PREMIER EDUCATIONAL ASSESSMENT SERVICES

Date of Initial Interview: ____________________

Name of Child: ____ Sex:

Date of Birth: _____________________ Place of Birth: _________________________ Age: ______

Address (number and street): ____

City: _________________State: ________Zip Code: ________Cell Phone:___________________

Home Telephone: __________________ Email:____

Education (grade): _____________________ Present School: __________________________________

Referral Source: ____

Mother's Name: ____ DOB: __________________

Home Phone: _________________________ Address: ____

Employed as: _________________________ Work Phone: _____________________________________

Father's Name: ____ DOB: __________________

Home Phone: _________________________ Address: ____

Employed as: _________________________ Work Phone: _____________________________________

Step-Parent's Name: ____ DOB: __________________

Home Phone: _________________________ Address: ____

Employed as: _________________________ Work Phone: _____________________________________

Parent Signature: _____________________________________ Date: ____________________

CHIEF COMPLAINT

Presenting Problems: (check all that apply)

Very unhappy	Impulsive	Fire-setting
Irritable	Stubborn	Stealing
Temper outbursts	Disobedient	Lying
Withdrawn	Infantile	Sexual trouble
Daydreaming	Mean to others	School performance
Fearful	Destructive	Truancy
Clumsy	Trouble with the law	Bed-wetting
Overactive	Running away	Soiled pants
Slow	Self-mutilating	Eating problems
Short attention span	Head banging	Sleeping problems
Distractible	Rocking	Sickly
Lacks initiative	Shy	Tobacco use
Undependable	Strange behavior	Alcohol use
Peer conflict	Strange thoughts	
Phobic	Suicide talk	

Dependency on illegal, prescribed, or over the counter drugs

Explain:

How long have these problems occurred? (number of weeks, months, years)

____

What happened that makes you seek help at this time?

____

Problems perceived to be: very serious serious not serious

What are your expectations of your child?

____

What changes would you like to see in your child?

____

What changes would you like to see in yourself?

____

What changes would you like to see in your family?

____

Religion or cultural affiliations that may affect treatment

____

PSYCHOSOCIAL HISTORY

Current Family Situation:

Mother – Relationship to child

natural parent / relative
stepparent / adoptive parent

Occupation: ______________________________

Education: ______________________________ Religion: ________________________

Birthplace: ______________________________ Birthdate: ________________________

Age: ________

Father – Relationship to child

natural parent / r relative
stepparent / adoptive parent

Occupation: ______________________________

Education: ______________________________ Religion: ________________________

Birthplace: ______________________________ Birthdate: ________________________

Age: ________

Marital History of Parents:

Natural Parents: married when _____________ age ______
Deceased?

Stepparents: married when __________________________
married when __________________________

If child is adopted:

Adoption source: ____

Reason and circumstances: ____

Age when child first in home: ____

Date of legal adoption: ____

What has the child been told? ____

Living Arrangements: Places Dates

Number of moves in child's life ________________ ____________________

________________ ____________________

________________ ____________________

Present Home renting buying ________________ ____________________

house apartment ________________ ____________________

Does the child share a room with anyone else? Yes No

If yes, with whom? ____

If no, how long has he/she had own room? ____

Was the child ever placed, boarded, or lived away from the family? Yes No
Explain: ____

What are the major family stresses at the present time, if any?

Brothers and Sisters: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug abuse (yes or no)
1.							
2.							
3.							
4.							
5.							
6.							

List all other extended family members by their relation to the client who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

1. ____
2. ____
3. ____
4. ____
5. ____

Others living in the home (and their relationship):

1. ____
2. ____

Health of Family Members: (excluding client)

Name	Relationship to child	Type of illness	When occurred	Length of illness
1.				
2.				
3.				
4.				

Does or did any member of the child's family have any problems with:
reading spelling math speech
(If yes, please explain)

Is there any history in the child's family of:
mental illness epilepsy birth defects Autism schizophrenia
(If yes, please explain)

Child Health Information: Note all health problems the child has had or has now.

