

The Sullivan Center for Children

3443 W. Shaw, Fresno, CA 93711 (559) 271-1186

Office Policies / Consent to Treatment / Financial Agreement Clinic Copy

Welcome to the Sullivan Center for Children. This document outlines our office policies and procedures; authorizes us to begin evaluation and treatment; and establishes the financial agreement between you and The Sullivan Center for Children. This document also provides information regarding how your medical and/or mental health information may be used and how you may access those records. Please read this information carefully. If you have any questions, please discuss them with your therapist.

MEDICAL/MENTAL HEALTH RECORD KEEPING: The privacy of your medical and mental health information is extremely important to us and we are committed to protecting your privacy. We create a record of care which includes dates of service and type of treatment provided. The Sullivan Center for Children maintains paper records and also makes use of electronic record keeping and electronic billing. All records, whether paper or digital, are maintained by the Sullivan Center for Children in full compliance with state, federal, and professional regulations.

LEGAL CONSENT TO TREATMENT: Any individual over the age of eighteen, who is not legally prohibited from doing so, consents to their own treatment. For minors under the age of eighteen, it is Sullivan Center policy that legal guardians provide written consent. In situations of joint legal custody, it is Sullivan Center policy that both legal guardians must consent to treatment. A parent having sole legal custody may consent to treatment. It is our policy to request proof of legal custody or guardianship. Exceptions to the above policy are rare and can be made only with the approval of the Clinical Director.

CONFIDENTIALITY: To maximize the benefit of evaluation and treatment trust must be developed between patient and therapist; you must be open and honest. Information disclosed within therapy is confidential and may not be revealed to anyone without your written consent except where disclosure is required by law. Your therapist will discuss issues of confidentiality and will ask for your consent to communicate with anyone considered essential for appropriate evaluation and treatment. Children and adolescents also have the right to confidentiality with their therapist. Sharing helpful information between parents and children is necessary in the treatment of adolescents and children. Your therapist will discuss what is needed and appropriate with you and your child and request your consent.

LIMITS OF CONFIDENTIALITY: Disclosure may be required in the following circumstances: 1.) Where there is a reasonable suspicion of a child neglect/abuse, abuse of disabled persons, or elder adult physical abuse/severe neglect. All Sullivan Center Clinicians are mandated reporters in accordance with California State Law. 2.) Where there is a reasonable suspicion that the patient presents a danger of violence to others or where the patient is likely to self-inflict harm, Sullivan Center Clinicians have a duty to warn persons in a life-threatening situation and may disclose confidential information to prevent serious imminent harm to a client's self or the public. 3.) The physicians of the Sullivan Center are mandated reporters to the Food and Drug Administration regarding the adverse effects of prescribed medications. 4.) Disclosure may also be required pursuant to some legal proceedings, such as custody disputes. The Sullivan Center will release confidential information in the course of judicial/administrative proceedings as required by law, law enforcement purposes as required by law, a valid court order, or as

provided by your specific written consent. 5.) In the event of an emergency, confidential information may be disclosed to notify a person responsible for your care regarding your location, general condition, or medical information. 6.) If you are seeking Worker's Compensation, or you are receiving services through Victims of Crime, Tulare County Mental Health, Golden State Agency, or any other third-party which is covering payment, it is necessary for the Sullivan Center to disclose confidential information to those agencies either as required by law or contract.

Since agencies vary, if your services are financially supported by a third-party agency, or mandated by court order, you and your clinician will discuss specific limits of confidentiality.

I understand and Agree. Please Initial Here _____

USE CONFIDENTIAL INFORMATION: The Sullivan Center for Children will use your mental health records for these purposes. 1.) Treatment: Clinicians will obtain treatment information and records. This information is used by clinicians involved in treatment, document progress, and record other information relevant to services rendered. 2.) Financial Arrangements/Payment: If you so desire, we will submit requests for payment to your insurance company in either electronic or hardcopy format, or both. We will provide Insurance companies with the information required in order for you to receive your mental/medical health insurance benefits. Since the policies of insurance companies will vary, please contact your clinician and insurance provider to obtain further specifics. The Sullivan Center will attempt to resolve billing concerns including financial difficulties, yet be aware that in the event that your account is in default, limited and specific information may be released to a Credit Collection Agency in order to settle your account. 3.) We may also obtain services from our business associates such as accounting/legal service providers or our insurers as necessary. Quality assurance consultants, transcriptionists, billing services, practice reviewers, auditors, certification/accreditation agencies, and other professionals may use confidential information. These business associates are required to appropriately safeguard your information and any statistical analyses or data exchanges made are conducted without inclusion of identifying information wherever possible. 4.) As a training institution, clinical records are reviewed by supervisors and their trainees.

