Harvey Shubert, Ph.D.
4115 East Valley Auto Drive, Suite 208
Mesa, AZ 85206
480-507-7880 ♦ Fax 480-507-8103

PARENT QUESTIONNAIRE

In order to best be able to help you and your child, we need to know some things about your family. Please answer each question as completely as you can and explain any "yes" or "no" answers.

Background Information:

Client's name: _____ Date of Birth: _____

Biological Parents' Name:	Age	Education	Occupation
_____	_____	_____	_____
_____	_____	_____	_____

Sibling Names	Age	Education	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any other living in the home: _____

_____

_____

Dates of marriage and/or divorce of biological parents: _____

_____

If the client's biological parents are divorced, please fill in the following information:

Name of Parent	Date(s) of Marriage	Name of Second Spouse
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Custody and visitation arrangements: _____

_____

_____

History of Problem:

What is the problem? Why are you bringing in your child for an evaluation? _____

_____

When and how did you first notice the problem?

What kinds of changes have you seen in your child which seems to be a part of the problem?

How have you tried to resolve the problem?

Please describe any major incidents, such as moving or the death of a family member, which seems to have affected your child. What was his/her reaction?

What other major changes have happened in the family (additions, losses, financial changes, moves, etc.?

Family Interaction:

Describe your relationship(s) with the client's sibling(s):

What do you do together as a family?

How are decisions made in your family?

Please describe early eating and sleeping patterns:

as an infant? _____

as a toddler? _____

as a preschooler? _____

childhood or later years? _____

Have you noticed any unusual eating patterns (such as fasting, constant dieting, eating a lot at one time followed by not eating, etc.) or changes in the client's eating habits? If yes, please describe:

_____

_____

Educational History:

What school is the client enrolled in? _____ Grade? _____

How old was the client when he/she started school? _____

Has the client repeated or skipped any grades? . Yes . No

Have there been any academic, behavioral, or emotional problems with peers or teachers? If yes, when did the problems begin? What were they? _____

_____

_____

_____

What kinds of grades does the client usually get? Describe any recent changes? _____

_____

_____

Has the client ever been assessed for learning problems (LD/EBD) or been in special classes (chapter 1 or tutoring)? If yes, please describe: _____

_____

Has the client ever been suspended or expelled from school? If yes, please describe why this happened and how you handled it: _____

_____

Treatment History:

Has the client ever been taken to a mental health or chemical dependence professional before? If yes, please fill in the following information:

Name of Professional	Dates of Service	Reason for Services
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe the history of your immediate family, including dates of births, marriages, divorces, major illnesses, moves, etc.: _____

Developmental History:

Was the client a planned child? How did parent(s) react to the pregnancy? _____

Were there any complications during the pregnancy and/or birth of the client? If yes, please describe? _____

Please describe the client's emotional and behavioral adjustment (response, activity level):

as an infant: _____
as a toddler: _____
as a preschooler: _____
during grade school: _____
during junior high: _____
during high school: _____

At what age did the client:

say a single word? _____ simple sentences? _____ complete sentences? _____
crawl? _____ walk? _____ bladder trained? _____
bowel trained? _____ interested in other children? _____

Were there any problems with toilet training? If yes, please describe: _____

Were there any problems with wetting or soiling the bed after the client had been toilet trained? If yes, please describe: _____

How well did the client tolerate normal separations before school age? _____

Has the client ever seen a school counselor or school psychologist? If yes, please explain, including the reason(s) and dates(s): _____

Has the client ever been placed out of the home for mental health, emotional and/or behavioral reasons (foster care, impatient treatment, residential treatment, juvenile detention, with relative, etc.): If yes, please explain: _____

Has anyone else in the family received psychiatric, psychological and/or chemical dependence treatment in an inpatient or outpatient setting? If yes, please explain: _____

How do you feel about seeking help for your child at this time? _____

What goal(s) do you have for the treatment of your child? _____

What educational material(s) have you read related to the problem area(s) for your child?

Miscellaneous:

What else do you need to know that we haven't asked you? _____

PATIENT LETTER OF AGREEMENT

INSURANCE BILLING AND PAYMENT POLICY

PLEASE INITIAL EACH ITEM BELOW

_____I request Harvey Shubert, Ph.D. to submit billing on my behalf directly to my insurance carrier.

_____I authorize the release of any information necessary to process the claim for payment.

_____Payment liability for Non-insured patients and for charges of DENIED services rests with the patient, or responsible party, who is the beneficiary of those services.

_____I agree to be personally responsible for payment of those services, as well as, any legal fees, court costs, collection fees, and late fees connected with collection of payment.

