Dear Parent(s),

Your child, ____________________________, is scheduled for an evaluation with Dr. Catherine Yeager and staff on __________________ at __________________. During this appointment you will be interviewed regarding your child’s history and current difficulties. Your child may begin testing either during or after the interview session; however, depending on the situation it is possible that no testing will be required or, if testing or other types of assessment (i.e., observation) are needed, that this will be scheduled for another date. A formal assessment plan, including a time for a feedback session, will be determined on the day of your child’s initial appointment.

If possible, we would like to have copies of your child’s relevant records on the day of his/her appointment. Such records may include:

- Previous psychological assessment records
- Special education/school records (e.g., intellectual or other assessments, 504 Plans, IEP)
- Previous psychotherapy records and/or inpatient psychiatric records
- Records for major medical problems (e.g., seizures, head injuries, genetic problems, surgeries, cancer)
- Records regarding psychiatric medications (e.g., ADHD, emotional problems)
- Occupational therapy, vision therapy/assessment, or speech/language therapy/assessment records

Please bring these records with you to the appointment, or if you would like us to request these records, please complete and return the enclosed Request for Records Form to this office before the appointment so that we can send out the appropriate Release of Information forms.

In addition, the following forms (enclosed) need to be filled out by you: the General Information Form for Pediatric Patients and the Child Behavior Checklist [Blue Form]. Please bring the forms back to us on the day of the appointment. If possible, your child’s teacher or caregiver (e.g., daycare provider) should fill out the Child Behavior Checklist [Green Form]. Your child’s teacher/caregiver can complete them and return them in the enclosed envelope.

Assessment and Therapy Associates of Grand Forks is located in the Grand Forks Family Medicine Residency Center (next to the University Bookstore on the UND campus). Please contact us if you need more detailed directions. If the need arises for you to cancel or reschedule the above appointment please call us at (701) 780-6821 as soon as possible to allow for another patient to fill the appointment time. If you have any additional questions please contact Dr. Yeager’s staff at (701) 780-6821.

Catherine Yeager, Ph.D., LP
# PEDIATRIC BACKGROUND INFORMATION FORM

## GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Child’s First Name:</th>
<th>Last Name:</th>
<th>Date of Birth:</th>
<th>Age:</th>
</tr>
</thead>
</table>

Name of Parent(s)/Guardian: (mother): (father):

Name of Person Completing This Form: Relationship to Child:

Do you have legal custody of this child?  Yes  No

Address: Street: City: State: Zip:

Phone: Home: ( ) - Work: ( ) - Cell/Other: ( ) -

May we leave messages at: Home?  Yes  No  Work?  Yes  No  Cell?  Yes  No

E-mail Address (if you would like to use this for communication):

How were you referred to this clinic?

Who is your child’s primary care physician/provider?

Would you like a copy of this evaluation sent to your child’s physician/provider?  Yes  No

If yes, where does this provider practice (i.e., name/address of clinic):

## INSURANCE INFORMATION

*(Please give your insurance card to the office manager)*

<table>
<thead>
<tr>
<th>Person responsible for bill:</th>
<th>Date of Birth:</th>
<th>Relationship to patient:</th>
</tr>
</thead>
</table>

Address of responsible party (if different): Home phone no.: ( ) -

Is this patient covered by insurance?  Yes  No

Name of Insurance Company/Plan:

Subscriber’s name: Plan Number/ID: Group Number:

Patient’s relationship to subscriber: Self  Child  Other

Subscriber’s Date of Birth:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinician. I understand that I am financially responsible for any balance. I also authorize Assessment and Therapy Associates of Grand Forks, PLLC or insurance company to release any information required to process my claims (please initial):
# CURRENT PROBLEMS

Please describe the problems that your child is demonstrating:

<table>
<thead>
<tr>
<th>How long have these problems been present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are these problems related to any specific event or situation?</td>
</tr>
<tr>
<td>If yes, describe the event/situation:</td>
</tr>
<tr>
<td>Is your child currently in therapy for these problems?</td>
</tr>
<tr>
<td>If yes, who is the therapist?</td>
</tr>
<tr>
<td>Does your child currently take medication(s) for this or any other emotional or behavioral problem?</td>
</tr>
<tr>
<td>If yes, what medication(s) does he/she take?</td>
</tr>
<tr>
<td>If your child is being seen for an assessment, what questions would you like to have answered?</td>
</tr>
</tbody>
</table>