I understand and Agree. Please Initial Here _____

TRAINING AND RESEARCH: The Sullivan Center for Children is a training and research institution. We are committed to ongoing training and research in the areas of childhood, adolescent, and family psychopathology, psychological assessment, psychological and psychiatric treatment, treatment outcomes, and mental health service delivery. Case material and mental health records of patients at the Sullivan Center may be used for such purposes. In addition patients may be asked directly to participate in a research study or provide information for research purposes.

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All personal data is thoroughly disguised for such purposes to assure maintenance of patient confidentiality. The Sullivan Center adheres to all ethical and legal standards for research and research participants outlined by the American Psychological Association and the California Board of Psychology.

I understand and Agree. Please Initial Here _____

PATIENT RIGHTS: Billing and patient care information is maintained in electronic and hardcopy records which is the physical of the Sullivan Center. If you wish to exercise any of these rights, please contact Diana Miller, Officer Manager at 271-1186, or Linda Rios 277-2561, 3443 W. Shaw Ave., Fresno, CA 93711, fax: (559) 271-8041, during normal business hours. Either can assist you in the proper exercise of your rights. The information maintained is available to you in accordance with the following rights.

1. If you would like to limit or restrict the use or disclosure of your health information, you have a right to make such a request in writing. The Sullivan Center may not unconditionally approve the request, but each request is carefully reviewed.
2. You will receive a hardcopy of the Sullivan Center "Notice of Privacy Practices for Protected Health Information." You may also access this information on our website, www.sullivancenterforchildren.com
3. By written request, you may request a copy of your health and billing records, although we are not required to approve all such requests. For copies, pre-payment of two-dollars (\$2.00) per page, with a thirty-dollar (\$30) minimum fee (in order to cover staff and equipment costs to reproduce your record) is requested. Records are available for in-person pickup within 30-days of receipt of pre-payment (delivery alternatives are available and must be requested in writing). In the event a clinician determines your access to information may be harmful, additional steps are necessary, and you may wish to contact your clinician to discuss questions you may have concerning request for records.
4. You may request, in writing, that your health record be amended to address incomplete or incorrect information. Not all requests are accepted although you may appear a denial by providing an appeal request in writing. If your appeal is denied you may file a statement of disagreement and request that this statement be attached to any required future disclosures.
5. By written request, you may obtain an accounting of disclosures of confidential information made without your permission or request.
6. You may revoke, in writing, any previous authorization to disclose confidential information at any time and the revocation will be effective upon receipt for all future disclosures.

The Sullivan Center for Children reserves the right to refuse services to anyone, including the discontinuation of services as established by legal and professional regulations. The Sullivan Center also reserves all rights to modify or amend these policies. You may file written complaints with our Clinical Director, Kathy Sullivan, Ph.D. You may also file a complaint with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. The Sullivan Center for Children does not require you to

waive your right to file a complaint in order to receive services here.

EMERGENCY PROCEDURES: The Center's telephone lines are staffed at all times, either by office personnel or by an answering service. If a need arises to contact your therapist between sessions, please call the Center at (559) 271-1178 and your call will be returned as soon as possible. If you have an emergency, be sure to inform the office staff or the answering services of the emergent nature of your call so that your call will be handed at once. The Sullivan Center has 24-hour telephone coverage via an exchange services and every attempt will be made to locate your clinician in an emergency; if they are unable to be located, a covering Sullivan Center clinician will return your call. Of course, if an emergency is life-threatening, please dial 911.

APPOINTMENTS: Initial evaluations may take anywhere from thirty minutes to three hours depending on the nature of the assessment. Individual therapy sessions are usually 40 to 50 minutes though longer or shorter sessions may be prearranged with the provider. Medication management sessions may take from 10 to 30 minutes unless otherwise arranged with the physician. You are expected to arrive to each appointment on-time and the therapist will not extend sessions to make up for lost time when you are late. Your therapist or physician will, likewise, make every effort to attend each appointment on-time. Appointments with our psychiatrist run differently than therapy sessions with our clinicians, and there is frequently some waiting time involved. Please be patient. There are also situations, where therapy sessions must be delayed, such as in emergency session-extensions. In such situations your therapist or physician will attempt to extend your appointment or provide other arrangements to make up for the lost appointment time.

