Seattle Child Psychology

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Seattle Child Psychology
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AGREEMENT AND NOTICE
(updated 4/15/2022)

Welcome to Seattle Child Psychology, the private practice of Dr. Gregory E. Moy, PhD. I look forward to working with you and/or your child. Please read through the following information, and be sure to discuss any questions with me.

This document (the Agreement) contains important information about my professional services and business policies. In order to protect you and/or your child, the State of Washington requires that all clients of psychologists receive certain basic information. This document covers services and policies around assessment and evaluation services. There is a separate document and consent form for therapy services. It is important that you understand what psychological, psychoeducational, and neuropsychological evaluations entail. Teens between the ages of 13 and 17 years of age must consent to undergo evaluation by reading and signing this form along with his/her/their parents. Your signature at the bottom indicates that you understand the information, and that you freely consent to participate in and agree to the conditions of the evaluation.

This document also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), 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 covered entities to provide patients with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of initial contact. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. 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 me unless I have taken action in reliance on it; if there are obligations imposed on me 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.

The Examining Board of Psychology regulates the practice of psychology in the State of Washington. If you have a problem you cannot resolve with Dr. Moy or wish to file a complaint, you may do so by contacting the Department of Health, Examining Board of Psychology, P.O. Box 47868, Olympia, WA 98504-7868.

Your Rights and Responsibilities

You have the right to choose the psychologist that you want you or your child to see. You have the right to discontinue the evaluation process at any time, to request a change in the evaluation process, or to request a referral to another provider. Should you discontinue the evaluation process, you will be expected to pay for those services already provided. Your request for discontinuance or referral to another provider will not affect your future relationship with Dr. Moy. If you are age 13 or older, you have the right to refuse evaluation or treatment. Choosing a psychologist and type of service are important decisions. You are encouraged to ask questions about the psychologist or the types of evaluation or treatment suggested so that you can make the choices that best suit your needs.

Confidentiality. In order to protect your privacy, state law mandates that confidential information provided to a psychologist is protected from disclosure to others. In other words, information about you and your family will not be given to other people or agencies without your written consent with only a few exceptions. These are:

1. If a judge authorizes a court order requiring the disclosure of your records, the psychologist must, by law, comply by releasing the information to the court.
2. If the psychologist discovers abuse or neglect of a child or dependent adult, the psychologist is required by law to report detailed information to the Department of Social and Human Services.
3. If the psychologist determines that you are a danger to yourself or to others, the psychologist must try to prevent harm, even it that involves breaking your confidentiality.
4. If the psychologist determines that you are suffering from HIV-related illness and do not have a physician providing for your care, the psychologist must report the identities of your IV drug using or sexual partner(s) to the local health care officer (WAC 248-100-072).

Please refer to the attached Notice for further information regarding confidentiality and privacy related to personal health information.

Professional Records. By Washington state law, Dr. Moy keeps a record of the services provided, including the dates and times of the services provided. You may ask to see and copy that record. You may ask to correct that record if it is found to be inaccurate. Your records will not be disclosed to others unless you direct the office to do so, or unless the law authorizes or compels the office to do so. Please refer to the attached Notice for further information regarding professional records.

Release of Records. Written records are released *only* after a consent form is signed by the client or their Parent/Legal Guardian. A psychological test report can be provided to the appropriate agency upon request. We will only release these records after you have signed a consent form. Should the agency request specific information (such as a particular report format or an additional form), this will be provided at an additional cost according to the assessment fee scale. At least two weeks' notice is required to complete any additional forms.

Required Reporting. As a result of state regulations adopted by the Washington State Department of Health, I am required to report myself or another health care provider in the event of a final determination of an act of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have knowledge of unprofessional conduct by another licensed provider. I will also have to report a patient who is a health care provider who may pose a clear and present danger to his/her patients or clients. If you have any questions or concerns about this requirement, please discuss them with me. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

About the Evaluation Process

The first stage of the evaluation process involves collecting background information about the current problem and relevant histories through a clinical interview. A signed copy of this Agreement and receipt of payment of the deposit is required prior to conducting the clinical interview. Contemporary practice is to conduct the clinical interview either in-person or via a secure and private videoconferencing service. You should have received a **Developmental and Health History Form** to fill out. Please upload this form to the shared folder created for you, or you may bring the completed form with you if you choose an in-person clinical interview appointment. The following information should also be uploaded or brought to the clinical interview appointment, if applicable:

1. All prior psychological, neuropsychological, or psychoeducational evaluation reports.
2. All available report cards and a copy of the cumulative school record, dating from kindergarten. These records are usually available through the office of your child's current school.
3. Individual Education Plan records (if applicable)
4. All relevant medical records.

