IATTAR-C, LTD

INSTITUTE FOR ADDICTION TREATMENT, TRAINING & RESEARCH-CARIBBEAN, LIMITED

■CLINICAL ■PSYCHOMETRIC ■SUBSTANCE ABUSE ■EAP ■FORENSIC ■PSYCHOLOGICAL SERVICES

Child's Name: **Address:** **Date of Birth:** ___/___/_____ **Age:** ____

Gender: ☐ M ☐ F O☐

Parent's Marital Status:

(This question refers to the biological parent's relationship)

☐ Single ☐ Married (legally) ☐ Divorced ☐ Cohabitating

☐ **D**ivorce in process ☐ Separated ☐ **W**idowed ☐ Other

Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

Mother's Name:

Birth Date:_____ Age: ____

Ethnic Origin:

Total years of education completed: _____

Occupation: _____

Place of Employment: _____

Military experience? ☐ Y ☐ N ☐ Unk

Combat experience ☐ Y ☐ N ☐ Unk

Current Status: ☐ Single, ☐ Married, ☐ Divorced, Separated, ☐ Widowed, ☐ Other *Please answer if you are no longer with your child's biological father OR☐ check here if you are still with bio-father

Assessment of current relationship if applicable:

☐ Poor, ☐ Fair ☐ Good

Home Phone:

Work Phone:

Cell Phone:

E-mail:

Father's Name

Birth Date: Age:

Ethnic Origin:

Total years of education completed:

Occupation:

Place of Employment

Military experience? ☐ Y ☐ N ☐ Unk

Combat experience? ☐ Y ☐ N ☐ Unk

Current Status ☐ Single ☐ Married, ☐ Divorced, ☐ Separated, ☐ Widowed, ☐ Other

*Please answer if you are no longer with your child's mother OR ☐ check here if you are still with **the** biological mother

Assessment of current relationship if applicable:

☐ Poor ☐ Fair ☐ Good

Home Phone: [ ] _____

Work Phone: [ ] _____

Cell Phone: [ ]_____

E-mail:

Current Reason for Seeking Counseling?

Please briefly describe the problem for which you are seeking to have counseling for?

Step-Parent's Name:

Home Phone: [ ] _____

Work Phone: [ ] _____

Cell Phone: [ ]_____

ACADEMIC HISTORY:

YOUR CHILD'S CURRENT GRADE POINT AVERAGE (GPA) (IF UNKNOWN, DESCRIBE TYPICAL GRADES)

What is school like for your child?

What are your Child's Strengths?

Please describe your child's weaknesses?

Does your child have any attention or behavioral problems? ☐ Y/ ☐ N ☐ **UNK**

Any diagnosed Learning or Speech disabilities? ☐ Y/ ☐ N ☐ **UNK**

Does your Child Participate in Resource, Special education or Gifted Program/s? ☐ Y/ ☐ N ☐ **UNK**

Is there a family history of Academic/Learning problems? ☐ Y/ ☐ N ☐ **UNK- please describe:**

Primary Care Physician Information:

Current Physician:
Physician Address:

Physician Phone:
Physician Fax:
MD E-Mail: _____
Date of most recent check-up? _____
Chronic illness/es? _____
Surgeries/ [Past/Planned]? _____
Emergency room trips? _____
Do you as a parent/s have access to your child's electronic communication? -☐ Y ☐ N-
Do you the parent/s have any issues with your child's use of phone, text, electronic communication? -☐ Y ☐ N-

Counseling/ Medical History:

Has this young person previously seen a counselor?
☐ Yes ☐ No --If yes, what did you find most helpful in therapy?

If yes, what did you find least helpful in therapy?

Approximate Dates of Counseling:

For what reason did this young person go to counseling?

Does this young person have a previous mental health diagnosis?

☐)-☐)-

What did you find most helpful to/ for this young person in their previous therapy?

Emergency Resources:

Medical:
Dental:
Who is the child's Legal Guardian?

