form: _____

Relationship to client: _____ Date of completion: _____

REASON FOR REFERRAL

How did you hear about Gentry PBS? _____
_____

What services are you interested in receiving from Gentry PBS?

O Independent Educational Evaluation
O Private Educational Evaluation
O Diagnostic Evaluation
O Functional Behavioral Assessment
O Counseling
O Parent Training
O Behavioral Consultation
O Unsure

Please describe why you want your child to be seen at this time?_____
_____
_____
_____

What are your goals for evaluation/treatment/consultation?

1. _____
2. _____
3. _____

CLIENT/CHILD INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Nickname: _____ SSN: _____ Gender: O Male O Female
Ethnicity: _____ Primary Language: _____ Language spoken at home: _____
Date of Birth: _____ Place of birth: _____
month / day / year city / state
Address: _____
street / city / state / zip code
County of Residence: _____ Home Phone: (_____) _____
E-mail: _____ Cell Phone: (_____) _____
Who does the client live with?
O Both parents O Mother O Father O Other (specify): _____
Physician: _____ Phone: (_____) _____
Address: _____
street / city / state / zip code

PARENT/GUARDIAN INFORMATION

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

Mother's name: _____ Date of Birth: _____
□ check here if contact information is the same as client's, and if so, skip directly to e-mail
Address: _____
street / city / state / zip code
County of Residence: _____ Home Phone: (_____) _____
E-mail: _____ Cell Phone: (_____) _____
Occupation (if applicable): _____ Work Phone: (_____) _____
Highest level of education completed: _____

Father/Guardian: O Birth father O Adoptive O Stepfather O Guardian O Other
Father's name: _____ Date of Birth: _____
□ check here if contact information is the same as client's, and if so, skip directly to e-mail
Address: _____
street / city / state / zip code
County of Residence: _____ Home Phone: (_____) _____
E-mail: _____ Cell Phone: (_____) _____
Occupation (if applicable): _____ Work Phone: (_____) _____
Highest level of education completed: _____

Parents' Marital status:
O Married O Divorced O Separated O Widowed O Never married O Unknown

Please indicate date married/divorced/separated/widowed: _____
If parents are separated/divorced, who has custody: _____
(please attach legal documentation)

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

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

Other members living in the household: O Yes O No

If yes, list names and relationship to the child: _____
_____

FAMILY HISTORY

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

O Moved _____ O Divorce _____
O Marriage _____ O Seperation _____
O Serious illness _____ O Accident _____
O Death _____ O Arrests _____
O Any other significant events: _____

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

DEVELOPMENTAL HISTORY

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

Describe any difficulties or complications during pregnancy: _____
_____

Length of pregnancy: _____ Birth weight: _____

Type of birth: O Vaginal O Caesarian Section

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

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

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

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

When did you start to worry about your child's development? _____
Has your child been diagnosed with a special need(s)? O Yes O No
If yes, indicate: _____
Is he or she receiving any special services and by whom? _____
_____

MEDICAL HISTORY

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

Serious illnesses or hospitalizations? O Yes O No If yes, explain: _____
_____
_____

Serious head injuries or accidents? O Yes O No If yes, explain: _____
_____

Vision Problems or glasses? O Yes O No If yes, explain: _____
Hearing Problems or hearing aides? O Yes O No If yes, explain: _____
Has your child been diagnosed with a physical condition or allergies? O Yes O No If yes, explain:
_____

Has the child ever had treatment for this? O Yes O No
If yes, when and where? _____
Has your child been diagnosed with a psychological or behavioral disorder? O Yes O No If yes, explain:
_____

Has the child/client ever had treatment for this? O Yes O No
If yes, when and where? _____

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

List any medication or supplements child/client is receiving:

Medication Dosage Time(s) given

_____
_____
_____
_____

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

Previous Psychological/Psychiatric Evaluations O Yes O No

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

_____
_____
_____

SOCIAL/BEHAVIORAL HISTORY

Please select any behavioral characteristics that apply to your child:

O Aggressive
O Contact with police
O Noncompliant
O Substance abuse
O Distractible
O Forgetful
O Short attention span
O Overly active
O Impulsive
O Angry
O Sad or depressed
O Cries a lot
O Happy
O Low self-esteem
O Worries a lot
O Fearful
O Perfectionist
O Shy
O Withdrawn
O Friendly

O Any other behavioral problems:_____
_____

Does you child play well and socialize with other children? O Yes O No
Explain: _____

Does he or she have friends? O Yes O No
Favorite toys or activities: _____

Any preoccupations/rituals/obsessions? _____

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

Does your child belong to any social groups, clubs, or sports teams? O Yes O No
If yes, please indicate: _____

STRENGTHS OF CHILD/CLIENT AND FAMILY

What are the child's strengths? _____
_____
_____

What are your family's strengths? _____
_____
_____

EDUCATIONAL HISTORY

School the child currently attends: O Preschool Name: _____
O Public School Name: _____
O Private School Name: _____

Grade: _____
Address: _____
street / city / state / zip code

School phone number: _____ School district: _____
Name of classroom teacher:_____ Teacher's email address: _____

List all schools attended, including preschool.

