Comprehensive Assessment Center
Psychological Evaluations, Consultations, and Interventions

6625 Miami Lakes Drive, Suite 328 ❖ Miami Lakes, FL 33014 ❖ Tel: 305-779-8565 ❖Fax: 305-779-8564

Child Information

Child's Name: _____ Date: _____

Age: _____ Birth Date: _____Birth Place: _____

Grade: _____ School: _____ School Phone Number: _____

Child's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _(___)_____Emergency Phone: _(___)_____

Custodial Parent: _____

If parents living apart, other parent's home phone number: _(___)_____

Address: _____City: _____ State: _____Zip Code: _____

How did you hear about our practice?_____

May we thank your referral source? Yes____ No _____

If yes, referral address: _____

Family Information

Mom:

Name: _____Age: _____ Birth Date: _____
Occupation:_____ Education: _____
Business Phone Number: _____Pager/Cellular:_____
Age at time of Marriage: _____ Age at time of Divorce (if applicable): _____

Dad:

Name:_____Age: _____ Birth Date: _____
Occupation: _____Education:_____
Business Phone Number: _____ Pager/Cellular: _____
Age at time of Marriage: _____ Age at time of Divorce (if applicable):_____

Brothers and/or sisters:

Name Sex Age School /Occupation
_____
_____
_____

Other People Who Live at Home:

Name Age Relation
_____
_____

How does your child get along with:

Mom? _____ Dad? _____
Sister(s)?_____ Brother(s)? _____

Is child living with both biological parents? Yes _____ No _____ If not, please explain
_____
_____

Who usually disciplines your child? _____
_____
How?_____
Usually for what reason? _____
Do parents differ on discipline? No _____ Yes _____ If so, how? _____
_____

Developmental and Health Information

Pediatrician's name _____Telephone number _____
Height _____ Weight _____Medication taken at this time? No ___ Yes ___ If yes, type
_____
Allergies? _____
What is your child's present health? Excellent _____ Good _____Fair _____
If fair, please explain _____
Approximate weight at birth_____ Months Carried ____ Type of Delivery _____

Mother's age at delivery _____ Health during pregnancy _____
Describe any complications during pregnancy or birth _____
_____
Describe your child's health during and after delivery _____
_____

Please give approximate ages for the following:
Sat up _____ Walked _____ Stopped bottle/ breast feeding _____Toilet trained _____
Stopped using pacifier _____ First word _____Talked in sentences _____

Please mark any areas that constitute a problem for your child:
Eating _____ Sleeping _____ Nightmares _____Thumb sucking _____ Nail biting _____
Bedwetting ____ Wetting in clothes ____ Soiling in bed ____ Soiling in clothing _____
Getting along with friends _____ Self-help skills (dressing, bathing, etc) _____
Unusual fears (describe) _____

School and Educational Information

Who cared for your child during the daytime as an infant? _____
Age began daycare/ nursery or preschool? _____ Age started Kindergarten _____
List schools your child has attended (include nursery/ daycare if applicable):
Name City Grade(s) Reason for Leaving____
_____
_____
Is your child in special classes? No _____ Yes _____ If yes, what kind? _____
Has your child ever repeated a grade? No _____ Yes ____ If yes, which grade? _____
Is there any family member (sibling, parent, grandparent, etc.) who presently or in the past has had learning difficulties or was in special classes? No____ Yes ____ If yes, who and what kind/ type?
_____
Child's feelings about school _____
Your feelings about the school program for your child? _____
_____
_____

Social and Emotional Information

List your child major interests and hobbies _____
_____

Is your child involved in extracurricular activities? No___ Yes ___ If yes, what kind?
_____
Does your child have difficulties making friends or relating to peers? No __Yes__If yes, please explain_____

_____
_____

Do you feel your child is having difficulties in school _____At home? _____

If so, what do you consider the problem to be and when and how did it begin?

_____
_____
_____

Are there any past or present circumstances that you think could be related to your child's present difficulties? _____
_____

Has your child ever experienced any traumatic events (e.g., death of a close relative or friend, accident, head trauma, etc)? No __ Yes __ If yes, please describe_____
_____
_____

Has your child ever had counseling, psychotherapy, or a psychological or psychiatric evaluation? No ___ Yes ___ If yes, date(s) _____
_____

Agency or name of therapist_____
_____

Do any family members have (or have had) a psychological disorder? No ___ Yes_____
If yes, who and what kind?_____
_____

Please put any other comments that will help me understand your child better:

_____
_____
_____

What are the concerns or difficulties that cause to seek professional help at this time?

_____

What, if anything, have you done to resolve this issue?_____
_____ _____

Consent for Treatment

I voluntarily agree to and give consent for treatment at Comprehensive Assessment Center, Inc. for myself and/or my family members.