# PREVIOUS TREATMENTS AND EVALUATIONS

Has your child had therapy previously? | Yes | No | If yes, who was therapist? |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What problems did previous therapy address?</td>
</tr>
<tr>
<td>Has your child previously taken any medication(s) for this or any other emotional or behavioral problem?</td>
</tr>
<tr>
<td>If yes, what medication(s) did he/she take?</td>
</tr>
<tr>
<td>Has your child ever been evaluated for learning, developmental, emotional, or behavioral issues?</td>
</tr>
</tbody>
</table>

If yes, what types of evaluation(s) has your child had (CHECK AND DESCRIBE ALL THAT APPLY):

| □ Emotional/Behavioral Problems | Who conducted evaluation? |
| □ Cognitive/Learning Evaluation | Who conducted evaluation? |
| □ Developmental Delays | Who conducted evaluation? |
| □ Speech/Language Problems | Who conducted evaluation? |
| □ Fine or Gross Motor | Who conducted evaluation? |
| □ Sensory Integration | Who conducted evaluation? |
| □ Visual Processing Evaluation | Who conducted evaluation? |
| □ Central Auditory Processing | Who conducted evaluation? |
| □ Other (Describe): | Who conducted evaluation? |
### PRENATAL HISTORY

*Did your child have any of the following problems? PLEASE CHECK AND DESCRIBE ALL THAT APPLY*

<table>
<thead>
<tr>
<th>Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal problems</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>Alcohol or drug exposure in utero</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>Delivery problems</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>Caesarian Section Delivery</td>
<td>Reason for C-Section:</td>
</tr>
<tr>
<td>Prematurity</td>
<td>If yes, how early was child delivered?</td>
</tr>
<tr>
<td>Health problems at birth</td>
<td>If yes, describe:</td>
</tr>
</tbody>
</table>

What was your child’s birth weight? pounds ounces

### MEDICAL HISTORY

*Has your child had any of the following medical problems? PLEASE CHECK AND DESCRIBE ALL THAT APPLY*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Ear Infections</td>
<td>Age infections began:</td>
</tr>
<tr>
<td>Chronic medical issues</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>Seizures</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>Prolonged high fevers</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>Head injury</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>Surgeries</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>Serious Medical Illnesses</td>
<td>If yes, describe:</td>
</tr>
</tbody>
</table>
**MEDICAL HISTORY (CONTINUED)**

Does your child currently take any medications for health problems?  □Yes  □No
If yes, what medications?
What are medications for?

Does your child have any of the following problems with sleep (CHECK ALL THAT APPLY):

- [ ] severe resistance to going to bed
- [ ] sleeping less than usual (WITH daytime fatigue)
- [ ] sleeping too much
- [ ] waking too early in the morning
- [ ] problems falling asleep once in bed
- [ ] sleeping less than usual (WITHOUT daytime fatigue)
- [ ] waking in the night

Does your child have any of the following appetite or eating problems (CHECK ALL THAT APPLY):

- [ ] excessively picky eating
- [ ] eating too much
- [ ] eating too little
- [ ] trying to lose weight when weight is normal

Has your child recently **gained** a significant amount of weight?  □Yes  □No  **If yes, how much?**

Has your child recently **lost** a significant amount of weight?  □Yes  □No  **If yes, how much?**

**DEVELOPMENTAL HISTORY**

*Has your child had developmental delays in any of these areas? PLEASE CHECK AND DESCRIBE ALL THAT APPLY*

- [ ] Gross (large) motor skills  If yes, describe:
- [ ] Fine (small) motor skills  If yes, describe:
- [ ] Language skills  If yes, describe:
- [ ] Self-help skills  If yes, describe:
- [ ] Social skills  If yes, describe:
- [ ] Other delays  If yes, describe:

What hand does your child use?  □ Right hand  □ Left hand  □ Both  □ Has not chosen dominant hand
# DEVELOPMENTAL HISTORY (CONTINUED)