The second stage of the evaluation process involves formal testing. Most evaluations require around 12 hours of formal testing. Depending on the referral reason and type of evaluation determined to be most appropriate, formal testing can range between two to eighteen hours. Formal testing involves sitting at a table and performing school work, problem-solving tasks, answering questions, looking at pictures, assembling puzzles, and other similar types of activities geared to the age of the child. These procedures generally concern cognitive abilities, such as attention and memory and information processing; social and emotional functioning; adaptive skills of daily living; and acquired academic skills and functioning. Comprehensive psychological evaluations also include personality assessments, and neuropsychological evaluations focus on brain-behavior connections. Targeted assessments to measure IQ, giftedness, or the presence of ADHD symptoms are typically on the shorter end of the range.

Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. Some children are nervous about formal testing, but most find it tolerable and even enjoyable once they learn what it involves. Dr. Moy will carry out the formal testing and may involve a psychometrist or psychological assistant if the support is warranted. Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you in for this assessment.

Preparing for the formal testing appointment helps to ensure the child's best and truest performance. Here are some ways to prepare:

- *Glasses or hearing aids should be brought to the appointment fully operational.*
- *Please inform Dr. Moy beforehand if your child will be taking prescription medication when the testing is being performed.*
- *A full night's sleep and a good breakfast are simple, but important steps.*
- *Please bring a snack if the child is accustomed to one during the testing time.*
- *Let the child know about the appointment in terms they can understand.*

- *Older children and teens who are aware of the current problem can understand that they will be seeing someone to help them with the problem.*
- *Younger children can be told that they will be working with a special teacher.*
- *Preschool children can be told that they will be playing games to show what they know.*

The third stage of the evaluation process involves the interpretation and discussion of the results at the feedback session. If at all possible, it is important that the primary caregivers attend the feedback session in order to best convey the results and discuss recommendations. One or two interested others, such as teachers and therapists, are welcome to attend if the parents (and older teen) agree. Preschool children usually should not attend the feedback session, as they will not benefit from the discussion and may find it confusing. Arrangements will be made to provide feedback to older children and teens as best fits their circumstances. A written report will be prepared which describes the evaluation results, any diagnosis(es), and recommendations.

In many cases, the recommended interventions can be carried out by those already working with the child (e.g., parents and teachers). Referral for additional services will be offered as needed. Depending upon the results of the evaluation, Dr. Moy may suggest additional services, including consultation with school personnel or other providers. Dr. Moy is available for additional feedback sessions or consultation with the parents on an ongoing basis if needed after the parent feedback session is held and the evaluation process is complete.

Fees and Billing

Assessment and Evaluation Services: My hourly fee is $238.00 for the initial clinical interview and all assessment and evaluation processes, including the formal testing, test scoring/interpretation, report writing, and feedback session. I charge this amount on a pro-rated basis for other professional services, such as school conferences that you have authorized, or telephone calls lasting over 15 minutes.

The time estimated for this assessment/evaluation is as follows:

_____ hour(s) intake session
_____ hour(s) formal testing
_____ hour(s) test scoring, interpretation, and report writing
_____ hour(s) feedback session

_____ total estimated hours x $238.00 =_____
estimated cost

A deposit of $1,000.00 is due on the date of the initial clinical interview appointment, and the balance is due at the end of the date of the final testing session. If Dr. Moy deems that additional or alternative testing be necessary after the first cost estimate is provided, and after perfoming some of the contracted testing services, Dr. Moy will describe the reasons for additional testing and will advise on any additional costs. You have the right to discontinue the evaluation process at any time, and should understand that Dr. Moy may be unable to provide feedback of the test results if testing is terminated. If testing is terminated, you will still be responsible for payment of any testing, scoring, and evaluation time provided up until that point.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, my hourly fees are higher, and a daily minimum fee of $2,000.00 will apply. Depending on the nature of the concern, I may refer you to speak with a forensic psychologist who specializes in legal proceedings.

