Judith Randall Company
8461 Turnpike Dr. #110 Westminster CO 80031

Intake

Child/Adolescent Development

(For clients under 18 years old)

Name of Patient:_____ D.O.B._____

Pregnancy and Birth: Full term Yes < No < C-Section Yes < No <
Complications or problems during pregnancy and/or birth:

_____

_____

_____

Developmental Milestones: (ages) sat-up _____ crawled _____ walked _____
talked _____ toilet training _____
Describe delays or complications in any of these areas:

_____

_____

_____

Describe any illnesses and/or surgeries or other medical conditions:

_____

_____

_____

Traumas: Yes < No < If Yes, describe:

_____

Day Care: Yes < No < If Yes, Where/When:

_____

Comments:

_____

Preschool: Yes < No < If Yes, Where/When:

_____

Comments: _____

_____

1st-5th Grade: Where: _____ Grades:

_____

Describe behavior:

_____

Type of classes (i.e. special ed., GATE, etc.)

_____

Comments:

_____

_____

_____

6th-8th Grade: Where: _____ Grades:

_____

Describe behavior:

_____

Type of classes (i.e. special ed., GATE, etc.)

_____

Comments:

_____

_____

9th-12 Grade: Where_____Grades:

Describe Behavior:_____

_____

Extracurricular Activities_____

_____

Siblings in the Home: _____

_____

Clients relationship/behaviors with siblings_____

_____

_____

Client's relationship/behaviors with peers_____

_____

_____

_____

Client's relationship with parents:_____

_____

_____

Client current medications:

Form completed by: _____Relationship to client:_____

JUDITH A. RANDALL COMPANY
8461 Turnpike Dr., Suite #110
Westminster, CO 80031

(720) 530-6031

PARENTAL CONSENT FOR TREAMENT OF MINOR CHILD/ADOLESCENT

I consent for treatment of my minor child/adolescent_____

_____ (DOB) _____, to participate in therapy sessions, with Judith A. Randall, LMFT. I understand that I can revoke this consent at any time.

Father's Name_____

Signature_____

Date

Mother's Name_____

Signature_____

Date

INFORMED CONSENT FOR TREATMENT

WELCOME TO JUDITH RANDALLCOMPANY

Client Name _____

Welcome! I am happy to have you or your family member as a client, and will do everything within my professional capacity to make the treatment as productive as possible.
The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals are essential for the best benefit of therapy. If you ever have any questions about the nature of the treatment or anything else about the care, please do not hesitate to ask.

CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION

It is understood that all information between patient and psychiatrist/therapist is held strictly confidential, and the psychiatrist/therapist will not release any information about therapy unless permitted by law or:
1. It is agreed upon in writing and complies with Colorado State Laws,
2. The patient presents an imminent danger to self,
3. The patient presents an imminent danger to others,
4. Child/elder abuse/neglect is suspected,
5. As necessary for continuity of care,
6. If a judge determines that our discussions are not confidential, a judge may request specific information,
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3 and #4, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions. Judith Randall follows the 'minimum necessary" rule for release.

CLIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child's case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment, payment and Health Care Operations. I further consent to the release of information to my health plan for claims, certification/case management/quality improvement and other health plan purposes.

GENERAL CONSENT FOR TREATMENT

I further authorize and request that my therapist carry out psychological examinations, treatment, and/or diagnostic procedures that now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. (If patient is a child or dependent of beneficiary) On the patient's behalf, I (the legal Guardian or Legal Representative) authorize Judith Randall to deliver mental health services to the patient. I understand that all policies stated on this page apply to the patient. I accept that the child's records are confidential and that by law, I cannot have access to the child's records if such access would be detrimental to the child

_____

Client/Legal Representative Signature Date

_____

Provider Signature and License Date

I know I have the right to revoke this Authorization which must be in writing and given to my provider. I understand that if I revoke this authorization, my providers may determine that treatment cannot be effective without Continuity of Care, and may elect to transfer my care outside of the JUDITH RANDALL COMPANY. This Authorization is valid as long as I am treated at JUDITH RANDALL COMPANY, or by my revoking this Authorization in writing.

_____

Parent/Legal Representative Signature Date

FINANCIAL TERMS:

INDIVIDUAL SESSIONS: $85 COUPLES/FAMILY SESSIONS: $100
I understand that I can submit Out of Network Provider Forms to my insurance company and it is ultimately my responsibility to know my insurance benefits and coverage. Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will reimburse me according to my contract with them for Out of Network Providers. I will be responsible for payments at the time of service at JUDITH RANDALL COMPANY. I agree to make these payments at each appointment. I understand the charge for a bounced check is $20.

EMERGENCY PROCEDURES
If you need to contact your provider, leave a message at (720) 530-6031 and your call will be returned by the next business day. If an emergency situation arises, call 911 or go to the nearest emergency room.. Please do this for true emergencies only. There may be a charge for telephone consultations that require 10 minutes or longer.

CANCELLED/MISSED APPOINTMENTS & REQUEST FOR RELEASE OF RECORDS
In the event of a "No Show" or failure to give a full 24-hour notice of a cancellation, a $50 charge will be assessed to all late cancellations and missed appointments. If I sign to request my records to be released, there will be a $20 fee for release of records (government agency request are excluded).
Patient's Initials

Client Notice of Privacy Practices

To My Valued Clients:

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their clients' consent for uses and disclosures of health information about the client to carry out treatment, payment, or healthcare operations.

As my client, I want you to know that I respect the privacy of your personal medical records and will do all I can to secure and protect that privacy. I strive to always take reasonable precautions to protect your privacy. When appropriate I provide the minimum necessary information to only those I feel are in need of your health care information. This includes information about treatment, payment and/or health care operations in order to provide health care that is in your best interest.

I also want you to know that I support appropriate access to your medical records. With your consent, I may disclose personal health information for purposes of treatment, payment, or health care operations such as communication to hospitals, co-treaters, pharmacies, health plans, and laboratories.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your Personal Health Information (PHI), I have the right to refuse to treat you. If you choose to give consent in this document, at some future time you may request to refuse to disclose all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. You may request a restriction on any authorization to disclose PHI. I am not required to agree with this restriction request. You have the right to have your physician amend you Protected Health Information. If I deny your request, you may file a disagreement and prepare a rebuttal, which will be added to your PHI. You have the right to receive accounting of any disclosures I have made.

I want you to know that all I continually undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." I strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

As part of this plan, I have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. More so, I welcome your input regarding any service problem, so that I may remedy the situation promptly.

Thank you for being one of my highly valued clients.

Judith A. Randall, LMFT