Are the Parents in Court/ Arbitration due to Custody/ Paternity/ Maternity Issues?
☐ Y ☐ N- Please Discuss:

Personal Strengths

What activities does your child enjoy and feel they are successful at when they try?

Chemical Use & History:

Does the child currently use alcohol? -☐ Y ☐ N-
If yes, how often do they drink? -☐ Daily,-☐ Weekly -☐ Occasionally, -☐ Rarely If yes, how much do you drink? _____ (#) per time?
Do they currently use Tobacco? -☐ Y ☐ N-
-If yes, how much do you smoke/chew? _____
Do they currently use any other drugs?
-☐ Y ☐ N-If yes, what drugs do you use?

If yes, how often do they use? -☐ Daily, -☐ Weekly, -☐ Occasionally, -☐ Rarely
Have they received any previous treatment for chemical use? -☐ Y ☐ N-If so, where did they go?

-☐ Inpatient? -☐ Outpatient?

School Information:

Current School :

Primary Teacher's name :
Grade/ Main contact at school:
School's phone #:
Fax:
E-Mail Address:
Principal:
School's Nurse:

School History:

1. Does your child like school?? -☐ Y ☐ N-
2. Does this young person attend school regularly? -☐ Y ☐ N-
3. What are this young person's current grades?

4. Do you feel that this young person is doing the Best they can at School? -☐ Y ☐ N-

Who are some of the influential and supportive people, activities (e.g., walking) or beliefs (e.g.? religion) in your child's life? (Please describe)

What would you like to see happen as a result of counseling this time?

Adolescents:

Please answer the following with [Y/N)

1. Have you ever used more than 1 chemical at the time to get high? _____

What did you find least helpful in therapy?

Has this young person used psychiatric services in the past? (-Y☐ -N☐)- If yes, who did they see?

If yes, was it helpful? ☐-N/A ☐-Yes ☐-No

Has your son or daughter taken medication for a mental health concern? ☐-N/A ☐-Yes ☐-No

Name of medication	Prescriber	Dosage	Was it helpful?

Please describe any other medical concerns such as use of medications, herbs, spiritual systems use etc.?

Family History

1. Are the parents married or divorced?

Peer Relations:

1. Is This Young Person considered socially to be: -☐ outgoing, -☐ shy, -☐ depends on the situation.

2. Does this young person seem happy with the number of friends they have? (-☐ Y -☐ N)

3. Has this young person ever been bullied? (-☐ Y -☐ N)

4. Are you as a parent happy with your child's friends? (Y-☐ /N-☐)

5. Is the young person involved in any organized social activities (e.g., sports, scouts, music, etc.)? (-Y☐ -N☐)

Legal Issues:

Please list any legal issues that are affecting your family at present, or that may have had a significant effect upon you in the past.

Does this child have any convictions:

2. Do you avoid family activities so you can use drugs/smoke? ☐

3. Do you have a group of friends who also use/ sm ☐

4. Do you use to improve your emotions such as wh feel sad or depressed?? ☐

Child's Developmental History

1. Were there any complications with the pregnancy or delivery of your child? (-☐ Y -☐ N --If yes, please describe:

2. Did your child have health problems at birth? (-☐ Y -☐ N -If yes, please describe:

3. Did your child experience any developmental delays (e.g., toilet training, walking, talking)? (-☐ Y -☐ N -☐ **N**ot sure)-- If yes, please describe:

4. Did your child have any unusual behaviors or problems prior to age 3? (-☐ Y -☐ N -☐ **N**ot sure)-- If yes, please describe:

5. Has your child experienced emotional, physical, or sexual abuse?)? (-☐ Y -☐ N -☐ **N**ot sure)--If yes, please describe:

Please describe as much as you feel comfortable.

Are your child's problems affecting any of the following?