Personal checks can be made payable to Stratagem Education, LLC. Stratagem Education is a business entity owned and operated solely by Dr. Gregory E. Moy, and encompasses all professional services provided by Dr. Moy and Seattle Child Psychology. Any ongoing monthly balances are charged a $20 per month rebilling fee. Returned checks will be charged a $100.00 handling fee. I accept credit card payments through a HIPAA-compliant patient portal. I am able to offer a 2% discount for cash payments in full.

I am not contracted with any insurance companies, but I will generate a statement that you can submit to them for reimbursement. If you would like to submit claims to your insurance company, you will need to find out such information as whether or not you need a referral, number of sessions covered, types of problems covered, types of sessions or evaluations covered, and at what rate your insurance company will reimburse you for my services. I will do everything I can to assist in this process, but it is your responsibility to keep track of this information so that you receive appropriate reimbursement.

No Surprises Act: Effective January 1, 2022, the No Surprises Act, which Congress passed as part of the Consolidated Appropriations Act of 2021, is designed to protect clients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities, holding them liable only for in-network cost-sharing amounts. The No Surprises Act also enables uninsured clients to receive a good faith estimate of the cost of care. Surprise billing occurs when clients receive care from out-of-network providers without their knowledge. Surprise billing therefore results in higher costs for medical services that would have been cheaper if rendered by providers inside their health plan's network. This can happen when someone involved in the client's care is not in-network. The rule is intended to cut down on surprise costs, and also to ban out-of-network charges without notice in advance (providing clients plain-language consumer notice).

Consumer Notice
• Dr. Gregory Moy and all providers who provide services as Seattle Child Psychology are out-of-network providers.
• An estimate of the cost of our services (which we will calculate in good faith) is provided in this Agreement;
• You are never required to give up your protections from surprise billing.
• You are not required to get out-of-network care.
• You can choose a provider or facility in your plan's network.

If you think you have been wrongly billed or have more questions, please contact us complaints may be directed to the Centers for Medicare & Medicaid Services (CMS) at
https://www.cms.gov/nosurprises/consumers

Cancellation Policy: Your appointment time is set aside exclusively for you, and I cannot fill that time slot without sufficient notice. If you must cancel an appointment, please make sure that you get in touch with me at least 72 hours in advance, or you will be billed the full session fee (unless we both agree that the appointment was unable to be kept due to circumstances beyond your control).

Assurances and Agreement

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM BELOW.

I agree for my child

_____,

born on

_____

_____,

to undergo an evaluation by Dr. Gregory E. Moy for the purpose of:

_____

_____

_____

_____

_____.

I understand that the evaluation may include an interview with me, my child, and with others who may know my child well; reviewing my child's medical, school, and other records; and by conducting a variety of psychological, academic, and neuropsychological tests. I understand that Dr. Moy will gather information about school, behavioral, social, emotional, and adaptive functioning through informant rating scales sent to the appropriate individuals. I understand that Dr. Moy will explain his findings and recommendations to me during a feedback meeting at the end of the evaluation process. I understand that Dr. Moy will write a report summarizing the results of the evaluation, and that this report will be sent to me or those individuals I designate, and will become a part of my child's records at this office.

I understand that the estimated total cost of the evaluation is $_____.00. I understand that I will pay a deposit of $1,000.00 of the evaluation fee via cash, check, or credit card at the time of the initial intake interview, and the remaining balance will be due at the time of the final testing session. If I request one, Dr. Moy will provide me with a statement of services and charges that I can submit

to my insurance company after the feedback session, and that I am solely responsible for paying the fees for services rendered. I have read and understood the information provided to me about my rights and responsibilities. I have had a chance to have my questions answered.

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Child

_____
_____
Child's Signature (required if age 13-17) Date

_____
_____
Witness Signature Date

HIPAA NOTICE

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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.

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

II. Uses and Disclosures Requiring Authorization
I 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 I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

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

Child and Vulnerable Adult Abuse: If I become aware that you may be abusing, exploiting, or neglecting a child under age 18, a developmentally disabled person, or an elderly person, a report must be made to the appropriate authorities. (RCW 26.44)

Danger to Others: If you become a danger to others, I must protect the other person(s) and you by warning the other person(s) at risk and report the danger to the appropriate authorities. (RCW 71.05)

Health Oversight: If the Washington Examining Board of Psychology subpoenas me as part of its investigations, hearings or proceedings

relating to the discipline, issuance or denial of licensure of state licensed psychologists, I must comply with its orders. This could include disclosing your relevant mental health information.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, 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.

