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PSYCHOLOGY SERVICES, LLC

Jennifer Tarbox, PhD, HSPP & Stephanie Ridel, PsyD, HSPP (317) 775-3942

CLIENT INFORMATION

Last Name:	First Name:	M.I.:	Nickname:	
Birth Date:	Age:	Sex:		
Street Address:		City:	State:	ZIP:
Home Phone:	Cell Phone:			
Physician/Pediatrician:	School:	Grade:		
Parents' Marital Status:	If divorced, who has primary custody of the child?			
Referred by: _____ Physician _____Friend _____Internet _____Other (please list):				

PARENT/LEGAL GUARDIAN INFORMATION (if patient is a minor)

Last Name:	First Name:	M.I.:		
Birth Date:	Social Security #:			
Home Phone:	Cell Phone:	Work Phone:		
Street Address:		City:	State:	ZIP:
Employer:	Occupation:			

PARENT/LEGAL GUARDIAN INFORMATION (if patient is a minor)

Last Name:	First Name:	M.I.:		
Birth Date:	Social Security #:			
Home Phone:	Cell Phone:	Work Phone:		
Street Address:		City:	State:	ZIP:
Employer:	Occupation:			

Counseling and Psychological Services

Dr. Jenny Tarbox and Dr. Stephanie Ridel are licensed in the State of Indiana as psychologists, which authorizes them to provide psychological services (Indiana License 20042417A for Dr. Tarbox & 20042413A for Dr. Ridel). Such services may include and are not limited to assessment services, including tests and procedures, as well as therapeutic treatments. Dr. Tarbox and Dr. Ridel are ethically and legally bound to provide only those services for which they have a license and have been trained. Should you require any service for which Dr. Tarbox or Dr. Ridel is not qualified, they will refer you to someone with the required expertise. Your psychologist's responsibility is to facilitate arrangements for referral. Your responsibility for continuity of care is to follow through with the best plan you can make based on all recommendations you gather.

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Consent to Treat

I hereby request and authorize Bloom Psychology Services, LLC and its respective personnel to provide mental health services/treatment to me or my dependent (if patient is a minor). I understand that mental health services/treatment may include psychological assessment and/or psychotherapy. I am agreeing only to those services that Bloom Psychology Services, LLC is qualified to provide within the scope of the provider's license, certification, and training. I also understand that, at any time, I can terminate this consent for treatment by putting such request in writing.

_____

Signature of Client or Parent/Guardian (if client is under the age of 18) Date

Policies and Procedures

This document contains important information about Bloom Psychology Services, LLC's professional services and business policies. Please read it carefully and feel free to ask if any questions that arise. When you sign this document, it represents an agreement between us.

Family Involvement in Treatment

Your child's treatment is most likely to be successful if you are fully informed and actively involved. The degree of your involvement with your child's treatment will be based on his/her age, your family situation, and the nature and severity of your child's needs. The psychologist may decide that an individual treatment approach would best suit your child. In this case, the psychologist will meet with your child for one-on-one sessions on a regular basis. Over the course of treatment, the psychologist will periodically provide updates on your child's progress; these may be in person parenting updates or scheduled phone consultations. The psychologist may also begin a dialogue with you about how you can help your child at home. You are welcome to call the psychologist at any time during the course of your child's treatment to ask questions or to share information about your child. In addition, you are always welcome to schedule an appointment to meet with the psychologist privately, with your spouse or partner, or with your child.

Confidentiality

Confidentiality is a cornerstone of the therapist-client relationship. Therapy is most effective in the context of a trusting, supportive, confidential therapist-client relationship. In addition, ethical standards require that the psychologist's work with you and your child remains confidential.

It is important for children and adolescents to discuss their problems and concerns with a neutral party without fear of judgment or repercussions. Thus, the specific information your child discusses with the psychologist during individual sessions will remain private. However, there may be instances in which something emerges in a therapy session that the psychologist believes should be discussed with you, the parent/guardian(s). On these occasions, the psychologist will work with your child to consider strategies for sharing the information with you. That may involve the psychologist disclosing to you with your child's permission or supporting your child's efforts to disclose to you directly.

The only occasions in which the psychologist would disclose something discussed in treatment without you or your child's permission are as follows:

- Child Abuse or Elder Abuse. Psychologists are mandated by law to report cases of suspected child abuse (of children and youth under age 18) and elder abuse (of adults over age 60) to the appropriate authorities.

