MARGARET ANN JESSOP, PSYD

Psychological, Counseling, and Consulting Services
53700 Generations Drive, Suite 200 • South Bend, IN 46635
Phone: (574) 245-0077 • Fax: (574) 258-6310
Email: meganajessop@gmail.com

Child and Adolescent Intake Form

Date: _____

☐ For Scheduling

☐ For Newsletter

Client Name: _____ E-mail: _____

Date of Birth: _____

Client lives with (Include all members of the household):

NAME	RELATIONSHIP	DATE OF BIRTH

Parent/Guardian Information

Name: _____ Home Phone: _____

Address: _____
(Street) (City) (State/Zip Code)

Marital Status: _____ Previous Marriage for: ☐ Husband ☐ Wife

In case of emergency, contact (name and phone): _____

_____

Responsible Party: _____

Health Information:

Is the client on medication now? ☐ Yes ☐ No (Please list medication, dosage, and reason for taking it:

_____

_____

Client's Physician: _____

Allergies: _____

Health Problems: _____

(Continued on page 2)

Previous Counseling (please list counselor name, dates of service, and reason for counseling):

_____

_____

Last Physical: _____ Present Health: _____

Sometimes it is helpful for us to discuss treatment with the client's physician. Your signature below indicates your permission for me to do so.

_____

Parent/Guardian Signature **Date:**

By whom were you referred?: _____

What do you see as the problem?: _____

_____

_____

_____

_____

School Information:

School Currently Attending: _____

Grade: _____ Teacher: _____

Are school grades and/or behavior of particular concern?: _____

_____

_____

Parent/Guardian Employment:

Name: _____ Employer: _____

Address of Employer: _____

May you be reached at work?: ☐ Yes ☐ No If yes, Phone: _____

Job Title: _____

Spouse's Employment:

Name: _____ Employer: _____

Address of Employer: _____

May you be reached at work?: ☐ Yes ☐ No If yes, Phone: _____

Job Title: _____

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INSURANCE INFORMATION AND RELEASE

If you want me to file insurance for you, please complete the information below and sign to give me permission. You must provide the identifying information, including name of insured and address for claims.

Identifying Information

Name of Insured: _____

Name of Patient: _____

Insured's Employer: _____

Insurance Company: _____ ID#: _____

Policy Number: _____ Group Number: _____

Claims Office Address: _____

_____

_____

_____

Phone Number: _____

Pre-authorization required? ☐ ***Yes*** ☐ ***No*** ***Authorization obtained?*** ☐ ***Yes*** ☐ ***No***

PATIENT OR AUTHORIZED PERSON SIGNATURES

I authorize the release of any medical information, including diagnosis and dates of service, necessary to process claims.

Signed: _____Date: _____

I authorize payment of any medical benefits for the services provided to the physician or supplier of services.

Signed: _____Date: _____

PLEASE NOTIFY MARGARET ANN JESSOP, PSYD OF ANY CHANGES IN YOUR INSURANCE.

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Custodial Parent Release Form*

**Please fill out this form for patients under the age of 18.*

Parent(s): _____ Child(ren):_____

_____ _____

I affirm that I have sole legal custody of the minor child(ren) listed above and consent to their treatment by Margaret Ann Jessop, PsyD.

Signature of Parent: _____ Date:_____

Signature of Witness: _____ Date:_____

OR

I affirm that _____ and I have joint legal custody of the minor child(ren) listed above, and the other parent consents to this treatment by Margaret Ann Jessop, PsyD.

Other Parent's Address:_____ Phone:_____

_____ _____

_____

I understand that Margaret Ann Jessop, PsyD reserves the right to send a copy of this form to the other parent.

Signature of Parent: _____ Date:_____

Signature of Witness: _____ Date:_____

OR

I affirm that I have sole legal custody of the minor child(ren) listed above, and the other parent does NOT consent to this treatment by Margaret Ann Jessop, PsyD.

Other Parent's Name:_____ Phone: _____

Other Parent's Address:_____ _____

(Continued on page 2)

I consent to treatment of the child(ren) listed above by Margaret Ann Jessop, PsyD. The other custodial parent ☐ ***is*** or ☐ ***is not*** aware of the need for counseling and does not agree to this treatment.

Please indicate to the best of your knowledge why this is so:

_____

_____

_____

I understand Margaret Ann Jessop, PsyD reserves the right to send a copy of this form to the other parent.

Signature of Parent: _____ Date:_____

Signature of Witness: _____ Date:_____

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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have, so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you; and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one, 55-minute session (one appointment hour of 55 minutes duration) per week, at a time we agree on—although some sessions

may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless:

- you provide 24-hour advance notice of cancellation, or
- unless we both agree that you were unable to attend due to circumstances beyond your control.

If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is $210-$160. If we meet more than the usual time, I will charge accordingly.

In addition to weekly appointments, I charge this same hourly rate for other professional services you may need—although I will prorate the hourly cost if I work for periods of less than one hour.

Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $250 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $.10 per page for records requests.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise, or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. (In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.)

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim.

In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you

(not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience, and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by the insurance contract.

CONTACTING ME

I am often not immediately available by telephone. Though I am **usually in my office between 9 AM and 3 PM,** I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available.

In emergencies, you can try me at my cell number. 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 and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATION POLICY

EMAIL COMMUNICATIONS AND TEXT MESSAGING

I use email communication and text messaging only with your permission and only for administrative purposes, unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters, because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone, or wait so we can discuss it during your therapy session. The telephone, or face-to-face context, simply is a much more secure mode of communication. If you don't hear back from an email or text, assume I didn't receive your message and give me a call.

SOCIAL MEDIA

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

WEBSITES

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

WEB SEARCHES

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person, and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related

errors because of confidentiality restrictions. If you encounter such reviews of me, or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent, or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents, and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully, so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child—not the parents/guardians, nor any siblings, or other family members of the child.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.

- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm (and the police).

- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused—physically, sexually or emotionally—or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.

- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of—or might be upset by—but that do not put your child at risk of serious and immediate harm.

However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

Example: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If your child tells me that he/she is drinking and driving, or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

Example: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of your state may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child.

You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court—whether in person or by affidavit—or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed, or a court order is provided; but I will not make any recommendation about the final decision(s).

Furthermore, if I am required to appear as a witness, or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

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HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

My signature below acknowledges that I have received a copy of *Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information,** as required by new federal legislation (HIPAA).

**Located at Front Desk.*

_____ _____

(Client Signature) *(Date)*

OUTPATIENT SERVICE CONTRACT SIGNATURES AND CONSENT FOR MENTAL ILLNESS SERVICES FOR CHILD/ADOLESCENT PATIENT

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date _____

** For very young children, the child's signature is not necessary.*

PARENT/GUARDIAN OF MINOR PATIENT

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. *[Initial(s)]* _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

[Initial(s)] _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

[Initial(s)] _____ _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Note: This page will be removed from the previous 7 pages and kept in your Clinical Chart.
You may keep the rest of the documents for your records.