☐ Handling everyday tasks /Chores ☐ Self-esteem
☐ Relationships with You/Others ☐ Hygiene ☐ Health
☐ Housing ☐ Recreational activities \
☐ Finances ☐ Work/School
☐ Legal matters

2. Is the parental relationship good? (☐ Y ☐ N /Unsure)

3. If the parents are divorced, with whom does this young person primarily live?

4. How often does this young person see each parent? Mom_____% Dad _____%.

5. Did this young person experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside their (your) home? (☐ Y ☐ N /Unsure)

Are there any pending charges against this young person (-☐ Y -☐ N -☐ **N**ot sure) If "yes" please discuss:

Conduct problems (fighting, lying, stealing)? (-☐ Y -☐ N -☐ **N**ot sure) If "yes" please discuss:

Are parents currently divorced/ Any custody actions (Include when this was initiated and by whom):

Has your child ever had thoughts, made statements, or attempted to hurt him/ herself, or others?
☐ Yes ☐ No ☐ Uncertain ☐ Other
Please discuss:

Please check [√] all your child's behaviors and symptoms that you consider problematic:

☐ Distractibility ☐ Change in appetite
☐ Visual hallucinations [*Seeing things that no one else can see*)
☐ Manipulative behavior (*Make's others do things they don't want to do*) ☐ Hyperactivity (*Can't sit still*)
☐ Withdrawal from people ☐ Defiance ☐ No friends
☐ Few friends ☐ Impulsivity (*Appears to act without thinking*) ☐ Anxiety (worry) ☐ Aggression (fights)
☐ Eating problems ☐ Boredom ☐ Panic attacks (*Gets (frightened for no reason*) ☐ Homicidal thoughts
☐ Sleep problems ☐ Poor memory ☐ **C**onfusion
☐ Fear away from home ☐ Frequent arguments
☐ Nightmares ☐ Sadness ☐ **D**epression
☐ Social discomfort (*Doesn't do well in groups*)
☐ Irritability (*anger*) ☐ Toileting problems
☐ Hopelessness ☐ Phobias (fears) ☐ Sadness
☐ Appetite changes ☐ Crying ☐ Weight changes Un-planned changes) ☐ Sleep disturbances
☐ Paranoid thoughts ☐ Dissociation ☐ Poor concentration ☐ **Hyperactivity** ☐ **Indecisiveness**
☐ **Binging/Purging** ☐ Low energy
☐ **decreased sex drive** ☐ Excessive worry
☐ Unresolved guilt ☐ Low self-worth ☐ Irritability
☐ Anger issues ☐ Nausea/ Indigestion
☐ Spiritual concerns ☐ Social anxiety
☐ Hallucinations ☐ Self-mutilation ☐ Racing thoughts
☐ Cutting themselves ☐ Restlessness ☐ Impulsivity
☐ Drugs use ☐ Nightmares ☐ Alcohol use
☐ Hopelessness ☐ Decreased creativity

☐ Peer/sibling conflict ☐ Fire setting
☐ Thoughts of death ☐ Obsessive thoughts
☐ Stealing ☐ Work problems ☐ School Issues
☐ Self-harm behaviors ☐ Compulsive behavior
☐ Destroys property ☐ Legal problems
☐ Crying spells ☐ Racing thoughts
☐ Running away ☐ Sexual behavior
☐ Loneliness ☐ Fatigue
☐ Wide mood swings ☐ Swearing
☐ Computer addiction ☐ Suspicion/paranoia
☐ Low self-worth ☐ Alcohol/drug use
☐ Curfew violations ☐ Hearing voices
☐ Lack of motivation ☐ Lying
☐ Recurring, disturbing memories
☐ Other?

AUTHORIZATION FOR MESSAGES

TELEPHONE

I ☐ DO *or* ☐ DO NOT give permission to leave messages (appointment reminders, etc.) on voice-mail or answering machine(s) and/or with any person(s) who answer(s) the phone at number(s) listed above

INTERNET

I ☐ DO *or* I ☐ DO NOT give permission to contact me by e-mail, SMS text message, chat, or social networking.