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

Does your child experience frequent absences from school? O Yes O No
If yes, please explain: _____

Has your child been retained? O Yes O No
If yes, please explain: _____

Ever suspended? O Yes O No
If yes, what grade(s)? _____ Why? _____

Has your child been tested at school recently? O Yes O No (If yes, please attach the report)
Has your child been identified as gifted? O Yes O No
Does your child receive special education services? O Yes O No

If yes, what is the eligibility category? _____
What services does you child receive at school?_____
_____

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

AUTHORIZATION TO RELEASE/EXCHANGE PROTECTED HEALTH INFORMATION (PHI)

_____ Date of Birth: _____
Print Name of Client

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

Address: _____
Street City State Zip Code

I hereby authorize the Gentry Pediatric Behavioral Services (G-PBS) to release/exchange the following confidential health information (for the purpose of continuity of care), related to the client named above via fax, phone, e-mail, or in person. With this consent, I understand that this means that confidential documents may be sent over the internet and that the internet is not always completely safeguarded and Protected Health Information could possibly obtained by unauthorized users. I understand that this consent may be withdrawn at any time by notifying Gentry PBS, in writing, at the following address: 7600 N. 16th St., #110, Phoenix, AZ 85020.

☐ Psychological ☐ Educational ☐ Medical ☐ Other _____

Release/Exchange to:

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

Address: _____
Street City State Zip Code

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

This authorization expires:

☐ on _____
Specify Date or Condition of Expiration

☐ one year from the date signed

☐ upon Gentry PBS's receipt of a written request to revoke authorization (at the address below)

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

INSURANCE INTAKE QUESTIONNAIRE

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

Patient's name:_____ Patient's DOB:_____

Name of policy holder: _____ Policy holder's DOB:_____

o check box if the patient is the policy holder

Policy holder's address:

_____

_____

Policy holder's phone number:_____

Name of insurance carrier: _____

Provider services phone number: _____

Insurance billing address:_____

ID:_____ Group #:_____

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

Group plan name:_____

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

_____

Signature of patient (or legal guardian) date

o verbal consent was give over the phone _____

signature of office staff

Office Use only:

Dx code:

GENERAL CONSENT

I, _____, consent to
Print Name(s) of Parent(s)/Guardian(s)/Adult Client, providing authorization

participation in, or authorize _____ to participate in assessment*, evaluation,
Print Minor Client's Name

treatment, and/or other services deemed necessary or advisable by Gentry PBS staff for those seeking to participate in Gentry PBS programs and/or services.

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

EMAIL CONSENT	Parent 1	Parent 2
	_____	_____
	Initial	**Initial**

_____ _____
Print Name of Parent/Guardian/Adult Client **Signature of Parent/Guardian/Adult Client**

Date Signed_____

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

_____ _____
Print Name of Parent/Guardian/Adult Client Signature of Parent/Guardian/Adult Client

Date Signed_____

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

Under the Americans with Disabilities Act, GENTRY PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, GENTRY PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials.

It also means that GENTRY PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: GENTRY PBS (602) 312-2911.

NOTICE OF PRIVACY PRACTICES

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

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

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

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

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

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

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

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

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

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

Health Oversight Activities
We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include monitoring, audits, investigations, inspections, and licensure.
Deceased Persons
We may disclose your health information to coroner's medical examiners.

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

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

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

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

Marketing
We may contact you for marketing purposed or fundraising purposes, as described below:
(Example)

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

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

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

Your Health Information Rights

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

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

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

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

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

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

Washington, DC 20201

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

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

_____	_____	_____
Print Name of Parent/Guardian/Client	Signature of Client/Parent/Guardian	Date Signed

_____	_____	_____
Staff Name, Title/Credentials	Signature	Date Signed

Client Rights

A client has the following rights:

1. To be treated with dignity, respect, and consideration;

2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;

3. To receive treatment that:
   a. Supports and respects the client's individuality, choices, strengths, and abilities;
   b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
   c. Is provided in the least restrictive environment that meets the client's treatment needs;

4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;

5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;

6. To have grievances considered by a licensee in a fair, timely, and impartial manner;

7. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;

8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;

9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;

10. To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);

11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
   a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
   b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
   c. For video recordings used for security purposes that are maintained only on a temporary basis; or
   d. As provided in R9-20-602(A)(5);

12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);

13. To review the following at the agency or at the Department:
   a. This Chapter;
   b. The report of the most recent inspection of the premises conducted by the Department;
   c. A plan of correction in effect as required by the Department;
   d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and
   e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;

14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;

15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;

16. To be offered or referred for the treatment specified in the client's treatment plan;

17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;

18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the

client's life or physical health, or is provided according to A.R.S. § 36-512;

19. To be free from:
    a. Abuse;
    b. Neglect;
    c. Exploitation;
    d. Coercion;
    e. Manipulation;
    f. Retaliation for submitting a complaint to the Department or another entity;
    g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
    h. Treatment that involves the denial of:
        i. Food,
        ii. The opportunity to sleep, or
        iii. The opportunity to use the toilet; and
        iv. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;

20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;

21. To control the client's own finances except as provided by A.R.S. § 36-507(5);

22. To participate or refuse to participate in religious activities;

23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;

24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;

25. To participate or refuse to participate in research or experimental treatment;

26. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;

27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;

28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility.