CANCELLATIONS: Scheduling an appointment involves reservation of time specifically for you. A **minimum of twenty-four (24) hours notice is required** for rescheduling or cancellation of an appointment. The full session fee (typically \$150.00) will be charged for missed sessions without such notification. Your therapist may waive this fee in the case of emergencies or acute medical illness. Your insurance company or other third party payer will not pay for uncancelled sessions; you will be solely responsible for this expense. This is a busy practice; your cooperation is essential so that we can provide maximum service to all clients. Even if you fail to provide advanced notice, contact the office or your therapist as soon as possible and explain the mishap. If you fail to communicate with our office about uncancelled missed sessions for two consecutive sessions or for three-missed sessions within any six (6) month period of time, your clinician **may** initiate **termination of your services here** and would then refer you to another agency for continued care. For safety purposes ongoing monitoring for children on medication is necessary. **Medication refills for patients being prescribed medication will not be approved without diligent scheduling of, and attendance at medication follow-up appointments.**

I understand and Agree. Please Initial Here _____

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BILLING AND INSURANCE REIMBURSEMENT: Clinical services are rendered and charged to the patient and not to the insurance company. You are expected to keep your account current, not waiting to see what the insurance will pay before making payment to the Center. Once you have provided our office with a copy of your insurance card and necessary information, the Sullivan Center will bill your insurance company weekly. A statement that reflects all charges and payments will be sent to you each month. For families with more than one family member in treatment, it will be **absolutely necessary** for you to indicate on your check the account number and the patient for whom you are making a payment.

I understand and Agree. Please Initial Here _____

PAYMENT FOR SERVICES: Payment is expected at the time of service unless insurance coverage requires another arrangement or there is a prior agreement with the provider or administration staff. There may also be fees associated with report preparation, letter writing, and extended telephone consultants. Please discuss specific fees or other detail with your individual physician or therapist prior to having these services performed. Due to the ever-changing insurance environment and wide variety of plans, we cannot be responsible for knowing the filing requirements of each insurance company. In order for us to continue to file some insurance, we must enforce that *it is your responsibility to know or find out the filing requirements and limitations of your own plan.* We are familiar with many insurance plans and managed care companies and are happy to assist in any way we can to help you find that information. *We are required by law to collect all co-pays at the time of service. There will be a \$25.00 service charge for any checks returned by your banking institution.* Discuss fees and payment with your therapist and please notify your therapist if any problems arise during the course of treatment regarding your ability to make timely payments. A Finance Charge of 1.5% per month (18% per annum) of the unpaid balance may be assessed after 90 days. The Center has a limited program that provides for reduced fees for some services for patients in clinical and financial need. If you are in such need, discuss the situation with our intake staff or your therapist to determine if you meet criteria for inclusion in this program.

I understand and Agree. Please Initial Here _____

ABOUT OUR PRACTICE: This is a multidisciplinary healthcare practice. We provide a variety of services including individual, couples, group, psychotherapy, psycho-education, consultation, school counseling, psychological assessment, forensic assessment, medication evaluation, and treatment. Our clinicians are all registered and supervised or licensed/board certified in their respective fields. Our clinicians are actively engaged in ongoing continuing education and follow the highest professional and ethical standards. Sullivan Center clinicians come from a variety of professional backgrounds. Psychologists have a doctorate degree in psychology, have completed both pre- and post-doctoral internships, and have completed strict state competency standards for licensure. Psychologist may conduct personality or neurocognitive assessments, forensic assessment, provide psychotherapy, or supervise psychological trainees and interns. Psychiatrists have a medical doctorate and have completed medical school with additional training including residency in Psychiatry. Psychiatrists may prescribe medications, assess medical conditions,

supervise trainees and interns, and provide psychotherapy. Licensed professional counselors, licensed clinical social workers, and licensed marital-family therapists have completed a Bachelors and/or Master's Degree in social work or a related field and can provide psychotherapy, case management/care coordination, and supervise psychological trainees. Psychology Post-Docs at the Sullivan Center have completed their doctoral degree and are practicing under the supervision of a Licensed Psychologist. Psychology Interns are in their final year of doctoral training, and Practicum Students are Master's level trainees. Psychological Interns, Psychological Assistants, and Practicum Level Psychological Trainees at the Center provide services similar to a psychologist. They are registered by the Board of Psychology as Psychological Assistants or by the Board of Behavioral Science as trainees, and are supervised by a Licensed Psychologist or Board Certified Psychiatrist.