Other Symptoms not noted above/ Or anything else that you believe would be helpful for the clinician to know about:
☐ Yes ☐ No

Please check [√]if your child has experienced any of the following types of traumas or loss/es

☐ Emotional abuse ☐ Neglect
☐ Lived in a foster home ☐ Sexual abuse
☐ Violence in the home ☐ Physical abuse
☐ Crime victim ☐ Homelessness
☐ Parent substance abuse ☐ Parent illness
☐ Loss of a loved one ☐ **Teen** pregnancy
☐ Placed a child for adoption ☐ Financial problems
☐ Multiple family moves ☐ fighting
☐ Disagreeing about relatives ☐ feeling distant
☐ Disagreeing about friend ☐ Loss of fun
☐ Alcohol use ☐ Lack of honesty ☐ Drug use
☐ Physical fights ☐ Infidelity (couple)
☐ Education problems ☐ Divorce ☐ Separation
☐ Financial problems
☐ Issues regarding remarriage
☐ Death of a family member
☐ Birth of a sibling ☐ Abuse/neglect
☐ Birth of a child ☐ Inadequate housing
☐ **F**eeling unsafe ☐ Inadequate health insurance
☐ Job change ☐ Job dissatisfaction

☐ Elevated mood ☐ Easily distracted ☐ Mood swings
☐ Traumas ☐ Flashbacks ☐ Disorganized
☐ **W**ork issues ☐ Anorexia Problems
☐ **Social Isolating (at home)** ☐ **Panic Attacks**
☐ Phobias ☐ Feeling anxious ☐ Obsessive Thoughts
☐ **Feeling Panicky** ☐ Grief ☐ Suicidal Thoughts
☐ Headaches ☐ Past Suicide Attempts

Special Confidentiality Notice for Parents:

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you

Special Confidentiality Notice for [US]Parents (Continued):

. According to Minnesota law, and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

• All Mental Health records for children age 16 or older. • All information concerning pregnancy, sexual activity, STDs, and drug/alcohol use or abuse, regardless of the child's age. • Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child. • You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety. • In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬. ▬▬▶

CONSENT TO BE TREATED

I voluntarily consent to be treated by Dr. Calvin Young, PhD and/or his clinical Associates through IATTAR-C, LTD

Name: _____

Date: _____

I was referred by:

_____

RELEASE OF INFORMATION, LIFETIME SIGNATURE ON FILE, CANCELLATION POLICY, PAYMENT AUTHORIZATION, ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES, PERMISSION TO SEE CHILD(REN) AND OTHERS

PRESENT IN COUNSELING

I understand that being on time for appointments is my responsibility. I agree to pay 50% of my usual fee for any block of time reserved for me unless I have provided 24 hours advance notification. I will be responsible for this and for any co-payments, deductibles, and for services provided that are not covered by my insurance plan. I authorize payment of all insurance benefits for services rendered by this office to be made payable to IATTAR-C, LTD or the provider and authorize the aforesaid to release to the Centers for Medicare and Medicaid-if relevant- its agents, or any other insurer or third-party payer all information necessary to determine benefits payable for related services.

Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being o/pen and honest with you

If I do not provide IATTAR-C, LTD with my complete and accurate insurance information, I will be a "cash pay" client (out of pocket or out-of-network) and I will be opting to not use any insurance with which I might be in-network. Further, if I provide insurance information at a later date, it will not be retroactively applied but will alter the agreement going forward only. If using Medicaid (or similar) Transportation, I authorize my provider to confirm my attendance at healthcare appointments with Medical Answering Service LLC and any transportation vendors: and to be seen in the presence of family members or unrelated persons I allow to attend appointments with me. I permit a copy of this authorization to be used in place of the original. This form will serve as a lifetime signature form. I acknowledge receipt of and reading the Notice of Privacy Practices, and that any future revisions will be posted on the web at iattrcltd.com.

