Intake and Medical History (Child)

1. **Please enter your information.**

First Name: ____________ Middle Initials: ____________ Last Name: ____________ Date of Birth: ____________

Gender:
- ○ Female ○ Male

Marital Status:
- ○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: ____________ Apt./Unit #: ____________ City: ____________ State: ____________ Zip Code: ____________

Mobile Phone: ____________ Home Phone: ____________ Work Phone: ____________

Email: ____________

Preferred contact method:
- ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Occupation ____________ Employer ____________

Referred to our clinic by
- ☐ Doctor ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Online ☐ Other

Other family members seen here: ____________

2. **Billing Information**

Person responsible for bill ____________

Birth date ____________

Address (if different) ____________

Home phone no.: ____________

Is this person a patient here?
- ○ Yes ○ No

Occupation: ____________ Employer: ____________

Employer address: ____________

Employer phone no.: ____________

3. In Case of Emergency

Name of a local friend or relative (not living at same address)

Relationship to patient

Phone Number

4. General Information

Child's Name

Current Height:

Current Weight:

Who referred you to our office?

What brings you to our office?

5. Family Background

Parent's Name(s)

Home Address

City

Zip Code

Home Phone

Father's Business Phone

Father's Cell Phone

Mother's Business Phone

Mother's Cell Phone

Biological Father's Age

Biological Father's Education (# of years)

Did Biological Father go to college? If yes, what was the degree?

Biological Father's Occupation

Biological Mother's Age

Biological Mother's Education (# of years)

Did Biological Mother go to college? If yes, what was the degree?

Biological Mother's Occupation

List name, age, sex, and relationship to your child of all persons living in the home:

Pediatrician's Name

Pediatrician's Phone Number

Is your child:
○ Adopted ○ Stepchild ○ Foster Child ○ Natural Child

Are the parents:
○ Married ○ Separated ○ Divorced ○ Deceased ○ Remarried

If divorced, does the individual filling out this form have legal custody of the child
○ Yes ○ No

How many languages are spoken in the child's home?

What is the dominant language of the home?

Does any disease run in the family?
○ Yes ○ No

If yes, please describe:

6. **Is there any history of the following in your immediate family or other relatives?**

	Describe
Chronic Illness	
Neurological Disease	
Seizures (Epilepsy)	
Genetic Disorders	
Hearing Problems	
Vision Problems	
Color Blindness	
Depression	
Emotional Problems	
Mental Retardation	
Language/Speech Problems	
Hyperactivity	
Learning Problems	
Dyslexia	
Bipolar Disorder	

7. **History of Pregnancy(ies) and Birth(s)**

Has the mother ever had any miscarriages?
○ Yes ○ No

If yes, how many?

____

Any complications in pregnancies? (excluding this child) If yes, please specify:

____

Mother's age at the time of child's birth:

____

Did the mother have any of the following complications during this pregnancy?
☐ High blood pressure ☐ Excessive sleepiness ☐ Swelling ☐ Exposure to X-Ray ☐ Fainting Spells
☐ Straining ☐ Morning sickness ☐ Viral Illness ☐ Rh Incompatibility ☐ Anemia ☐ Tension ☐ Dizziness
☐ Headaches ☐ Toxemia ☐ Bleeding ☐ Smoked ☐ Medication ☐ Drugs ☐ Alcohol

How much weight did the mother gain during pregnancy?

____

How many hours from first contraction to birth?

____

Was labor induced?
○ Yes ○ No

Was the baby born head first?
☐ Yes ☐ No ☐ Caesarean Section

Were forceps used?
○ Yes ○ No

Did the baby have any bruising?
○ Yes ○ No

If yes, where?

____

Was the mother medicated during labor?
○ Yes ○ No

If yes, what type of medication?

____

Was the mother under anesthesia during childbirth?
○ Yes ○ No

If yes, what type?

____

Which month of pregnancy was birth?
○ <6 ○ 7 ○ 8 ○ 9 ○ >9

If greater or less than 9 months, approximately how many weeks was the baby carried before delivery?