Signature: _____ Date: _____

Print Name: _____Relationship (if other than patient)_____

Patient Payment Responsibility

I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or family members. I understand that I am responsible to meet my insurance deductible and co-payments, in addition to payment for any services of treatment not covered by my insurance carrier. In the event that my insurance carrier refuses to make payment against my claim for services, I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to Comprehensive Assessment Center, Inc.

When I reserve an appointment exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible to pay an incurred fee of $70.00 for the reserved appointment.

Upon prior discussion and agreement, I understand that charges will be added to my account for other professional services rendered (telephone contacts, court time, etc.).

Signature: _____ Date: _____

Signature on File

Kindly accept a photocopy of this authorization as if it were an original executed authorization. I authorize the release of any payment and medical information necessary to process my, or my family member's claim and related claims.

Signature: _____ Date: _____

Assignment of Benefits Agreement

I hereby authorize payment directly to Comprehensive Assessment Center, Inc. for Psychological Services of the insurance benefits otherwise payable to me for all professional services.

Signature: _____ Date: _____

Missed Appointments/No Show/No Cancellation Policy

Comprehensive Assessment Center, Inc. is a group of dedicated professionals whose mission is to ensure that each of our clients reach their maximum potential. In an effort to attain your therapeutic goals, we ask that you commit to your scheduled appointments. Should you be unable to attend, we ask you notify the office a minimum of 24 hour before your scheduled visit. This policy is necessary to ensure the smooth and adequate functioning of the office.

Should you fail to notify the office within the **24 hours** of your scheduled appointment, you will be responsible for a $50.00 cancellation fee. This amount is not your full fee, but a minimum charge the office has set for missed, no show or no cancellation appointments. We cannot bill your insurance company or missed appointments so you will be responsible for this payment.

I _____ hereby authorize "Comprehensive Assessment Center, Inc" to charge my credit card account in the amount of $50.00 in the event that I do not call to cancel my appointment within 24 hours in advance of my scheduled appointment or without prior notice.

CARD INFORMATION:

Credit Card Number

_____

Expiration Date: ____/____ VID Code: _____

BILLING ADDRESS

Street: _____

City: _____ State: _____

Zip Code: _____ -_____

Country: (if not US) _____

Telephone: _____-_____-_____

As the credit card holder, I hereby authorize this transaction.

Cardholder's Signature _____ Date: _____/ _____/ _____

HIPAA Notice of Privacy Practices

When I examine, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. A complete detailed report can be found on our website and in our offices. By signing this form you are agreeing to let me use your information here and send it to others. **If you do not sign this consent form agreeing to what is in the Notice of Privacy Practices, I cannot treat you.** In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, you can get a copy by calling me at 305-779-8565. After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Confidentiality
The information you share with me, both written (i.e., intake paperwork) and verbally, is part of your Protected Health Information (PHI) and is considered confidential. I will not release your information to anyone, including your family and healthcare providers, without a written consent. If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/child, therapist/child, and the therapist/parent for their particular situation. It is important that you understand the legal limitations to confidentiality which include, but are not limited to:

1. When individuals express intent to harm themselves or others, the therapist may be required to break confidentiality to assure the health and safety of all concerned.
2. Therapist are mandated by law to report to the appropriate state authorities information documenting child and/or elder abuse or neglect.
3. When a judge orders that information be disclosed, I annot guarantee that an appeal will be upheld, but I will do everything in my ower not to disclose your confidential information.
4. The PATRIOT Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon requrest and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.
5. I will release protected health information when you authorize me to do so by signing a Consent for Release of Information. Your confidential files will be routinely be accessed only by me (your therapist) and/or Dr. Tania Diaz. Administrative assistants will only access the portions of your file pertinent to administration, such as your contact information and payment history, not your medical records or notes.

Waive right to subpoena:
In order to protect you and the information you and/or your child(ren) provide to me during our sessions, I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged. If you anticipate the need for a therapist's involvement in court activity, I will be happy to refer you to someone who is more suited to meet your needs.

The undersigned client has read, discussed and understands this agreement and stated policies.

_____ _____

Print Name Signature

Notice of Agreement Not to Participate in Legal Forums

This form is an agreement between you, _____, and the acting clinician at Comprehensive Assessment Center, Inc. When I use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When I examine, diagnose, treat, or refer you, I will be providing services that relate to your psychological assessment and or treatment. I will not be serving as your representative in any legal matters that may arise nor will I appear in court to represent you or your guardian. The findings of the assessment and or treatment may be provided, independent of my appearance in court.

By signing this form you are agreeing to the above mentioned Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in the Notice of Agreement Not to Participate in Legal Forums, I cannot treat you.

_____ ____/____/_____

Signature of client or his/her personal representative **Date**

_____ _____

Printed name of client or personal representative **Relationship to client**

_____

Signature of authorized representative of this practice **Date**