- Suicide. If your child is in imminent danger of killing himself or herself, the psychologist will need to breach confidentiality in order to keep your child safe. This may include informing family member(s) or taking action to see that your child is admitted to a hospital.
- Homicide. If your child discloses that he or she is planning to kill or hurt someone, the psychologist is required by law to inform the police, inform the intended victim(s), and inform any other necessary individuals in order to prevent loss of life.
- As mandated by law. For example, if the psychologist receives a subpoena, the psychologist may be required to submit your records as part of a legal proceeding.

These situations are relatively rare. Should this occur in your case, the psychologist will make every effort to discuss it fully with your child and you before taking any action.

Contacting Bloom Psychology Services, LLC

If you need to contact your psychologist between sessions, the best way to do so is by telephone.
Although we are often not immediately available by phone, voicemail is checked on a regular basis. We will make every effort to return your call on the same day you make it, or by the next business day, with the exception of weekends, holidays, and vacations. If you are unable to reach your psychologist and feel that you cannot wait for your call to be returned, dial 911 or proceed to your nearest emergency room immediately.

If you contact your psychologist via email, please note that email is used only for scheduling appointments. We do NOT conduct therapy through the Internet, and will NOT respond to questions related to your emotional or medical condition, except by telephone or in person. Please see Bloom Psychology Services, LLC's social media policy statement for more information on the use of the Internet and therapy.

Cancellations and Missed Appointments

If you wish to change a scheduled appointment, we require that you do so **48 hours prior (in business days)** to the appointment in order to avoid being billed for the session. Please note that if your appointment falls on a Monday, it must be changed by the prior Thursday; a Tuesday appointment must be changed by the prior Friday. Exceptions to this policy will be handled on an individual basis. Should two late cancelled or missed appointments occur in a row, payment of associated fees will be required to hold an appointment on your psychologist's schedule.

Professional Fees and Non-Covered Services

In order to offer consistent quality care and to coordinate this care with other providers or organizations, your psychologist may need to provide complementary treatment activities that are not covered or reimbursed by your insurance company. Examples include telephone calls; email or phone consultation with other professionals in relation to your child's treatment (e.g., your child's teacher, a prescribing physician, previous treating therapists); review of psychological reports and records; preparation of reports, letters, or documents for other providers or organizations; duplication of your medical records; and legal proceedings requiring your psychologist's participation. Complementary treatment activities that total less than 15 minutes per month will not be charged; complementary treatment activities that total more than 15 minutes per month will be billed directly to you at the pro-rated standard hourly rate. If you have any questions regarding this policy, feel free to ask.

If you ever have difficulties with your bill, please address your questions or concerns as soon as possible. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Bloom Psychology Services, LLC reserves the right to use legal means to secure payment, which may include retaining the services of a collections agency or initiating a small claims suit.

In cases in which parents are divorced or separated, **the parent/guardian who brings the child to the appointment will be considered financially responsible**. The parent/guardian who signs the document below will assume sole financial responsibility for services rendered, including responsibility for all appointments not cancelled 48 hours in advance.

Insurance Reimbursement

Payment (co-pay/co-insurance/deductible, etc.) must be made either by check, cash, or credit card at the time of your visit. Payment from your insurance company will be made directly to Bloom Psychology Services, LLC.

Due to the increased complexity of health insurance in recent years, **you are highly encouraged to call your insurance company prior to your initial appointment to fully clarify all important issues related to fees and financial responsibilities.** Please notify your psychologist immediately as to any change in your health insurance, place of employment, home address, or other information pertinent to our records. (Failure to do this may result in difficulty processing insurance claims and could disrupt your child's treatment.)

The financial responsibility for your child's treatment is ultimately yours. If required, Bloom Psychology Services, LLC will file claims for insurance reimbursement as allowed by your policy. Bloom Psychology Services, LLC **files primary insurance only.** Bloom Psychology Services, LLC files your insurance as a courtesy and therefore will file only two times for any given date of service. Any monies remaining owed beyond this will be due from you. Bloom Psychology Services, LLC will make available to you any documentation necessary to assist you in filing claims for reimbursement purposes (and/or for secondary insurance).