The undersigned agrees that all unpaid fees owing after the date of service may be assessed a service charge at the rate of one and one-half percent (1-1/2%) per month or eighteen percent (18%) per annum from that date. In the event of default where it becomes necessary to turn this account over to a third party for collection, the undersigned agrees to pay all costs of collection, including reasonable attorney's fees and court costs.

Symptom Checklist:

Place a check mark next to the symptoms that you are experiencing. For EACH symptom checked, please note the severity (1-10 from least to most problematic) and how long you have been experiencing this

☐ Depressed mood ☐ Feeling ☐ Social withdrawal
☐ Lack of interest in previously enjoyed activities
☐ Changed sleep patterns (too much or too little)
☐ Changed appetite (too much or too little)
☐ Difficulty concentrating
☐ Irritability ☐ Fatigue ☐ Mood swings
☐ Recklessness ☐ Thoughts of suicide
☐ Suicide attempts ☐ Self-harm (cutting, self-mutilating)
☐ Obsessive thoughts ☐Social anxiety
☐ Panic attacks (check relevant symptoms):
◊palpitations, pounding heart, or accelerated heart rate ◊sweating ◊trembling or shaking
◊sensations of shortness of breath or smothering
◊feeling of choking
◊chest pain or discomfort ◊nausea or abdominal distress o feeling dizzy, unsteady, lightheaded, or faint ◊feelings of unreality or being detached from oneself o fear of losing control or going crazy
◊fear of dying o numbness or tingling sensations
◊chills or hot flashes
☐ Careless, poor attention to details
☐ Difficulty sustaining attention
☐ Unable to listen to others
☐ Difficulty organizing
☐ Tend to avoid effortful tasks
☐ Often lose necessary things
☐ Easily distracted
☐ Forgetful in daily activities
☐ Fidgety, unable to sit still
☐ Always on the go
☐ Acts as if driven by motor
☐ Talking excessively
☐ Difficulty waiting their turn
☐ **I**mpulsive/ acts without thinking first

To the best of my knowledge, the above information is true. I understand that falsification of any information above could result in termination of services. *If seeking services for a child under age 18:* I consent to all the above on behalf of my minor child and myself.