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

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

you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: Gentry PBS (602) 312-2911.

CLIENT FEES & REFUNDS

Client Fees

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

Client Refunds

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

_____ _____

Signature Date

Under the Americans with Disabilities Act, Gentry PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, Gentry PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that Gentry PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity.

If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: Gentry PBS (602) 312-2911.

FAMILY CONFIDENTIALITY AGREEMENT

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

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

By signing this document, I agree to:

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

Print Child/Client Name	Print Parent/Guardian Name
Parent/Guardian/Client Signature	Date
Signature of GENTRY PBS Staff	Date

Under the Americans with Disabilities Act, GENTRY PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, GENTRY PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that GENTRY PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an

activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: GENTRY PBS (602) 312-2911.

GRIEVANCE POLICY

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

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

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

Date & Time: _____ Staff Member Receiving the Grievance: _____

Complainant: _____ Phone Number: _____
Address
_____
City, State, Zip:
_____
Name of Client(s) involved:
_____
Complainant's relationship to client(s) or involvement in situation:
_____
Name and title of any staff members involved:
_____
Describe the situation (include events leading up to and after the event/situation): *Continue on the back of this form, if necessary*.
_____
_____
_____
What does complainant want to happen?
_____
_____
_____
If grievance was <u>not</u> resolved, grievance was <u>referred</u> to:
_____
Staff Comments:
_____
Resolution:
_____
Resolved by: _____ Date: _____
Date complainant was notified: _____ ☐ Telephone ☐ Writing ☐ Other:_____
Comments:
_____
_____

Under the Americans with Disabilities Act, GENTRY PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, GENTRY PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that GENTRY PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an

DISCHARGING A CLIENT
INCLUDING AN INVOLUNTARY DISCHARGE

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

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

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

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

Acknowledgement of Receipt of Information

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

acknowledge the receipt of the following:

1) Notice of Privacy Practices

2) General Consent for Services

3) Gentry PBS's Fees & Refunds Policy

4) Family Confidentiality Agreement (if applicable)

5) Consent form(s) for audio, video, photographs (if applicable)

6) An explanation of client rights

7) Gentry PBS's Grievance Policy

- Please **complete**, **sign, and date** items 1-5, in **bold**, and **return** them to Gentry PBS.

_____	_____	_____
Print Name of Parent/Guardian/Client	**Signature of Parent/Guardian**	**Date Signed**

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

_____	_____	_____
Print Name of Parent/Guardian/Client	**Signature of Parent/Guardian**	**Date Signed**

Under the Americans with Disabilities Act, Gentry PBS must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, Gentry PBS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that Gentry PBS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact: Gentry PBS (602) 312-2911.

Psychotherapist- Client Contract
Informed Consent

Outpatient Services Contract

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

Psychological Services

Psychotherapy is not easily defined in general statements. It varies depending on the personalities of the psychologist and client and the particular problems you bring forward. There are many different methods I might use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on this we talked about during our session when you are on your own.

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

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

School Evaluations and FBA's
School based evaluations, including FBA's, and psychoeducational evaluations are other services that can be included under this agreement. Rates for these services are also currently $150 per hour, including observations, assessment and assessment scoring, teacher/parent interviews, report writing, and meeting attendance. Although the risks involved in assessment are much less than during typical psychotherapy, the limits of confidentiality are the same, and can be read below in the confidentiality section of this agreement.
Initial_____

Meetings

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

Professional Fees
My current private pay hourly fee is $150. In addition to weekly appointments, I charge this hourly rate for other professional services you might need, though I will break down the cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 30 minutes, attendance at meetings with other professionals you have authorized (IEP meetings), preparation of records or treatment summaries, and the time spent performing any other services you request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $300 or more per hour for preparation and attendance at legal proceedings.
Initial_____

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

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the service provided, and the amount due.
Initial_____

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

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. I will provide you with whatever information I can based on my experience and will be happy to help you in

understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

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

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

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

Contacting Me
I am often not immediately available by telephone. While I am usually working between the hours of 9 A.M. and 5 P.M., I will probably not answer the phone if I am with a client. When I am not available I suggest you leave a message on my voicemail, which I check regularly. I will make every effort to return your phone call within 24 hours with the exception of weekends and holidays. If you are difficult to reach, please inform me of times you will be available. If you are unable to reach me and feel you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the clinician/psychologist/psychiatrist on call. If I will be unavailable for an extended holiday, I will provide you with the name of a colleague to contact, if necessary.
Initial_____

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

Minors
If you are under 18 years of age, please be aware that the law might provide your parents with the right to examine your treatment records. It is my policy to request an agreement with parents that they give

up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have about what I am prepared to discuss.
Initial_____

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

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

- For example, if I believe that a child, elderly person, disabled person, etc. is being abused I must file a report with the appropriate state agency.

- If I believe a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

- If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection.

These situations rarely occur in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel it is important to our work together.
While this written of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicated that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature_____Date_____

Printed
Name_____