____

Infant's birth weight (lbs., ozs.)

____

APGAR Score (1st & 2nd)

____

Did the baby have breathing problems?
○ Yes ○ No ○ Don't Know

Was the cord around the baby's neck?
○ Yes ○ No ○ Don't Know

Did the baby cry quickly?
○ Yes ○ No ○ Don't Know

Was the baby's color normal?
☐ Yes ☐ No ☐ Don't Know ☐ Blue ☐ Yellow

Did the baby receive: (Check all that apply)
○ Oxygen ○ Transfusion ○ Phototherapy (lights) ○ Placed in an incubator or special crib

If any were checked above, please specify for how long and the reason for each:

____

Were there any other complications before the baby was brought home?

____

Was the baby breast fed?
○ Yes ○ No

If yes, until what age?

____

8. **At what age did your child do the following: (Please answer all developmental milestones to the best of your ability)**

	Age
Sit without support	
Stand	
Babble	
Say 3-6 different words	
Sleep through the night	
Toilet train (day)	
Toilet train (night)	
Crawl	
Walk alone	
Stop drooling	
Combine words	
Dress self	

9. **Developmental History**

Check the items that apply to your child's infant behavior:
☐ Frequently smiled ☐ Frequently cried (no cause) ☐ Cried when wet ☐ Easy to soothe
☐ Cried when hungry ☐ Difficult to soothe ☐ Enjoyed being held ☐ Enjoyed being rocked
☐ Regular feedings ☐ Regular sleep pattern ☐ Fussy ☐ Very active ☐ Very quiet
☐ Failed to gain weight

Does your child seem to speak as well as others of the same age?
○ Yes ○ No

If no, please explain:

____

Does your child have problems with any of the following: (Check all that apply)
☐ Pronouncing words ☐ Small vocabulary ☐ Not speaking ☐ Stuttering or stammering

Is your child's speech better in some situations than others?
○ Yes ○ No

If yes, please explain:

____

10. Please indicate the age at which any of the following items applied to your child:

	Age
Thumbsucking	
Head banging	
Toe Walking	
Sleepwalking	
Impulsiveness	
Nail biting	
Staring into space	
Playing with hair	
Frequent headaches	
Uncoordinated	
Tics	
Twitches	
Nightmares	
Clumsiness	
Frequent falls	

11. Child's Medical History

Has your child had his/her eyes examined?
○ Yes ○ No

If yes, what was the date and results of exam?

Has your child had his/her hearing testing?
○ Yes ○ No

If yes, what was the date and results of the test?

Does your child have a history of: (Check all that apply)
☐ Ear infections (before 2 yrs old) ☐ Ear infections (after 2 yrs old) ☐ Tubes inserted ☐ High fever
☐ Convulsions ☐ Seizures ☐ Fainting ☐ Asthma ☐ Colds ☐ Allergies ☐ Chronic Illness

If you checked any of the above, please provide a description and dates below:

As an infant, did your child have difficulties with: (Check all that apply)
☐ Sucking ☐ Eating Solid Foods ☐ Swallowing ☐ Sleeping ☐ Chewing

What major childhood illnesses has your child had? (e.g., chicken pox, mumps, etc.) Give dates for each.

In past years, what medications has your child taken for more than one week?

Does your child take any medications on a regular basis?
○ Yes ○ No

If yes, please list the medication(s): (Please include dosage, frequency and reason given)

Has your child ever been hospitalized?
○ Yes ○ No

If yes, what was the date and reason for hospitalization:

Has your child ever had an injury to the head?
○ Yes ○ No

If yes, give date and describe injury:

Did child lose consciousness? If so, for how long?

Has your child ever seen a psychiatrist?
○ Yes ○ No

If yes, please provide the name of the Dr. and dates seen:

If yes, what was the purpose of the appointment(s)?

Has your child ever seen a counselor or a therapist?
○ Yes ○ No

If yes, please provide the names and dates seen:

If yes, what was the purpose for the appointment(s)?