	AGE		AGE
__ High fevers	______	__ Dental problems	______
__ Pneumonia	______	__ Weight problems	______
__ Flu	______	__ Allergies	______
__ Encephalitis	______	__ Skin problems	______
__ Meningitis	______	__ Asthma	______
__ Convulsions	______	__ Headaches	______
__ Unconsciousness	______	__ Stomach problems	______
__ Concussions	______	__ Accident-prone	______
__ Head injury	______	__ Anemia	______
__ Fainting	______	__ High or low blood press.	______
__ Dizziness	______	__ Sinus problems	______
__ Tonsils out	______	__ Heart problems	______
__ Vision problems	______	__ Hyperactivity	______
__ Hearing problems	______	__ Other illnesses (explain)	______
__ Earaches	______		
__ Infectious diseases (explain)			

Has the child ever been hospitalized? Yes No
(If yes, please explain)

Age	How Long	Reason
________	_________________	____

Has child ever been seen by a medical specialist? Yes No

Age	How Long	Reason
________	_________________	____

Has child ever taken, or is he/she taking presently, any prescribed medications? Yes No

Age	How Long	Reason
________	_________________	____

Name of Primary Care Physician: ____

Developmental History:

PRENATAL – Child wanted? Yes No Planned for? Yes No
Normal pregnancy? Yes No
If mother ill or under serious distress during pregnancy, please explain:

Length of pregnancy: ____
Paternal support and acceptance: (explain)

BIRTH – Length of active labor: _______ hrs. Easy Difficult
Full term: Yes No

If premature, how early: ____

If overdue, how late: ____

Birth weight: ______ lbs. _____ oz.

Type of delivery: spontaneous cesarean with instruments
head first breech

Was it necessary to give the infant oxygen? Yes No If yes, how long? _____

Did infant require blood transfusion? Yes No

Did infant require x-ray? Yes No

Physical condition of infant at birth:
(If yes, explain)

anorexia	Yes	No
trauma	Yes	No
other complications	Yes	No

Did mother use/abuse alcohol/drugs during pregnancy? Yes No

NEWBORN PERIOD –

			How Long?
Irritability	Yes	No	________________
Vomiting	Yes	No	________________
Difficulty breathing	Yes	No	________________
Difficulty sleeping	Yes	No	________________
Convulsions/twitching	Yes	No	________________
Colic	Yes	No	________________
Normal weight gain	Yes	No	________________
Was child breast-fed	Yes	No	________________

DEVELOPMENTAL MILESTONES – Age at which child:

Sat up: ________________________ Bladder trained: ____________________

Crawled: ______________________ Bowel trained: _____________________

Walked: _______________________ Weaned: __________________________

Spoke single words: ____________ Sentences: _____________________

Describe the manner in which toilet training was accomplished:

EARLY SOCIAL DEVELOPMENT –

Relationship to siblings and peers:

individual play	group play
competitive	cooperative
leadership role	a follower

Describe special habits, fears, or idiosyncrasies of the child:

Educational History:

Name of School	City/State	Dates Attended: From	To	Grades completed at this school

Preschool ____

Elementary ____

Junior High ____

High School ____

Type of classes: regular / continuation / emotionally disturbed / learning disability / opportunity / other

Did child skip a grade? Yes No Repeat a grade? Yes No
(If yes, please explain in detail.)

____

Did child have any specific learning difficulties?	Yes	No
Has child ever had a tutor or other special help with schoolwork?	Yes	No
Does child attend school on a regular basis?	Yes	No
Does child appear motivated for school?	Yes	No
Has child ever been suspended or expelled?	Yes	No

Academic Performance:

Highest grade on last report card? _________________________

Lowest grade on last report card? _________________________

Favorite subject? _______________________________________

Least favorite subject? ___________________________________

Does child participate in extracurricular activities? Yes No
(explain)

In school, how many friends does child have? a lot a few none

What are child's educational aspirations? quit school / graduate from high school / go to college

Has child had special testing in school? (If yes, what were the results? Explain Below)

Psychological Yes No Vocational Yes No

List child's special interests, hobbies, skills:

Has the child ever had difficulty with the police? Yes No
(if yes, explain)

Has the child ever appeared in juvenile court? Yes No
(if yes, explain)

Has the child ever been on probation? Yes No

From	To	Reason	Probation Officer

Has the child ever been employed? Yes No

Job	Employer	How long?