Psychological Testing

Payment for testing services is expected on the date of the provided service. Depending on your insurance policy, payment may include a co-pay, coinsurance, or fees applied toward deductible. Some testing charges are not covered by insurance; should this be the case for your evaluation, these charges will be reviewed with you prior to testing. In addition to the fee charged for testing, your psychologist will hold a testing feedback session with you to review the results in person and answer any questions you may have. Please note that the feedback session is a separate charge.

Please note that in rare circumstances, an insurance company may review a testing charge and refuse to cover it. In such cases, you will be financially responsible for all testing fees (including cases in which the insurance company deems the testing "not medically necessary"). You may choose to appeal the insurance company's decision and seek reimbursement from the insurance company, but Bloom Psychology Services, LLC will not initiate such an appeal.

Appointments for psychological testing typically last between two to four hours, depending on the battery of tests selected. Should you need to cancel your testing session, please give no less than 48 hours' notice. **If a cancellation occurs with less than 48 hours' notice, you will be responsible for paying a late cancellation fee that is equal to 25% of your overall testing fee.** (For example, if your testing fee is $500, you would be responsible for paying $125 for a late cancellation). This fee is not covered by insurance.

Late Payments

There will a returned check fee of $25.00 should there be any problems clearing your check. If, for any reason, you do not pay your bill at the time of service or within 30 days from the date of your monthly invoice, a $35.00 late fee will be assessed for each 30 days that you do not pay. We understand that it can sometimes be difficult to stay on top of bills and payments. Thus, if you should have any concerns or questions about your fee or monthly invoice, please address them with your psychologist immediately.

PSYCHOLOGY SERVICES, LLC

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Authorization & Acknowledgements

By signing below, I acknowledge that I have reviewed Bloom Psychology Services, LLC's Policies and Procedures, understand the information included in this document, and freely choose to abide by its terms during our professional relationship. I am aware that a copy of this packet will be given to me if I ask for a copy. I can access this document at any time via the website at www.bloompsychologyservices.com.

_____

Signature of Client or Parent/Guardian (if client is under the age of 18) Date

I hereby acknowledge that I have reviewed a copy of Bloom Psychology Services, LLC's Notice of Privacy Practices of the Health Insurance Portability and Accountability Act (HIPAA) and understand the information included in this document. I am aware that a copy of this notice will be given to me if I ask for a copy. I understand that if I have further questions regarding the Notice or my privacy rights, I can address these questions to Bloom Psychology Services, LLC.

_____

Signature of Client or Parent/Guardian (if client is under the age of 18) Date

Consent to Use Email Communications

Bloom Psychology Services, LLC uses a secure, HIPAA-compliant email service provided by LuxSci to send and receive emails.

I hereby agree to sending and receiving from Bloom Psychology Services, LLC email communications as part of comprehensive treatment for my child. I understand that I will need to register my email address with LuxSci in order to send and receive the communications within a secure, confidential environment. I understand the risks of sending Protected Health Information (PHI) through email, and with this agreement I am accepting these risks to my child's PHI. I accept that Bloom Psychology Services, LLC shall not be held responsible for any exposure of email communications at my home or place of employment, depending on the location of my email address. I also understand that email communications can fail in their transmission, and I agree to contact Bloom Psychology Services, LLC if I have not obtained a response from my email communication within three business days. I also agree to never use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing Bloom Psychology Services, LLC in writing. With my signature, I believe that the benefits of using email communications for my child's healthcare outweigh the security risks.

_____

Signature of Client or Parent/Guardian (if client is under the age of 18) Date

Email Address: _____ (please print)

Bloom Psychology Services, LLC may leave messages at the following number: _____

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HISTORY QUESTIONNAIRE

Briefly describe the problems your child is having & when they began.

MENTAL HEALTH HISTORY

Has your child ever been abused (emotionally, physically, or sexually)? [ ] YES [ ] NO Explain:

Has your child ever experienced any other emotional or physical trauma? [ ] YES [ ] NO Explain:

Has your child ever:

a) been in counseling [ ] YES [ ] NO

b) been hospitalized for emotional or alcohol/drug problems [ ] YES [ ] NO

c) been professionally evaluated [ ] YES [ ] NO

d) received special education services [ ] YES [ ] NO

If yes to any of the above, please provide dates, names of agencies, reason for service, & outcome.