12. **Child's Education:**

Name of your child's school:

Type of school:
○ Public ○ Private ○ Other

Grade (Current)

Teacher: Counselor:

Has your child ever been enrolled in any special education program?
○ Yes ○ No

If yes, what type of program?

Has child ever repeated a grade?
○ Yes ○ No

If yes, what grade? Reasons for repetition?

Has your child ever received any kind of special services outside of school?
○ Yes ○ No

If yes, what type and when? What subjects is your child good at in school?

What subjects does your child have difficulty with? What are your child's current grades?

Do current grades represent a decrease or increase from previous?

Does your child have difficulty learning?
○ Yes ○ No

If yes, describe difficulties:

13. **Please fill in the following completely regarding where your child has attended school:**

	Name of School Attended:	Difficulties?
Preschool		
Kindergarten		
1st		
2nd		
3rd		
4th		
5th		
6th		
7th		
8th		
9th		
10th		
11th		
12th		

14. **Social Information**

Where does your child play most often?
○ Home ○ Outdoors ○ Friends

Does your child prefer to play alone?
○ Yes ○ No

What was your child's first experience in a play group situation?

____

When interacting with peers, he/she may generally be described as: (Check all that apply)
☐ Shy ☐ Withdrawn ☐ Assertive ☐ Enthusiastic ☐ Aggressive ☐ Follower ☐ Friendly ☐ Leader

What do you feel are your child's most positive behavioral characteristics?

____

What behaviors concern you?

____

When your child misbehaves, how do you respond?

____

How does your spouse respond?

____

Who usually disciplines and how?

____

How does your child respond to discipline?

____

Are there significant conflicts between parent and child?
○ Yes ○ No

Are there significant conflicts between siblings?
○ Yes ○ No

15. Give a brief description of your child's relationship with:

	Description of relationship
Mother	
Father	
Brother(s)	
Sister(s)	
Pet(s)	

16. Leisure

What type of leisure time activities does your child enjoy?

____

What are your child's favorite toys?

____

Does your child spend most of his/her play time:
○ Playing alone ○ Playing with siblings ○ With adults ○ With peers

On the average, how much television does your child watch each day?

____

What are their favorite programs?

____

Does your child belong to any organized groups? (e.g., Scouts)
○ Yes ○ No

If yes, which ones?

____

Does your child play organized sports?
○ Yes ○ No

If yes, which ones?

____

17. Presenting Problems

What do you feel is the major problem?

____

What does your spouse feel is the major problem?

____

What does the school believe to be the problem?

____

In what situations is the problem most apparent?

____

In what situations is the problem least apparent?

____

Have there been any incidents in the child's life that you believe caused noticeable changes in his/her behavior?
○ Yes ○ No

If yes, please explain:

___

Please provide any other pertinent information that you feel would be helpful to us in the evaluation of your child:

___

___

18. During the past TWO (2) WEEKS, how much (or how often) has you child...

	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4
Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4
Had problems sleeping - that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4
Had problems paying attention when he/she was in class or doing his/her homework or reading a good or playing a game?	0	1	2	3	4
Had less fun doing things than he/she used to?	0	1	2	3	4
Seemed sad or depressed for several hours?	0	1	2	3	4
Seemed more irritated or easily annoyed than usual?	0	1	2	3	4
Seemed angry or lost his/her temper?	0	1	2	3	4
Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4
Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4
Said he/she felt nervous, anxious, or scared?	0	1	2	3	4
Not been able to stop worrying?	0	1	2	3	4
Said he/she couldn't do things he/she wanted to do or should have done, because they made him/her feel nervous?	0	1	2	3	4
Said that he/she heard voices - when there was no one there - speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4

Said that he/she had a vision when he/she was completely awake - that is, saw something or someone that no one else could see?	0	1	2	3	4
Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or someone else?	0	1	2	3	4
Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4
Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4
Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4

19. **In the past TWO (2) WEEKS, has your child...**

	Yes	No	Don't Know
Had an alcoholic beverage (beer, wine, liquor, etc.)?			
Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?			
Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?			
Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?			
Has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?			
Has he/she EVER tried to kill himself/herself?			