Additional comments:

Psychologist　　　　　　　　　　　　　　　　　　　　　　　Date

Child Checklist of Concerns and Positive Traits

Name: ______________________________________ Date: ________________________

This checklist contains concerns as well as positive traits that apply mostly to children; therefore, mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

__ Affectionate
__ Argues, "talks back," smart-alecky, defiant
__ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
__ Cheats
__ Cruel to animals
__ Concern for others
__ Conflicts with parents over persistent rule breaking, money, chores, homework, grades
__ Complains
__ Cries easily, feelings are easily hurt
__ Dawdles, procrastinates, wastes time
__ Difficulties with parent's paramour/new marriage/new family
__ Dependent, immature
__ Developmental delays
__ Disrupts family activities
__ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
__ Distractible, inattentive, poor concentration, daydreams, slow to respond
__ Dropping out of school
__ Drug or alcohol use
__ Eating – poor manners, refuses, appetite increase or decrease, odd combinations, overeats
__ Exercise problems
__ Extracurricular activities interfere with academics
__ Failure in school
__ Fearful
__ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
__ Fire setting
__ Friendly, outgoing, social
__ Hypochondria, always complains of feeling sick
__ Immature, "clowns around," has only younger playmates
__ Imaginary playmates, fantasy
__ Independent
__ Interrupts, talks out, yells
__ Lacks organization, unprepared
__ Lacks respect for authority, insults, dares, provokes, manipulates
__ Learning disability
__ Legal difficulties – truancy, loitering, panhandling, drinking, vandalism, stealing, fights
__ Likes to be alone, withdraws, isolates
__ Lying
__ Low frustration tolerance, irritability

__ Mental retardation
__ Moody
__ Mute, refuses to speak
__ Nail biting
__ Nervous
__ Nightmares
__ Need for high degree of supervision at home over play/chores/schedule
__ Obedient
__ Obesity
__ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, noisy
__ Oppositional, resists, refuses, does not comply, negativism
__ Prejudiced, bigoted, insulting, name calling, intolerant
__ Pouts
__ Recent move, new school, loss of friends
__ Relationships with brothers/sisters or friends/peers are poor – competition, fights
__ Responsible
__ Rocking or other repetitive movements
__ Runs away
__ Sad, unhappy
__ Self-harming behaviors – biting or hitting self, head banging, scratching self
__ Speech difficulties
__ Sexual – sexual preoccupation, public masturbation, inappropriate sexual behaviors
__ Shy, timid
__ Stubborn
__ Suicide talk or attempt
__ Swearing, blasphemes, bathroom language, foul language
__ Temper tantrums, rages
__ Thumb sucking, finger sucking, hair chewing
__ Tics – involuntary rapid movements, noises, or word productions
__ Teased, picked on, victimized, bullied
__ Truant, school avoiding
__ Under active, slow moving or slow-responding, lethargic
__ Uncoordinated, accident-prone
__ Wetting or soiling the bed or clothes
__ Work problems, employment, work, alcoholism/overworking, can't keep a job

Any other characteristics:

____

Look back over the list and choose the one that concerns you the most. Which is it?

____

INFORMED CONSENT NOTICE AND FEE AND PAYMENT AGREEMENT

Before we begin our services together, there are some things that you ought to know about the process and about our office. Legally, this is called "Informed Consent". This information contained here will help you understand better what to expect and will explain some limitations about what we will be doing together.

A BRIEF HIPAA OVERVIEW:
The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with our privacy practices for use and disclosure of PHI for treatment, payment or health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information before this session. When you sign this document, it will also represent an Agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it, if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

CONFIDENTIALITY
All of our work together, our conversations, your records and any information that you give us, is protected by legal privilege. This means that the law protects you from having information about you or your child given to anyone. Our office respects your privacy and we intend to honor your privilege. However, there are some exceptions to your privacy that you should understand.

LIMITS ON CONFIDENTIALITY

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

We 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 we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose 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 our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and 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 we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

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

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If we have cause to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.

- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners of Psychologists, Licensed Professional Counselors or Social Workers, they have the authority to subpoena confidential mental health information from us relevant to that complaint.

- **Judicial or 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 we will not release information, without written authorization from you or your personal or 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:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. *Client's Rights and Psychologist's/Clinician's Duties*

Client's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are 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 us. Upon your request, we 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 our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny access to PHI under circumstances, but in some cases you may have this decision reviewed. You may examine and/or receive a copy of your, or in the case of a minor, the minor client's Psychotherapy Notes unless we determine that release would be harmful to your or the minor's physical, mental or emotional health. On your request, we will discuss with you the details of the request and denial 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. We may deny your request. On your request, we 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice.) On your request, we 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 us upon request, even if you have agreed to receive the notice electronically.