Does your child demonstrate any of the following behaviors or problems (CHECK ALL THAT APPLY):

- tics
- unusual movements
- speaking “her own language”
- poor eye contact
- “echoing” or repeating what he/she hears
- repeating movies/conversations
- not responding to his/her name when called
- difficulty imitating others
- hand flapping or other unusual behavior when excited
- walking on his/her toes
- waving fingers or other objects in front of his/her face
- lining up toys in play
- lack of imaginative play
- poor response to changes or transitions
- disinterest in people/peers
- unusual interests or attachment objects
- problems talking about things other than his/her interests
- oversensitivity to sounds
- seeking out loud sounds or noises
- oversensitivity to visual stimuli
- oversensitivity to touch
- high pain tolerance
- oversensitivity to smells
- oversensitivity to food textures

Describe your child’s friendships and peer relationships:

Describe your child’s strengths:

---

# FAMILY AND SOCIAL HISTORY

Where does your child live (city, state)?

Who does child live with?

Mother’s name:  
Mother’s occupation:  
Child’s relationship with mother:

Father’s name:  
Father’s occupation:  
Child’s relationship with father:

Other Caregivers (e.g., step-parents):  
Child’s relationship with caregivers:

**List child’s siblings below:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Child’s relationship with this sibling:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Have any of the following stressors impacted your child in the last year?**

- Divorce
- Death of friend
- Victim of accident
- Conflict in family
- Conflict with friends
- Expelled from school
- Break-up of relationship
- Natural disaster
- Death of parent
- Starting new job
- Serious illness
- Financial problems
- Death of a pet
- Birth of a child
- Conflict at work
- Surgeries
- Death of family member
- Abuse/victim of crime
- Illness of family member
- Illness in close friend
- Foster home placement
- Separation from family
- Moving to a new area
- Separation

Provide further description of family stressors (if needed):
### FAMILY MEDICAL AND PSYCHIATRIC HISTORY

List any family medical problems that your child is at risk for:

**Family Psychiatric History (CHECK ALL THAT APPLY):**

<table>
<thead>
<tr>
<th>☐ Depression</th>
<th>☐ Bipolar Disorder (Manic-Depression)</th>
<th>☐ Anxiety/nervousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Panic Attacks</td>
<td>☐ Schizophrenia</td>
<td>☐ Suicide Attempts</td>
</tr>
<tr>
<td>☐ Alcohol problems</td>
<td>☐ Drug problems</td>
<td>☐ Suicide Completion</td>
</tr>
<tr>
<td>☐ Learning Problems</td>
<td>☐ Attention Problems</td>
<td>☐ Legal Problems</td>
</tr>
<tr>
<td>☐ Autism</td>
<td>☐ Hyperactivity</td>
<td>☐ Delayed Development</td>
</tr>
<tr>
<td>☐ Eating Disorders</td>
<td>☐ Hospitalization for mental problems</td>
<td>☐ Tics/Tourette’s Syndrome</td>
</tr>
</tbody>
</table>

### ACADEMIC HISTORY

What grade is your child in currently?  
What school does your child attend?

Who is your child’s teacher (if child is in middle or high school and has multiple teachers, enter “team”): 

**Does child currently have problems in any of the following academic areas? CHECK AND DESCRIBE ALL THAT APPLY**

<table>
<thead>
<tr>
<th>☐ Reading problems</th>
<th>If yes, describe:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Writing problems</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>☐ Math problems</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>☐ Behavior problems (at school)</td>
<td>If yes, describe:</td>
</tr>
<tr>
<td>☐ Homework problems</td>
<td>If yes, describe:</td>
</tr>
</tbody>
</table>

Does your child have an Individualized Education program (IEP)? ☐ Yes ☐ No  If yes, what does programming address?

| ☐ Speech/language problems | ☐ Specific Learning Disability | ☐ Autism |
| ☐ Noncategorical Delay     | ☐ Mentally Handicapped         | ☐ Emotional/Behavioral Problems |
| ☐ Other Health Impaired    | ☐ Traumatic Brain Injury       | ☐ Other (describe) |