Signature *(for all of the above)*

Date:_____ _____

INFORMED CONSENT FOR TREATMENT & EVALUATION

Dr. Calvin Young, PhD, MSHSA, MSc, MA, LCPC, SAP. C-DBT, C-SOTP, CMNCS-is a-trained mental health clinician. I graduated with a Bachelor of Arts [BA] degree from the University of Illinois at Chicago (Circle) with a major in Sociology and a minor in Psychology. I then earned a Master of Sciences (MSc) degree in Human Services Administration from the Sparus College in Chicago. Later I earned a Master of Science (MSc) degree in Counseling, with an emphasis in Addiction Treatment and Psychometrics [Clinical Psychology core] from National-Louis University, in Wheeling, Illinois. I further obtained a Master of Arts (MA) degree in Human and Organizational Development from the Fielding Graduate University in Santa Barbara, California. I am currently on hiatus from completing the Dissertation to be awarded a Doctorate (Ph.D.) in Human and Organizational Development from the Fielding Graduate University. My professional affiliations include past and/or current memberships in: the American Association of University Professionals (AAUP); the American Mental health Counselors Association (AMHCA); the Illinois Mental Health Counseling Association (IMHCA); the American College of Certified Forensic Counselors (ACCFC); the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc. (IAODAPCA), and the Jamaica Psychological Society (JAMPSYCH), among other professional Associations related to the field of Counseling, Drug Abuse Assessment and Counseling & Academics. I am nationally (USA) -qualified as a Forensic Assessment and Substance Abuse counseling professional. As such I am an Expert Witness in Substance Abuse and Mental health issues qualified to present at the Federal level (up to the Supreme Court) in the United States. Have worked as a mental health provider to stakeholders in the Legal Justice system. I have testified in Court & Administrative Hearings as an Expert Witness on issues related to drug abuse and/or dependency and mental health. As a mental health Assessment and Treatment provider I have over ten (10) years of experiences as a contracted provider of clinical mental health and substance abuse treatment services to subscribers to multiple managed care network networks in the United States and locally. Professionally I have over ten years of experience on the field of applied social and behavioral sciences; having treated patients in inpatient, residential, hospital, and out- patient settings on an Individual basis; or as a part of a therapeutic Treatment Team. I am experienced in treating addressing Family issues, and addressing Organizations' psycho social needs. My clinical experiences include work with juvenile and adult substance abusers and sex offenders. And I have treated both victims and perpetrators of violence. I have experiences and training that include employment at several universities as a professor of Counseling, Psychology, and Sociology, among other related discipline areas. As a Patient you have certain rights and possibilities when consulting a psychologist, psychiatrist, nurse practitioner, psychotherapist, social worker or counselor for treatment or evaluation: You have the RIGHT TO BE INFORMED REGARDING THE TERMS UNDER WHICH TREATMENT OR EVALUATION WILL BE PROVIDED. Policies related to charges, billing third party payers, appointments, emergencies, and coverage for when your therapist is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed. 2. You have the RIGHT TO CHOOSE THE BEST TREATMENT AND PROVIDER. There are a variety of professionals offering counseling, psychotherapy, psychiatric evaluations. There are also a number of different approaches to working with human issues. It is your right and responsibility to choose the treatment and provider that best match your needs and to participate in the development and periodic review of an individualized treatment plan. You also have a right to a detailed explanation of any treatment or procedure your provider may choose to use including the risks involved and the side-effects if any. If you believe you are not receiving the treatment you require, then raise this concern with your therapist or provider and s/he will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet our needs. You have the RIGHT TO KNOW THE QUALIFICATIONS AND TRAINING of your provider. You may be requesting a therapist information sheet from your provider. If you have concerns, complaints, or believe a breach of professional conduct has occurred, you may contact the vice president or his designee to discuss the problem. Every attempt will be made to resolve the difficulty so that treatment may continue unhindered. If the difficulty is not resolved, you have the right to make a formal complaint to the relevant licensing agency.

4. You have the RIGHT TO REFUSE TREATMENT OR TO STOP TREATMENT at any time and for any reason. In the case where a minor is the patient/client, then the parent(s) or legal guardian has the right to refuse or stop treatment for the minor. You also have the right to refuse or stop evaluations. Your provider also as the right to refuse or terminate treatment, in which case you will be provided with alternatives. It is our hopes that if you have concerns regarding your treatment or wish to discontinue you will discuss this with your provider You have the RIGHT TO YOUR DIAGNOSIS. This means that after your initial mental health assessment, the treatment provider will provide the client with his/her initial diagnosis or provisional diagnosis.

6. You have the RIGHT TO CONFIDENTIALITY. This means that what you tell your therapist or provider and what is contained in your clinical file will not be repeated or released by the therapist to anyone else without your expressed permission (i.e., by a signed release of information). You have the right to see and have access to the contents of your file. You have the right to discuss your own Evaluation with anyone you choose, including another provider. The content within group therapy is confidential and may not be shared with anyone outside of the group.

7. **[UNITED STATES]** For minors 14-17 years old. Psychologists and LCSWs may provide treatment to a fourteen-year-old without the consent of his or her parent. Oregon law requires your therapist to have your parents involved in treatment before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. Our Practice does not need to involve your parents in treatment if you have been sexually abused by your parent, or if you are emancipated. It is the policy of Calvin Young, ABD, MSHSA, MSc, MA, LCPC, SAP to notify the parents on or before the third (3rd) sessions. I am an experienced educator who has taught at the secondary (High School), tertiary and graduate levels. I have trained and conducted seminars and workshops with professional and lay audiences. I am a veteran of the United States Army; where I received training and experienced the requisite preparations of a Special Forces Medic [Practical Nurse]. My treatment philosophy is shaped by my acceptance of the fact that in the successful psychotherapeutic alliance, clients are best assisted with accomplishing the goals identified in therapy through and in a manner that –as much as possible- integrates and involves, the latest advances in the nutritional sciences and herbology as it relates to mental health and optimal mental functioning, technological advances, the latest scientific research in the field of Applied Psychology and Counseling, religious and spiritual systems (church, temple, mosque, etc.), local communities, other social services organizations, along with businesses, school districts, and even legislators in a highly confidential manner that exceeds the maximum professional standards -as the most effective and beneficial manner of moving clients forward in order to achieve and maintain changed behaviors.