Psychologist's or Clinician's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify 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 notify you in writing by mail.
- The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining your privacy will be carried out in accord with the rules and guidelines of HIPAA, the American Psychological Association and other professional organizations.
- Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
- Tests and test results will be kept in a locked, safe place either onsite for one year and/or at a secure offsite location for seven years.
- You should be aware that pursuant to Texas law, psychological test data are not part of a client's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

IV. Complaints
If you are concerned that we have violated your rights, or you disagree with a decision we made about access to your records, you may contact Ms. Nancy Peskin, Privacy Officer for Premier Educational Assessment Services by telephone at (713) 521-7327 or in writing to: 3730 Kirby Drive, Suite 800 Houston, TX 77098. You may also file a complaint to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, 1301 Young Street, Suite 1169 Dallas, TX 75202 or calling (214) 767-4056.

CONSENT TO TREATMENT

I, ______________________________hereby seek and consent to take part in the assessment process and authorize Premier Educational Assessment Services to perform an initial interview and/or testing on __________________________. (client's name)

I understand that services may include face-to-face contact interviewing and/or testing services with a follow-up appointment to receive the results of testing. Services may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, report writing and any other activities to support these services. I agree to help as much as I can by supplying full answers, making an honest effort and working as best as I can to make sure that the findings are accurate.

Additionally, I acknowledge that no guarantees have been made to me regarding the results of testing or procedures by this office. Further, I understand that evaluation services will involve the discussion of personal events in my and/or my families own history which, at times, can be discomforting and is at times very personal. I am aware that I may terminate my services at any time without consequence, but that I will remain responsible for payment for services that I have received.

A psychologist has told me the risks and benefits of receiving these services and the risks and benefits of not receiving these services for myself, and/or for this minor and his or her family.

MISSED APPOINTMENT POLICY
The policy concerning missed appointments has been explained to me. I understand that if I miss a confirmed appointment and do not call to reschedule within 7 days, this office will accept this as your notice that you have terminated this agreement and that you wish to discontinue services with our office. I understand that I may be charged for my missed appointment equal to the fee of the appointment. Additionally, I understand that after two late cancelled or missed appointments I may be referred out to another clinic. I also understand that if I do not return the front office's confirmation call by 3 p.m. the day before my appointment that my appointment may be filled with another waiting family. Additionally, if I no-show a multi-hour testing appointment, I understand that it may not be re-scheduled.

EMAIL CORRESPONDENCE*
The internet is not a totally secure medium for purposes of transmitting counselor-client or other privileged information. Professional advice will not normally be provided via internet. Any inquiry or contact with our website or office via the internet should not be considered a substitute for telephonic, written, or in-person communication. If you send messages by email or other electronic form of transmission, you acknowledge and agree that you may be compromising confidentiality by using such means of communication. If you do correspond with us by email, this indicates your consent to receive emails back from PEAS and hold PEAS harmless.

BILLING AND PAYMENTS

The client assumes 100% responsibility for all services, including any and all balances from pre-approved insurance coverage. I understand that the fee for this (these) service(s) will be $225 for the initial clinical interview. Full testing is charged hourly at $165/hr and includes time administering, scoring, record reviewing and report writing. NOTE: Our private school entrance exam fee (for a WPPSI-IV or WISC-V **only**) is $275. Payment is due at time of services. The rate of insurance reimbursement varies according to individual insurance contracts and I understand that I will be reimbursed based on my own health plan benefits and that I can request a “superbill” (a more detailed invoice) from Premier so that I may submit bills to my insurance company for said benefits. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for payment for these services. I am aware that missed appointments may be subject to a charge equal to the hourly fee of $165.

Your signature below indicates that you have read the information in the Informed Consent to Services and agree to abide by its terms during our professional relationship.

______________________________________ ____________________
Client’s Printed Name Client’s Date of Birth

______________________________________ ____________________
Signature of client (or parent/guardian if client is a minor) Date

____
***Email address** you authorize PEAS to use for correspondence (please print neatly)

I, the psychologist, have discussed the issues above with the client or with the minor client's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent of said client or of the minor client's services.

________________________________ ____________________
Signature of Psychologist Date

Original to client’s chart Copy of HIPAA document to client or guardian