Please list any medications your child currently takes for emotional or behavior problems. [ ] NONE

Please list any medications your child has taken in the past for emotional or behavioral problems. [ ] NONE

_____

_____

Please list any family history of mental health/substance abuse problems.

_____

_____

GENERAL MEDICAL HISTORY

Height:_____ Weight: _____ Are immunizations up to date? [ ] YES [ ] NO

Please list all allergies, childhood illnesses (including chronic illnesses and infectious diseases), accidents, injuries, concussions, hospitalizations, and surgeries (including ear tubes placed and tonsils/adenoids removed), as well as the associated date.

_____

_____

_____

List all prescription and over-the-counter medications your child takes for any medical reason (include any vitamins & herbal supplements).

_____

_____

_____

Please indicate when your child's most recent hearing and vision screening occurred. If any problems or concerns were detected, please describe.

_____

_____

Please list any family history of medical problems.

_____

_____

_____

How many hours of sleep does your child get on school nights: _____ Weekend nights: _____

Does your child have any difficulty falling asleep or staying asleep? If so, please describe.

_____

_____

_____

Please describe your child's eating habits, as well as any eating-related concerns you may have.

_____

_____

About how many minutes of exercise does your child get on a typical school day: _____ Weekend day: _____

What type(s) of exercise does your child engage in?

_____

_____

FAMILY STATUS

Please describe your child's living arrangements, including visitation with the other parent if applicable.

_____

_____

_____

List all people currently residing in your home, and the relationship of each to your child.

_____

_____

_____

Are there any traditions/events that are important to your child?

_____

_____

Is there any additional information you feel would be helpful to the treatment of your child?

_____

_____

DEVELOPMENTAL HISTORY

Pregnancy

Was the pregnancy planned? [ ] YES [ ] NO Mother's age at delivery _____

Please check any of the following experienced during mother's pregnancy with the child being evaluated.

[ ] Excessive vomiting [ ] Excessive spotting/blood loss [ ] Threatened miscarriage [ ] Toxemia/Infection

[ ] Smoking [ ] Alcohol consumption [ ] Prescription medications [ ] Hospitalization (other than delivery)

[ ] Drug use [ ] Illness [ ] X-rays

Were there any complications with the pregnancy?

_____

_____

Was Pregnancy: [ ] Full Term [ ] Premature – how much? _____ [ ] Late – how much? _____

Were there any complications with the delivery?

_____

_____

List your child's birth weight. ___ pounds, ___ ounces

Was your child healthy at birth? [ ] YES [ ] NO Please explain:

_____

_____

Early Childhood

Milestones ~ **Please report ages (in months)** or if you cannot remember check one of the following:

Smiled	_____	[ ] Early	[ ] Average	[ ] Late
Crawled	_____	[ ] Early	[ ] Average	[ ] Late
Sat up on own	_____	[ ] Early	[ ] Average	[ ] Late
Stood unassisted	_____	[ ] Early	[ ] Average	[ ] Late
Walked unassisted	_____	[ ] Early	[ ] Average	[ ] Late
Spoke first words	_____	[ ] Early	[ ] Average	[ ] Late
Said sentences	_____	[ ] Early	[ ] Average	[ ] Late
Toilet Trained	_____	[ ] Early	[ ] Average	[ ] Late
Ran	_____	[ ] Early	[ ] Average	[ ] Late
Fed Self	_____	[ ] Early	[ ] Average	[ ] Late
Dressed Self	_____	[ ] Early	[ ] Average	[ ] Late

Were there any illnesses, behavioral difficulties, or discipline problems during early childhood?

_____

_____

_____

Did your child have temper tantrums? [ ] YES [ ] NO Describe:

_____

_____

_____

What discipline techniques were used?