By signing this informed consent document, you:

A. Authorizes Dr. Calvin Young and/or his clinical associates/ assigns to contact your parents and to give them a summary of your treatment in the case -in the case of minors.

B. authorizes your therapist to use his or her best clinical judgment on when to inform your parents/ legal Guardian(s) of important issues related to your treatment.

c. authorize Dr. Calvin Young to release your treatment records to your parents/ legal guardians upon their request (it is the policy of Dr. Calvin Young to require both you and your parents to sign any release of information to anyone other than your parents/guardian/s) Understand and accept that there are however -some limits and exceptions to complete confidentiality:

CHILD OR ELDER ABUSE: Generally, providers are required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or other appropriate State agency/ Governing authority.

b. **VIOLENCE**: If a provider learns that someone is about to kill or to do harm to someone else, s/he will do her/his best to warn the intended victim.

c. **SUICIDE:** If a provider learns that a client intends to harm his/her self, the provider will breach confidentiality to the extent necessary for his/her protection.

D **NON-CUSTODIAL PARENTS**: *By law, non-custodial parents can gain access to their children's records pertaining to treatment or evaluations.

e. **SUPERVISION**: If you are seeing an unlicensed therapist (e.g., an un-licensed master's level counselor, psychology intern, or a psychologist resident, etc.) then it is expected that your therapist will initially present your case in a clinical staffing and also periodically review and discuss your treatment with a supervisor. You will be informed as to who the supervisor is prior to receiving treatment or evaluation.

f. **CONSULTATION:** Occasionally, it is in your best interest for your provider to consult other providers who are on the staff of Dr. Calvin Young, PhD regarding your treatment (e.g., medication issues, family issues, obtaining another's expert opinion, covering emergency phone calls, etc.). This will be carried out with the utmost consideration for your privacy. In cases where consultation with another professional outside of Western Psychological and Counseling Services, P.C. is required, then your written consent will be obtained.

g. **INSURANCE:** Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment, or other relevant information in order to authorize services or process claims. A release of information will be obtained for this if you are utilizing an insurance company.

FEE STRUCTURE: **Our session fees generally begin at *JMD$8,500 –JMD$12,000 per session. A *session is a thirty [30]-minute to one [1]-hour] face-to-face session with your therapist, unless some other time arrangement has been made and agreed to with your Clinician. Session costs may be adjusted depending on your income, and/or other factors.**

Session fees may not necessarily include materials fees for testing, other assessment and treatment tools, and/or psychological assessment instruments that may be necessary and used to conduct psychotherapy, screening, assessment, and/or evaluation of the client(s). Materials fees may incur separate charges to the patient(s). By signing this Agreement, you are stating your understanding and acceptance that after choosing the initial specific payment option as described in this Agreement- that continued authorizations for care and payment may be given verbally to your Clinician. Your Clinician will document your agreement to continue treatment, along with this payment arrangement, that you have chosen in your Treatment Plan and also in the Clinical notes. We* charge JA$15,000 per hour, and require an initial deposit of JA$30,000 for preparation and attendance at any legal proceeding. SOME cases MAY REQUIRE PRE-PAYMENT. PLEASE DEPOSIT FUNDS TO ANY BRANCH OF SAGICOR Bank -ACC#5502010718 - payable to Dr. Calvin Young. ***By signing hereon, you are stating that you have read and understand /my rights and responsibilities as outlined in the Dr. Calvin Young and Associates *Informed Consent for Treatment and Evaluation* form. Furthermore, by signing this form, you consent to receive Mental Health and/or Chemical Dependency Services to be provided by Dr. Calvin Young, PhD), MSHSA, MSc, MA, LCPC, SAP and/or his Clinical Associates and his assigns