Does your child have a 504 Accommodation Plan? ☐ Yes ☐ No  If yes, what do accommodations address?

| ☐ attention/organizational problems | ☐ fine motor problems | ☐ emotional problems |
| ☐ behavioral problems              | ☐ sensory problems    | ☐ other (describe): |

Has your child ever been retained (held back) in a grade? ☐ Yes ☐ No  If yes, why?
### BEHAVIOR

*Check the symptoms your child demonstrates regularly and/or symptoms severe enough to cause impairment:*

#### Attention Problems (CHECK ALL THAT APPLY):
- ☐ fails to give close attention to details
- ☐ makes careless mistakes in schoolwork
- ☐ has difficulty sustaining attention in tasks or play
- ☐ demonstrates poor listening when spoken to directly
- ☐ avoids tasks that require sustained mental effort
- ☐ becomes easily distracted by extraneous stimuli
- ☐ has difficulty refocusing after distraction
- ☐ has difficulty following through on instructions
- ☐ fails to finish work
- ☐ has difficulty with multitasking

#### Organization Problems (CHECK ALL THAT APPLY):
- ☐ generally messy
- ☐ loses things necessary for tasks
- ☐ forgets to turn work in
- ☐ has many missing assignments
- ☐ forgetful in daily activities
- ☐ forgets to bring home homework

#### Activity Level Problems (CHECK ALL THAT APPLY):
- ☐ fidgets or squirms in his/her seat
- ☐ leaves her seat in the classroom or in other situations
- ☐ runs about or climbs excessively
- ☐ reports feeling restless
- ☐ often has difficulty playing quietly
- ☐ is ‘on the go’ or often acts as if ‘driven by a motor’
- ☐ talks excessively

#### Impulse Control Problems (CHECK ALL THAT APPLY):
- ☐ blurts out answers to questions
- ☐ has difficulty awaiting her turn
- ☐ interrupts or intrudes on others
- ☐ behaves in a way that could be dangerous because she does not think through her actions

#### Other Behavioral Problems (CHECK ALL THAT APPLY):
- ☐ is often angry or resentful
- ☐ has anger management problems
- ☐ often loses her temper
- ☐ has temper tantrums
- ☐ argues with adults
- ☐ often blames others for her own mistakes or misbehavior
- ☐ steals at home
- ☐ steals outside of home
- ☐ uses alcohol/drugs
- ☐ has trouble with the law
- ☐ steals at home
- ☐ steals outside of home
- ☐ uses alcohol/drugs
- ☐ has trouble with the law

How long have the behavioral problems you checked above existed?
### EMOTIONS

**Check the symptoms your child demonstrates regularly and/or symptoms severe enough to cause impairment:**

<table>
<thead>
<tr>
<th>Depressive Symptoms (CHECK ALL THAT APPLY):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ excessive, frequent sadness and crying</td>
<td>☐ excessive physical complaints</td>
</tr>
<tr>
<td>☐ poor self-esteem</td>
<td>☐ energy loss/excessive fatigue</td>
</tr>
<tr>
<td>☐ excessive or frequent irritability</td>
<td>☐ loss of interest in activities</td>
</tr>
<tr>
<td>☐ overreactions to events</td>
<td>☐ social withdrawal</td>
</tr>
<tr>
<td>☐ extreme mood swings</td>
<td>☐ suicidal thoughts/behavior</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANXIETY SYMPTOMS (CHECK ALL THAT APPLY)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ specific fears</td>
<td>☐ obsessive thoughts</td>
</tr>
<tr>
<td>☐ general worry about what is going to happen</td>
<td>☐ repetitive acts</td>
</tr>
<tr>
<td>☐ worry about family members</td>
<td>☐ fear of public places</td>
</tr>
<tr>
<td>☐ worries about school</td>
<td>☐ fear of social interaction</td>
</tr>
<tr>
<td>☐ panic attacks (i.e., racing heart, extreme fear)</td>
<td></td>
</tr>
</tbody>
</table>

**How long have the emotional problems you checked above existed?**

**Are the above describe emotional and/or behavioral problems related to a specific situation/event?**  ☐ Yes  ☐ No

If yes, describe:

**What questions would you like to have answered as a result of this evaluation?**

**Is there anything else you feel we should know about your child?**
Assessment and Therapy Associates of Grand Forks
Pediatric Psychology Services Patient Contract

Providers of Service: Psychological Services at Assessment and Therapy Associates of Grand Forks are provided by a licensed clinical psychologist, a post-doctoral resident, a psychology technician (i.e., testing) or a psychology intern. Post-doctoral residents have their Ph.D. in clinical psychology and are currently being supervised by a licensed psychologist in preparation for independent licensure. Psychology interns are advanced graduate students from the University of North Dakota who have their Master’s Degree in psychology and are working toward their doctorate. Interns also work under the supervision of a licensed psychologist.

Confidentiality: Discussions with your psychology care provider are confidential unless you (i.e., the child’s legal custodial parent/guardian) grant written permission to release this information. In order to submit insurance claims, your insurance company needs to be aware that your child is receiving services and they will require disclosure of your child’s diagnosis. If you plan to have claims submitted to an insurance company, by signing this form you consent to have your child’s diagnostic information provided to your insurance company at the time of billing for services. Your insurance company may also request additional records; however, these records will not be released to your insurance company or any other third party until we have obtained your written permission. There are three exceptions to this promise of confidentiality that do not require written permission: (1) instances of suspected child abuse or neglect; (2) instances in which a patient threatens to harm him/herself; and (3) instances in which a patient threatens to harm another person. In these cases your care provider has an ethical and legal obligation to report this information to the appropriate parties/agencies.

Contacting Your Doctor During Normal Business Hours: If you or your child need to contact your care provider during normal business hours, you can call Assessment and Therapy Associates of Grand Forks at (701) 780-6821. Your mental health care provider will return your call as soon as possible. In the case of an emergency, it is advised that you call 911, go to the Emergency Department at Altru Hospital, or call the 24-hour crisis line at Northeast Human Service Center at (701) 775-0525.

Contacting Your Doctor on Evenings and Weekends: In the case of an emergency, it is advised that you call 911, go to the Emergency Department at Altru Hospital, or call the 24-hour crisis line at Northeast Human Service Center at (701) 775-0525.

Billing and Payment: Licensed Psychologists and post-doctoral residents are considered providers of medical services for most insurance companies. It is important that you check with your insurance company to determine what services are covered, because payments and restrictions vary with each company. It is strongly encouraged that you pay for services at the time of your appointment.

Missed Appointments: Assessment and treatment involve considerable commitments of time, effort, and cost for you, your child, and your service provider. In order for assessment and treatment to be successful, it is important to maintain appointments. If changes to the original assessment or treatment plan need to be made, this can be discussed with your mental health care provider and the plan can be revised to meet scheduling needs. If you are unable to come for an appointment, it will be expected that you call to reschedule at least 24 hours in advance of your missed appointment. If two consecutive appointments are missed without prior notification, our business office may cancel all previously scheduled appointments with your mental health care provider.

I have read and understand this contract and agree to the terms and conditions stated. In addition, I agree that I am truthfully representing myself as the legal custodial parent/guardian of this child.

________________________________________________________
Child’s Name

________________________________________________________
Child’s Birthday

________________________________________________________
Signature of Responsible Party

________________________________________________________
Date
THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ATAGF. Uses and Disclosures for Treatment, Payment, and Health Care Operations

ATAGF may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- **“PHI”** refers to information in your health record that could identify you.
- **“Treatment, Payment and Health Care Operations”**
  - Treatment is when ATAGF clinicians provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when your doctor or therapist consults with another health care provider, such as your family physician or another doctor or therapist.
  - Payment is when ATAGF obtains reimbursement for your healthcare. Examples of payment are when ATAGF discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- **“Use”** applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **“Disclosure”** applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- **“Psychotherapy Notes”** are notes your doctor or therapist has made about your conversation during an assessment interview private, group, joint, or family counseling session, which your doctor or therapist has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