HIV-related issues: If you tell me that you are suffering from HIV-related illness and do not have a physician providing for your care, I must report the identities of your IV drug using or sexual partner(s) to the local health care officer. (WAC 248-100-072)

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 protected health information about you. However, I am 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 me. Upon your request, I 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 and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I 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. I may deny your request. On your request, I 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, I 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 me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify you by mail with a revised version of this document.

V. Complaints
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact me at my business address. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Office of Civil Rights, 200 Independence Ave. SW, Washington, D.C. 20201 (877-696-6775 toll free).

VI. Effective Date, Restrictions and Changes to Privacy Policy
This notice will go into effect on 5-01-2022. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to conduct in-person testing/assessment of you or your child during this public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an agreement between us regarding coronavirus mitigation procedures and a release of liability should you contract coronavirus within 14 days of our in-person meeting.

Decision to Meet Face to Face

We've agreed to meet in person for one to two testing/assessment appointments for you or your child. If there is a resurgence of the pandemic or if other health concerns arise, however, we may have to further postpone these appointments. If you have concerns about further postponement, we'll talk about it first and try to address the issue. You understand that, if I believe it is necessary, I may determine that we postpone for everyone's well-being. If you decide at any time that you would feel safer postponing the appointments, I will respect that decision.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk) for yourself and/or your child. This risk increases if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain in-person services for your child, you agree to take certain precautions which will help keep everyone (you, me, our families, my office colleagues, and our other clients) safer from exposure, sickness and possible death. Your failure or refusal to adhere to these safeguards may result in termination of the in-person appointment and discussion of other options. **Please read the following and initial each to indicate that you understand and agree to these actions:**

- You will only keep your in-person appointment if you and your child are symptom free. ___
- Only one person will accompany a child or teen to the appointment. Unless arrangements have been made beforehand with your provider, that person will wait in the car during the appointment, with the exception of using the restroom. ___
- You will take your temperature and your child's before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have or have recently had (past two weeks) other symptoms of the coronavirus, you agree to cancel the appointment. If you cancel for this reason, the normal cancellation fee will be waived. ___
    - Symptoms include – fever, cough, and shortness of breath
- You and/or your child will wait in your car and call or text me (206-817-1925) to let me know when you have arrived for the appointment. ___
- You will wear masks and use hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing room. For example, you won't move chairs or sit where we have signs asking you not to sit.___

- You will wear a mask in all areas of the office (I will too). There may be situations in which it is important for test accuracy that you (or your child) are asked to briefly remove their mask. You (or your child) will be provided with a face shield to wear for protection during this time, which will not exceed ten minutes. ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me. ___
- You will try not to touch your face or eyes with your hands. If you do, you will promptly wash or sanitize your hands. ___
- If you are bringing your child, you and I will work together to make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps before and between appointments to minimize your exposure. ___
- If you have a job that exposes you to those who are infected, you will let me know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know. ___
- If you or another resident of your home tests positive for the coronavirus infection, you will immediately let me know and we will discuss options for proceeding versus postponing further in-person appointments. ___

I may need to change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the virus within the office and we have posted our efforts in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, my in-office colleagues, our clients, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you or your child have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We will follow up by phone to discuss how best to proceed.

If I or one of my clients or office colleagues test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details of the reason(s) for your visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent that we agreed to at the start of our work together.

We all recognize that in spite of following precautions, it may be possible that you or I or one of my office colleagues may become exposed to and contract the virus in connection with our appointment. In such event, we mutually agree to release and hold each other harmless from liability related to contracting the virus so long as each party made a reasonable effort to follow the safety precautions described herein.

Your signature below shows that you agree to these terms and conditions.

_____	_____
Parent/Client	Date
_____	_____
Psychologist	Date

Safety Precautions at Cascade Neuropsychological Services During the COVID19 Public Health Crisis

Our office is taking the following precautions to protect our clients and help slow the spread of the coronavirus.

- Office seating in the waiting room and in testing rooms has been arranged for appropriate physical distancing.
- Providers and clients/parents wear masks while inside the building.
- Providers and clients/parents maintain safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- Hand sanitizers that contain at least 60% alcohol are available in the building lobby and testing room.
- We schedule appointments at intervals to minimize the number of people in the office and waiting room.
- We ask all clients/parents to wait in their cars or outside until no earlier than 5 minutes before their appointment times.
- Areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.