_____

_____

_____

Did the parents use consistent discipline? [ ] YES [ ] NO

EDUCATIONAL HISTORY

School: _____ Grade: _____

How many different schools has your child attended? _____

Has she/he ever repeated or skipped a grade? [ ] YES [ ] NO Which one? _____

What is her/his attendance like at school? _____

Has she/he had any discipline problems at school and/or been suspended or expelled? _____

_____

_____

What are her/his grades like? _____ Have they changed recently? [ ] YES [ ] NO

With which subject does she/he experience difficulty? _____

Have you or your child's teacher worried that your child may have a learning disability? [ ] YES [ ] NO
If yes, please describe: _____

_____

Does she/he receive special education services? [ ] YES [ ] NO

Briefly describe services: _____

_____

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SOCIAL HISTORY

Does your child make friends easily? [ ] YES [ ] NO

Does your child have difficulty keeping friends? [ ] YES [ ] NO

Does your child avoid making eye contact? [ ] YES [ ] NO

Briefly describe any peer interaction problems experienced by your child. _____

_____

_____

Have there been any losses, changes, or transitions in your child's life? _____

_____

_____

Does the family have any spiritual, cultural, or religious beliefs that influence the child? _____

_____

Is your child involved in any organized activities (e.g., art class, soccer, taekwondo, Scouts, swimming)? If so, please describe.

_____

_____

_____

Has your child struggled in the past with attempts to participate in organized activities? If so, please describe.

_____

_____

_____

About how many minutes of screen time does your child get on a typical school day: _____ Weekend day: _____

Does your child have a TV in his/her room? [ ] YES [ ] NO

Does your child have his/her own smart phone? [ ] YES [ ] NO

Please describe the types of screen time your child engages in (e.g., YouTube, TV, computer/video games).

_____

_____

Does your child have any social media accounts? If so, please describe.

_____

_____

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Please describe your child's strengths, weaknesses, accomplishments, talents, and areas of interest.

_____

_____

_____

Below are some common problems of children and/or teenagers. Please read each item carefully. If an item applies to the child, please mark appropriately. Feel free to write it any comments.

Behavior Problems

[ ] Violates Curfew
[ ] Destroys Property
[ ] Steals
[ ] Lies often
[ ] Has been in trouble with police/probation
[ ] Has run away from home
[ ] Has attempted or talked about suicide
[ ] Argues when told to do something
[ ] Is cruel to animals
[ ] Rarely sits still
[ ] Has to have everything her/his own way
[ ] Acts like a younger child
[ ] Has problems with anger
[ ] Sets fire
[ ] Prefers to be alone

Academic Problems

[ ] Is truant from school
[ ] Does not complete assignments in the classroom
[ ] Does not do homework
[ ] Is in special education classes
[ ] Feels unfairly treated by teachers/administrators
[ ] Has a short attention span
[ ] Often clowns in class
[ ] Makes below average grades
[ ] Is too often out of seat at school
[ ] Has trouble following directions
[ ] Cheats

Problems with Feelings

[ ] Is upset by any changes in routines/schedules
[ ] Has a lot of fears
[ ] Lacks self confidence
[ ] Feels sad a lot
[ ] Easily irritated
[ ] Does not seem to feel guilt
[ ] Is extremely critical
[ ] Cries easily or often
[ ] Does not like to be touched
[ ] Resents even gentle criticism
[ ] Has an "I don't care" attitude
[ ] Feels bored a lot
[ ] Has frequent nightmares

Problems with Thinking

[ ] Says and does things over and over
[ ] Hears or sees things that aren't there
[ ] Has trouble concentrating
[ ] Has ideas that don't make sense

Family Problems

[ ] Avoids contact with family members
[ ] Gets along poorly with parent(s)
[ ] Gets along poorly with siblings
[ ] Parents get along poorly with each other
[ ] Clings to parent(s)

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Social Problems

[ ] Hangs around with a bad crowd
[ ] Is too easily led by others
[ ] Chooses friends a lot younger
[ ] Chooses friends a lot older
[ ] Teases other children
[ ] Doesn't like being alone
[ ] Has few friends
[ ] Tattles on other children
[ ] Seems shy
[ ] Often boasts
[ ] Often interrupts others
[ ] Won't argue/fight back when most would
[ ] Fights

Drug/Alcohol Abuse

[ ] Uses alcoholic beverages
[ ] Uses drugs
[ ] Sells drugs
[ ] Smokes cigarettes

Physical Complaints

[ ] Has a lot of physical complaints
[ ] Has trouble sleeping
[ ] Sleeps a lot
[ ] Is seriously overweight
[ ] Is seriously underweight
[ ] Has lost a lot of weight recently
[ ] Has gained a lot of weight recently
[ ] Has poor bladder control at night
[ ] Has poor bladder control during the day
[ ] Has poor bowel control at night
[ ] Has poor bowel control during the day
[ ] Is clumsy or awkward