_____I agree to pay a **$25.00** fee for any personal checks returned for insufficient funds.

_____I agree that the person who brought the child in to see the doctor, is responsible for all the fees associated with the visit.

APPOINTMENT POLICY

_____The cooperation of each patient is necessary to assure that everyone's needs are met. Frequently, patients are placed on a "waiting list" for appointment cancellations. It is therefore necessary that every consideration be given to avoid missed appointments that could be used by someone else.

_____Each patient is responsible for keeping appointments with his or her provider. If it becomes necessary to break an appointment, it is EXPECTED that a patient contact this office 24 hours in ADVANCE of scheduled appointment.

_____If a patient misses his or her scheduled appointment or fails to provide 24 hours advance notice, there will be a charge of **$50.00**. This charge will not and cannot be billed to your insurance company. You are personally responsible for this charge. **In the event my account is turned over for collection. I understand that I will be responsible for all collection costs.**

SIGNATURE OF AGREEMENT

_____

DATE_____

WITNESSED BY:

_____

DATE_____

Harvey Shubert, Ph.D.

Consent For Treatment of Minors (Under 18)

Child's Name _____ Date of Birth _____

Treatment of Minors Policy Statement

Harvey Shubert, Ph.D. does not accept patients' children whose families are engaged in custody litigation. I do not provide child custody, psychological or family evaluations for the purpose of litigation, do not accept court referrals, do not supervise visitations, do not serve as a court advisor, nor provide child advocate services. I can refer you to another provider if necessary.

I/We _____ am/are the legal custodial parents/guardians of_____ and give my/our permission to Harvey Shubert, Ph.D. to provide psychological services to my/our child (children).

I/We have read and understand the Treatment of Minors Policy Statement and will inform Harvey Shubert of any current, pending, or anticipated litigation.

If the child's biological parents are not together, please complete:

What is the custody arrangement for this child? (joint/sole custody? Who is primary custodian?)

_____

If applicable, please describe the child's current visitation schedule:

_____

Signatures:

_____	_____	_____
Parent Signature	Parent Printed Name	Date
_____	_____	_____
Parent Signature	Parent Printed Name	Date

Harvey Shubert,, Ph.D.
4115 E. Valley Auto Drive, Ste. 203, Mesa, AZ 85206
TEL: (480) 507-7880 FAX: (480)507-8013

List of Medicines

List/Name of Meds	Dosage	Reason for Taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

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4115 E. Valley Auto Drive, Suite 208
Mesa, AZ 85206
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of Harvey Shubert, Ph.D. Notice of Privacy Practices. This notice describes how Harvey Shubert, Ph.D. may use and disclose my protected health information, certain restrictions on the use of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of patient or personal representative Date

_____

Relationship to patient

Harvey Shubert, Ph.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This notice tells you about the ways in which Harvey Shubert, Ph.D. may collect, use, and disclose your protected health information and your rights concerning your protected health informatin. "Protected Health Information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by Federal and State laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards. The HIPAA Privacy Rule for the first time creates national standards to protect individuals' medical records and other personal health information.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

PAYMENT: We use and disclose your protected health information to your insurance company in order to receive payment for your covered health expenses.

HEALTH CARE: We may use and disclose your protected health information to other health care providers (physicians, healthcare professionals, laboratories, or hospitals) to better assist in your diagnosis and treatment.

MEDICAL RECORDS REQUEST: We will disclose your protected health information if we receive a request from another physician who is treating you or will be treating you, with a signed request from you. We will disclose your protected health information to another physician if we refer you to that physician. We will disclose your protected health information to an insurance company if we have filed a claim on your behalf. We will disclose your protected health information, with your authorization, to a life insurance underwriter or health insurance company if you are seeking life or health insurance coverage and have requested a company to contact us for your medical history.

MARKETING: If our office ever decides to use a patient's protected health information for marketing purposes, a patient's prior written authorization to use this patient's information will be required. Daniel J. Christiano, Ph.D. will never sell lists of patient's name/information to any third party.

OTHER PERMITTED OR REQUIRED DISCLOSURES

As Required by Law: We must disclose protected health information about you when required to do so by law.

Parents & Minors. State law governs disclosures to parents.

Patients 18-22, who are financially dependent on their parents, yet legally are adults: Without prior authorization, we cannot disclose an adult patient health status to anyone including parents (and in some cases, we cannot disclose a minor's individual health data).

Children under 18: It is our office policy that any child under the age of 18 must be accompanied by a parent or legal guardian on their first visit to our office. The parent or representative may then sign an authorization for treatment of the child when they are not with them.

General Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.

Victims of Abuse, Neglect, or Domestic Violence. We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.

Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process, and disclose records to legal counsel for the purpose of seeking legal advice.

Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Coroners, Funeral Directors, Organ Donations. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.

Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Government Functions. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Government Functions. We may disclose protected health information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, effective with the date of the letter of revocation.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that our office maintains about you.

RIGHT TO ACCESS YOUR PROTECTED HEALTH INFORMATION. You have the right to review or obtain copies of your protected health information records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying, mailing your requested information, but we will tell you the cost in advance.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION If you feel that the protected health information maintained by our office is incorrect or incomplete, you may request that we amend the information. Our request must be made in writing and must include the reason you are seeking a change. We may deny your request, for example, you may ask us to amend something in your record that was not created by our office, as is often the case when the information may come to us from another physician, health care professional, laboratory, or

hospital. We may deny your request if you ask us to amend a record that is already accurate and complete.

If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

RIGHT TO AN ACCOUNTING OF DISCLOSURES BY THE PLAN. You have the right to request an accounting of disclosures we have made of your protected health information. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years, and may not include dates before September 21, 2009. Your request should indicate in what form you want the list (example: on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists, we reserve the right to charge for the cost of providing the list.

RIGHT TO REQUEST RESTRICTIONS ON THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment, or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS. You have the right to request that we use a certain method to communicate with you if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

FOR INFORMATION REGARDING EXERCISING YOUR RIGHTS. You may exercise any of the rights described above by contacting Dan Bernal. See the end of this Notice for the contact information.

HEALTH INFORMATION SECURITY

Harvey Shubert, Ph.D. requires its employees and associates to follow the the office security policy and procedures that limit access to health information about patients to those employees and associates who need it to perform their job responsibilities. In addition, Harvey Shubert, Ph.D. maintains administrative, and technical security measures to safeguard your protected health information.

CHANGES TO THIS POLICY

Harvey Shubert, Ph.D. reserves the right to change the terms of the Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in the Notice.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing and sent to the Office listed at the end of this Notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

RIGHT TO REVOKE HEALTH CARE AUTHORIZATION

You have the right to revoke the HEALTH CARE AUTHORIZATION FORM, in writing, at any time. However, your written request to revoke your AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on our authorization. You may revoke your AUTHORIZATION by mailing or hand delivering a written notice to our office at the address listed at the end of the Notice. The revocation is not effective until it is received by our office.

The written notice must contain the following information:

- Your name, Social Security Number and date of birth
- A clear statement of your intent to revoke your AUTHORIZATION,
- The date of your request, and
- Your signature.

The AUTHORIZATION is requested by Harvey Shubert, Ph.D. for its own use/disclosure of your protected health care information. (Minimum necessary standards apply.)
You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Harvey Shubert, Ph.D. reserves the right to refuse service. A copy of the signed AUTHORIZATION will be provided to you at your request.

MISSED APPOINTMENTS Unlike some other medical or paramedical professionals who operate on more flexible and inexact schedules, your counselor commits a specific time period, usually 45-55 minute sessions, to each patient. It is important that you appreciate the fact that this block of time has been set aside for you. Our schedules are usually crowded. Your canceling or rescheduling your appointment without sufficient notice often means the loss of an hour of therapy, and it is difficult to reassign the hour to someone else on short notice. A charge may be made for any appointment not canceled 24-hours in advance.

PAYING YOUR BILL We accept insurance payments but you are responsible for any balance on the account. Cash accounts or insurance co-payments are due at the time of service. If we are to submit for reimbursement for your insurance carrier, it is your responsibility to provide us with the proper forms and necessary signatures. New claim forms may be needed at the beginning of each calendar year.

OFFICE HOURS Business hours are 8:00 am to 12 noon and 2:00 to 5:00 pm. Monday through Friday. If you telephone the office at other than those times listed or when the therapist is in session or out of the office, an answering machine will record your message and we will return your call as quickly as possible. You may also use the answering machine to advise us if you need to cancel an appointment. **Our after hour Urgent Care number is the Maricopa Crisis Center 24 hour crisis line at (602)222-9444. Should you have a life-threatening emergency, we suggest that you call 911 or the 24 hours crisis line.**

CONTACTING HARVEY SHUBERT, PH.D. If you have any questions or complaints about this Notice or you want to submit a written request to our office in any of the previous sections of the Notice, please call (480) 507-7880 or write to us at:

Harvey Shubert, PH.D.

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Phone: 480-507-7880, Fax: 480-507-8013
Day number and message number 24 hours a day (480) 507-7880