II. Uses and Disclosures Requiring Authorization

ATAGF may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when ATAGF is asked for information for purposes outside of treatment, payment, or health care operations, ATAGF will obtain an authorization from you before releasing this information. ATAGF will also need to obtain an authorization before releasing your Psychotherapy Notes.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) ATAGF has relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy

III. Uses and Disclosures with Neither Consent nor Authorization

A psychologist may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse** – If a psychologist is treating a child and knows or suspects that child to be a victim of child abuse or neglect, the doctor or therapist is required to report the abuse or neglect to a duly constituted authority.
- **Adult and Domestic Abuse** – If a psychologist has reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, the psychologist must report this belief to the appropriate authorities.
- **Health Oversight Activities** – If the North Dakota Board of Psychologist Examiners is conducting an investigation into a psychologist’s practice, then the psychologist may be required to disclose PHI upon receipt of a subpoena from the Board.
- **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment, and the records thereof, such information is privileged under state law, and your psychologist will not release information either without your written authorization, the authorization of your legally appointed representative, or a
court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety** – A psychologist may disclose PHI to the appropriate individuals if the psychologist believes in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s). This includes a credible and reasonable belief that you may harm or kill yourself or another person the psychologist can identify.

- **Worker’s Compensation** – A psychologist may disclose PHI as authorized by, and to the extent necessary to comply, with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

### IV. Patient’s Rights and Psychologist’s Duties

**Patient’s Rights:**

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of PHI. However, your psychologist is not required to agree to a restriction you request.

- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a provider in our office. On your request, ATAGF will send your bills to another address.)

- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI in your psychologist’s mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your doctor or therapist may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. ATAGF STRONGLY RECOMMEND, ENSURE ACCURATE UNDERSTANDING AND TO POTENTIAL EMOTIONAL HARM YOU GET FEEDBACK ON PSYCHOLOGICAL ASSESSMENTS IN PERSON. YOU CAN THEN GET YOUR QUESTIONS ANSWERED, ADDRESS ANY EMOTIONAL REACTION TO THE INFORMATION, AND ADDRESS ANY CONCERNS (IF ANY) YOU MAY HAVE. You may inspect and copy Psychotherapy Notes (which is separate from PHI) unless your doctor or therapist makes a clinical determination that access would be detrimental to your health. On your request, your clinician will discuss with you the details of the request and any denial review process.

- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. A psychologist may deny your request. On your request, your clinician will discuss with you the details of the amendment process.

- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI. On your request, your doctor or therapist will discuss with you the details of the accounting process.

- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from your doctor or therapist upon request, even if you have agreed to receive the notice electronically.

**Psychologist’s Duties:**

- A psychologist is required by law to maintain the privacy of protected health information regarding you and to provide you with notice of the psychologist’s legal duties and privacy practices with respect to PHI.

- ATAGF reserves the right to change the privacy policies and practices described in this notice. Unless ATAGF notifies you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will post a notice of revisions in our office. ATAGF will send a paper notice by mail upon your written request (you may request in writing that notices be sent by mail at any time during the course of therapy, and all subsequent notices will be sent to you).

### V. Complaints

If you are concerned that your psychologist or anyone in our office has violated your privacy rights or you disagree with a decision your doctor or therapist made about access to your records, you may contact Catherine Yeager, Ph.D. or send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

### VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.
ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Assessment and Therapy Associates of Grand Forks, PLLC.

Print Patient Name:_____________________________________________________

Signature of Patient:____________________________________________________ *

Date of Receipt and Signature:___________________________________________

*If person signing is not the patient, please print your name and relationship to patient:

Name _________________________________________________________________

Relationship ___________________________________________________________

For Office Use:

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment:
I hereby authorize Assessment and Therapy Associates of Grand Forks, PLLC to disclose to my current insurance carrier, present and past information required to prepare an insurance claim. The insurance company will use this information to process my claim for benefits.

I authorize all insurance claims payable on claims originating from Assessment and Therapy Associates of Grand Forks, PLLC to be paid directly to Assessment and Therapy Associates of Grand Forks, PLLC. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

I understand that no other use will be made of this information except for that otherwise authorized by law.

______________________________  ______________________________
Child’s Name  Child’s Birthday

______________________________  ______________________________
Signature of Responsible Party  Date