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH

Doxy.me or SImpleHealth is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice and/or Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice or Doxy.me nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice or Doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice or Doxy.me – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice or Doxy.me.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a health care provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the health care provider in diagnosis and treatment of your condition.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Session Notes: I do keep "Session notes" and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

   a. For my use in treating you.

   b. For my use in training or supervising associates to help them improve their clinical skills.

   c. For my use in defending myself in legal proceedings instituted by you.

   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

   e. Required by law and the use or disclosure is limited to the requirements of such law.

   f. Required by law for certain health oversight activities pertaining to the originator of the session notes.

   g. Required by a coroner who is performing duties authorized by law.

   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a health care provider, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a health care provider, I will not sell your PHI in the regular course of my business.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the patients who received one form of care versus those who received another form of care for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "session notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on the date electronically transmitted

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Informed Consent for Psychotherapy

General Information: The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality: The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Treatment Agreement

Welcome to my practice! This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

NEUROPSYCHOLOGICAL/PSYCHOLOGICAL SERVICES

Assessment: Neuropsychological/psychological assessment can last anywhere from 2 to 6 hours depending on the nature of the referral question. Following administration of tests, I spend additional time scoring, interpreting, and writing a narrative report summarizing the findings. The results are then discussed in a feedback session which is conducted in the office.

Therapy: Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Our first few sessions will involve an evaluation of your 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. If you have questions about my procedures, we should discuss them whenever they arise.

MEETINGS

Therapy: Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 business hours advance notice of cancellation. Failure to provide 24-business hours advance notice will result in a cancellation fee of **$50.00** for therapy sessions.

Assessment: Due to the several hours reserved for neuropsychological evaluations, we require at least a 48-business hour advance notice for cancellations. Failure to provide a 48-business hour advance notice will result in a cancellation fee of **$500.00** for neuropsychological/psychological evaluations.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

PROFESSIONAL FEES

Fees are due at the time of service. My fee for an initial appointment is $ 195.00. Thereafter, my session fee is $165.00 for psychotherapy.

My hourly fee for neuropsychological assessment purposes is $230.00. Assessment refers to the administration, scoring, interpretation, and report writing. Other services may include telephone conversations, consulting with other professionals with your permission, and preparation of records or treatment summaries. If you are or become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. If you are here for evaluation at the request of a third party, signing this notice acknowledges that the limits of confidentiality have been explained to you and you understand these limits with respect to the evaluation and test results. This form serves as written, informed consent to all aspects of evaluation and treatment by Dr. Legler.

You agree that the fee for services is payable by:

Myself. Though my health insurance may reimburse me for some of these fees, I understand that I am fully responsible for payment for these services.

Additionally, I recognize that I am ultimately responsible for fees incurred on behalf of my care, which are the reasonable and customary fees of Dr. Legler.

CONTACTING ME

Due to my office schedule, I am often not immediately available by telephone. I will be unable to answer the phone when I am with another patient. I will make every effort to return your call on the same day you make it (with the exception of weekends/ holidays). If you experience an emergency, you should contact the nearest emergency room, or dial 911.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of Florida. Under the Florida Telemedicine Act, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

2. All existing confidentiality protections are equally applicable.

3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to treatment, better continuity of care, and reduction of lost work time and travel costs. Effective treatment is often facilitated when the healthcare provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. The provider may make assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in services, potential risks include, but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed,

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the provider not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the provider.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the treatment is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason or you request another provider, I will provide you with a list of qualified Psychologist to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. IN ADDITION, THIS SERVES AS AN ACKNOWLEDGEMENT THAT YOU BEEN PROVIDED WITH THE HIPAA NOTICE FORM DESCRIBED ABOVE FOR YOUR REVIEW.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Child Therapy Agreement

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $450 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Abbreviated Contract Draft

- If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.
- You are waiving your right to access to your child's treatment records**.**
- I will inform you if your child does not attend the treatment sessions.
- At the end of treatment, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
- You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

BY SIGNNG BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.