CNS Office Policies During COVID19

In an effort to stay safe as we resume in-person testing appointments, the practitioners at Cascade Neuropsychological Services (CNS) agree to the following policies with regard to COVID-19:

1) Contact all clients two weeks prior to first testing appointment to review Consent for InPerson Services/Policies.

2) Contact all clients 1-2 days prior to their appointment to confirm their compliance with previously emailed/discussed testing policies over the past 14 days (i.e., no covid-19 symptoms including fever, cough, or shortness of breath; no exposure to infected individuals or anyone suspected or diagnosed with coronavirusl 9; no recent travel within and outside the US; no attendance or participation at activities where >10 people were present).

3) Only one client and one other person (in addition to the clinician) will be allowed at CNS at one time. Clinicians will stagger schedules to ensure no overlap.

4) The clinician will meet their client in the parking lot (with their mask on) to ensure they disinfect their hands and don a mask before entering the building. Please remember to maintain physical distance of six feet at all times.

5) The client's escort will remain in their car (first choice) or the waiting room (only if necessary for the comfort of a young child or other special situation) for the entirety of the testing session. Access to the bathroom, but not the kitchen or extra office, is allowed.

6) Wash your hands, and encourage your clients to wash their hands, approximately every hour and after coughing or sneezing. Try to avoid touching your eyes, mouth, or nose.

7) If you or your clients need to cough or sneeze, please do the following: cover your mouth and nose with a tissue and put your used tissue in a wastebasket. If you don't have a tissue, cough or sneeze into your upper sleeve, not your hands. Wash your hands after coughing or sneezing.

8) Please wipe down the following surfaces <u>before and after</u> working at CNS.
    a. Your hands
    b. All door handles (including closet door handles), door strike-jams, and light switches
    c. Toilet handle, bathroom sink faucets
    d. Kitchen surfaces including countertop; sink, fridge, and microwave handles
    e. Testing desktop
    f. Keyboard, mouse (if laptop was used)
    g. All test materials including manipulatives (e.g., blocks) and stimulus booklets.
    h. Writing implements used by clinician
    i. Desk-top sneeze guard — both sides
9) Please use a disinfectant wipe when leaving CNS for setting the alarm and closing the door behind you.

10) Clinicians and their clients are required to wear masks in public spaces, but are free to remove/replace them at the clinician's discretion for no more than ten minutes during sessions. During such time, a face shield will be used instead of a mask.

SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Child's full name_____ DOB_____

Age_____ Grade_____

School District/School Name/ Teacher_____

_____

Current Address: _____

How long at this address? _____

Person providing information: _____

Relationship to child_____

Primary email address

_____

Who does child live with: □ both parents □ mother □ father □ other (specify) _____

_____

Biological father_____ Occupation_____ Highest education: _____

Father's home phone_____ Work #_____ Cell #_____

_____

Biological mother_____ Occupation_____ Highest education: _____

Mother's home phone _____ Work #_____ Cell #_____

_____

Guardian's name_____ Occupation _____Highest education:

_____

Guardian's home phone _____ Work #_____Cell # _____

_____

Please list all people in child's immediate family/living in household:_____

_____

_____

Please list all other non-family members who live in household:_____

_____

_____

Language(s) spoken at home _____

_____

Primary Language at home_____

_____

Please list all locations (city, state) that your child has lived (use back of page, if needed):

1. Birthplace _____ Moved at age grade_____

2. _____ Moved at age grade_____

3. _____ Moved at age grade_____

4. _____ Moved at age grade_____

Are biological parents of child currently: □ married □ separated □divorced □ never married

• If separated or divorced, who has legal custody? □ mother □ father □ other (specify): _____

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce?_____

• If there is a stepparent, describe the relationship and involvement with your child.