CLIENT SIGNATURE (12+): **DOB:** **ID#:** **DATE:**

GUARDIAN/ WITNESS: **DATE:**

GUARDIAN/ WITNESS: **DATE:**

CLINICIAN: **CREDENTIALS:** **DATE:**

INFORMED CONSENT FOR TELEMENTAL HEALTH SERVICES

This Informed Consent for Telemental Health Services contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telemental Health: Telemental Health refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of Telemental Health is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telemental Health, however, requires technical competence on both our parts to be helpful. Although there are benefits of Telemental Health, there are some differences between in-person psychotherapy and Telemental Health, as well as some risks. For example:

Risks to confidentiality. Because Telemental Health sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation. Also, if other people may walk through the area where you are, you may want ensure they are appropriately attired to avoid embarrassment!

Issues related to technology. There are many ways that technology issues might impact Telemental Health. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention. Usually, I will not engage in Telemental Health with clients who are currently in a crisis situation requiring high levels of support and intervention. In any event, we will have an emergency response plan to address potential crisis situations that may arise during the course of our Telemental Health work.

Efficacy. Most research shows that Telemental Health is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications: I use the Doxy.me/ psychologytoday, or other HIPAA-compliant telemedicine platform/s for video conferencing (as well as other platforms from time to time). There is no additional cost to you for using any of these services. You will need to have a computer that has audio and video capabilities for us to use video conferencing. You will also need fairly reliable internet service. For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room.

Confidentiality: I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our Telemental Health. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for Telemental Health sessions and having passwords To protect the device you use for Telemental Health).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Professional Disclosure Statement and Confidentiality in Psychotherapy forms contained in the Client Handbook. These still apply in Telemental Health. Please let me know if you have any questions about exceptions to Confidentiality

Appropriateness of Telemental Health: From time to time when it is feasible to do so, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that Telemental Health is not a good option for us to engage in. If this is the case, we would discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology: Assessing and evaluating threats and other emergencies can be more difficult when conducting Telemental Health than in traditional in-person therapy. To address some of these difficulties, we are creating an emergency plan before engaging in Telemental Health services. You must identify an emergency contact person who is near your location who I will contact in the event of a crisis or emergency to assist in addressing an emergent situation. By executing this document, you are authorizing/allowing me to contact your emergency contact person as needed during such a crisis or emergency.

My emergency contact person is: _____This person can be reached at: _____

If the session is interrupted for any reason, such as the technological connection fails, *and you are having an emergency,* do not call me back; instead, call 119/ 911 or go to your nearest emergency room. Call me back after you have called or obtained emergency services. Another option in case of an emergency might be to call the National Suicide Prevention Hotline 1-800-273-8255. We can also discuss other local resources. If the session is interrupted and you are not having an emergency, disconnect from the session and I will attempt to re-contact you via the Telemental Health platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me at 876. 798. 9484. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time. TIP: If you are not plugged in, be sure your device is fully charged and/or be close to somewhere you can plug in. If you are tethering to get the internet, be sure your phone is also fully charged and that you are ready to plug in if it starts to go dead.

Fees: The same fee rates will apply for Telemental Health as apply for in-person psychotherapy. We have already confirmed that your insurance will cover this service. If your insurance lapses, you will be billed at my regular rate for these services.

Records: The Telemental Health sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a written record of our session in the same way I maintain records of in-person sessions in accordance with my policies, as is required of me by law.

Informed Consent: This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____
Client (12+) Date

_____ _____
Guardian I Date

_____ _____
Guardian II Date

_____ _____
Dr. Calvin Young, PhD, LCPC Date