_____

_____

_____

Are there other adults who have a significant part in raising your child? □Yes □No
If so, please indicate name & relationship (grandparent, boyfriend/girlfriend, etc.)_____

Have there been any significant changes in the home over the last 2 years? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc.)_____

What do you feel are your child's…
Strengths_____
Weaknesses _____
Interests_____

Briefly describe your concerns for your child._____

II. HEALTH AND DEVELOPMENT
A. Pregnancy and Birth
Is your child: □ biological child □ adopted child □ foster child □ other: _____

Mother's age at birth? _____ Did mother receive routine medical prenatal care? □Yes □ No
Please specify any medications used during pregnancy and the reason used: _____

Pregnancy lasted _____weeks / months Child's birth weight: _____pounds _____ounces
APGAR score …at 1 minute_____ …at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No
If No, explain why: _____

Please check the conditions below that describe the health of the child and mother during…

Mothers pregnancy	Child's Delivery	Child's Condition at Birth
☐ No complications	☐ Normal	☐ Normal
☐ Blackouts	☐ Induced labor	☐ Lack of oxygen
☐ Falls	☐ C-section	☐ Breathing problem
☐ Physical injury	☐ Breech birth	☐ Birth injury/defect
☐ Excessive bleeding	☐ Unusually long labor (>12 hours)	☐ Jaundice
☐ Hypertension	☐ Premature # of weeks	☐ Newborn ICU # of days _____
☐ Diabetes	☐ Overdue # of weeks	☐ Other problem (specify)
☐ Emotional stress	☐ Other problem (specify)	
☐ Toxemia		
☐ Alcohol and/or drug use		
☐ Use of tobacco		

B. Health
Describe the state of your child's current health: □ Excellent □ Good □ Fair □ Poor
Is your child currently taking any medication? □Yes □ No
If yes, please list medications and uses: _____

Has your child ever been identified as having a disability? □Yes □ No
If so, by whom, what age, & what disability? _____

Has your child ever received psychological counseling? □Yes □ No
If so, by whom (professional/agency) and when: _____

Has your child ever participated in therapy services from a private entity? (i.e., speech, occupational, physical, vision therapy, etc)? □Yes □ No
If so, by whom (professional/agency) and when: _____

Has your child ever been evaluated by or participated in educational services from a private entity (i.e., private tutor, Sylvan Learning Center)? □Yes □ No
If so, please attach relevant reports.
If so, by whom (professional/agency) and when: _____

_____

_____

Has your child ever participated in an early intervention program? □Yes □ No
If so, by whom (professional/agency) and when: _____

_____

_____

Has your child had any of the following? Please check all that apply.	Please describe and give details, dates, and/or age of onset
□ Serious Illnesses	
□ Head Injuries	
□ Seizures or convulsions	
□ Surgery/Hospitalization	
□ History of Ear Infections	
□ Allergies and/or Asthma	
□ Vision Problems	Date of last exam:
□ Hearing Problems	Date of last exam:
□ Frequent Nightmares and/or Bedwetting	
□ Other health problem	

Family History

Is there a family history for the following problems?	Biological family member with the history…
□ Learning Difficulties (reading, math, writing, spelling)	
□ Speech or Language problem (articulation, stuttering, etc.)	
□ Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
□ Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
□ Intellectual Disability	
□ School Failure (failing grades, dropout, etc)	
□ Drug or Alcohol Addiction	

C. Development

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Crawled								
Walked alone								
Walked up stairs								
Spoke first words								
Spoke in phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								

III. BEHAVIOR

A. Behavior in Infancy

During your child's first few years of life, were any of the following present to significant degree?

- ☐ Did not enjoy cuddling
- ☐ Was not easily calmed by being held or being stroked
- ☐ Difficult to comfort
- ☐ Colicky
- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Frequent head banging
- ☐ Difficult nursing
- ☐ Poor eye contact
- ☐ Did not turn towards caregivers
- ☐ Did not respond to name
- ☐ Did not respond to speech of caregivers
- ☐ Fascination with certain objects
- ☐ Constantly into everything

* Please describe all checked items_____

_____

_____

_____

B. Child's Early Temperament: (Toddler through five years of age)

Activity Level – How active has your child been from an early age?_____

Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks? _____

Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way? _____

Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)? _____

Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.? _____

Mood – What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament? _____

 Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.? _____

Prior to age six, did your child have more difficulty than other children his/her age…

- Sitting still at meal time
- Staying focused on TV, movies, or video games
- Paying attention when read to
- Waiting for a turn to play
- Throwing a ball
- Knowing left and right
- Catching a ball
- Acting without thinking
- Buttoning and zipping
- Dressing self
- Holding a crayon or pencil
- Tying shoe laces
- Accidentally dropping things
- Accidentally knocking things over

C. Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- Often depressed/irritable mood

- ☐ Talks excessively, interrupts often, doesn't listen
- ☐ Low energy/fatigue
- ☐ Poor concentration
- ☐ Difficulty initiating tasks
- ☐ Difficulty completing tasks
- ☐ Difficulty following instructions
- ☐ Engages in impulsive behaviors (acts before thinking)
- ☐ Immature compared to peers
- ☐ Engages in physically dangerous activities
- ☐ Often argumentative with adults
- ☐ Often actively defiant to adult requests and rules
- ☐ Blames others for own mistakes
- ☐ Often angry or resentful
- ☐ Somatic complaints of not feeling well
- ☐ Excessive separation difficulties
- ☐ Easily frustrated
- ☐ Lies
- ☐ Steals
- ☐ Aggressive towards others
  - o Adults
  - o Peers
- ☐ Often loses things, very disorganized compared to others his/her age.
- ☐ Shy
- ☐ Feeling of worthlessness or low self-esteem
- ☐ Withdrawn
- ☐ Overly anxious or fearful
- ☐ Sleeping too little/insomnia
- ☐ Sleeping too much
- ☐ Difficulty making decisions
- ☐ Cries easily
- ☐ Temper tantrums
- ☐ Rapid mood changes/mood swings
- ☐ Suicidal thoughts
- ☐ Excessive need for reassurance
- ☐ Poor appetite
- ☐ Overeats
- ☐ Explosive temper with minimal provocation
- ☐ Odd fascinations
- ☐ Unrealistic worry about futures events
- ☐ Substance abuse
  - o Drug
  - o Alcohol
  - o other

Please explain all checked items: _____

_____

_____

_____

D. Home Behavior:

How often is each of the following settings a problem for your child?

While getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently

When eating at the dinner table	□ Rarely	□ Sometimes	□ Frequently
When playing by him/herself	□ Rarely	□ Sometimes	□ Frequently
When playing with siblings/other children	□ Rarely	□ Sometimes	□ Frequently
When with a babysitter or daycare	□ Rarely	□ Sometimes	□ Frequently
In public places (church, store)	□ Rarely	□ Sometimes	□ Frequently
When in the car	□ Rarely	□ Sometimes	□ Frequently
When told to do something he/she doesn't want to do	□ Rarely	□ Sometimes	□ Frequently
During sit-down homework time	□ Rarely	□ Sometimes	□ Frequently
When watching TV or playing video games	□ Rarely	□ Sometimes	□ Frequently

How would you describe your child's personality at home?_____
_____
_____

How does your child get along with brothers/sisters? _____
_____

Which adult would your child prefer to talk with about a problem? _____
_____

Who is the family member with whom your child feels closest? _____
_____

Who is primarily responsible for discipline at home? _____
_____

What is the most effective way to deal with your child's behavior problems at home? talking, positive reinforcement, time-out, grounding, spanking, revoking privileges,etc.)_____
_____
_____
_____

How does your child respond to discipline?_____
_____

List any responsibilities your child has at home: _____
_____

Does your child do these regularly? __Yes __ No
Does your child need frequent reminders? __Yes __No
Indicate child's… Bed time? ____:____PM Wake time? ____:____ AM Does child sleep well? __Yes __ No
How much time does your child typically spend on electronic media?
_____
Watching TV: _____hrs/day; Playing video/computer games: _____hrs/day;
Other:_____ hrs/day

Have any family members expressed concerns about your child's behavior? __Yes __ No
Explain:_____

_____

_____

_____

_____

E. Social Behavior:
How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?) _____

_____

_____

_____

How does your child interact with children in the neighborhood?_____

_____

_____

IV. Educational History

How does your child feel about school? _____

_____

Has your child ever repeated a grade? □ Yes □ No If so, which grade?

_____

Describe your child's strengths at school.

_____

_____

_____

What are your child's weaknesses at school?

_____

_____

_____

How motivated do you feel your child is to learn? _____

_____

About how much time does your child spend on homework each night? _____

_____

How much of a struggle is homework? □ Not a struggle □ Sometimes a struggle □ Often struggles

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? □ Yes □ No

If yes, what services, when did they begin?_____

_____

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool/Daycare _____

_____

_____

Elementary School _____

_____

_____

Middle School _____

_____

_____

High School _____

_____

_____

Other information you believe may be relevant in the evaluation of your child:

_____

_____

_____

_____

_____

_____

_____

_____

Please return this form to the psychologist after completing. Thank you.