Psychotherapy and counseling have earned a reputation for enhancing the quality of life of others. Although the vast majority benefit from these services, there are no certainties and each person will experience these services differently. All psychotherapy involves a substantial commitment, and as with most endeavors, the amount of effort you put forth into your treatment will effect the outcome greatly. Psychotherapy often involves an unsteady rate of progress and many people experience periods of depression, anger, resentment, guilt, fear, tension, anxiety, and other feelings during treatment. Services are provided without warranty or guarantee, but it is important to notify your clinician if you feel you or your child are experiencing any negative effects as a result of treatment. You can expect your clinician to share with you:

- a. their understanding of the problems you have brought to their attention
- b. their approaches to those problems
- c. other approaches they are aware of
- d. what research says about the advantages and disadvantages of approaches
- e. their assessment of progress or lack thereof and resultant options they are aware of
- f. their best opinion about what may happen without treatment

Our therapists make every effort to inform patients of all options for treatment. If you feel that your treatment is not progressing in the way that it should, please discuss this with your therapist, your therapist's supervisor, or both. Sometimes treatment advances most rapidly during moments where you and your therapist directly address such obstacles. In any event, please note that you are also welcome to contact our Clinical Director, Kathy Sullivan, Ph.D., (559) 271-1186, if you would like to do so.

I have read and understand each of the above policies. I agree to follow and abide by them. I understand that I may revoke my consent, by submitting revocation in writing to the Sullivan Center, which will be made effective upon receipt. Your signature below also acknowledges that you have received a copy of these policies and that HIPPA Notice of Privacy Practices.

Signature of Patient or Responsible Party

Today's Date

Revised: 05/12/08

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. **Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include, as Required By Law: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research: Criminal Activity, Military Activity, and National Security, Workers' Compensation, Inmates. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information: You have the right to inspect and copy your protected health information Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint This notice was published and becomes effective on/or before April 14, 2003 We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Dated: _____

Patient or Legal Guardian

The Sullivan Center for Children

3443 W Shaw, Fresno, CA 93711 (559) 271-1186

Adult Intake Packet

It is absolutely necessary to complete each item thoroughly and accurately. Please take your time and give thoughtful consideration to each question, and **do not leave any items blank**. When done, return this packet to our Front Desk staff.

Today's Date ____/____/____				<i>If person filling out this form is not the patient:</i> What is your name and relationship to the patient?	
Patient's Last Name		First	Middle	Birth Date	Sex
				/ /	<input type="checkbox"/> M <input type="checkbox"/> F
Home Street Address	City	State	ZIP Code	Patient's Social Security No.	Home Phone No.
					()
					Cell Phone No.
Work Street Address	City	State	ZIP Code	Email Address	()
					Work Phone No.
Occupation:		Employer:			()
Do you require any special accommodations? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please describe:				Best Time/Place to Call	
Chose Clinic Because/Referred to Clinic by (Please check one box)			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Website	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	
Highest Grade or Degree Completed:				Marital Status: <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Engaged <input type="checkbox"/> Separated	
Your Children's Names & Ages (If applicable, give further detail if adopted, by previous marriage, etc.):					
What is the highest grade or degree you've completed? <input type="checkbox"/> Grade: ____ <input type="checkbox"/> High School <input type="checkbox"/> Technical School <input type="checkbox"/> Some College <input type="checkbox"/> Associates <input type="checkbox"/> Masters <input type="checkbox"/> Doctoral degree <input type="checkbox"/> Other: _____					

If a translator is present today:	Name of translator:	Company Name:
<p><i>If the listed "Primary Contact" is not the *same person filling out this form* or is not a legal custodian:</i> then you must read and sign the following statement, or notify the front desk staff of your inability to do so. "I am completing this form on behalf of the person listed above as the primary contact responsible for this client's treatment at the Sullivan Center for Children. I accept responsibility for the accuracy of this information and any translation or recitation services I am providing here. I realize that this is confidential and privileged information and I will not disclose anything I have communicated today for any reason. If translating, I agree to translate accurately, <i>word for word</i>, including all off-topic communications. I agree that I will be held liable for deliberate/negligent distribution of misinformation and/or translation. I will notify staff that I completed this form on behalf of the listed Primary Contact."</p>		
Print Your Name	Sign	Date

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Consent for Treatment

I authorize Sullivan Center for Children to provide these services:

Psychological Services Yes No Psychiatric/Medication Services Yes No

Consent for Verification and Billing of Insurance

If intending to use insurance coverage for payment of services you must provide this information and sign below.
Please give your insurance card to the receptionist to have a copy made for your file.

Person Responsible for Bill	Birth Date / /	Address (if different)			Home Phone No. ()
If another family member is a client here, list name(s)					
Subscriber's Name	Subscriber's SSN	Birth Date / /	Group #	Policy #	Co-Payment \$
Insurance Company Name, Phone Number & Address (on card):					
Occupation	Employer	Employer Address			Employer Phone No. ()
Patient's Relationship to Subscriber	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	Drivers Lic. # _____
Name of Secondary Insurance (if applicable)		Secondary Subscriber's Name		Group #	Policy#
Subscriber's SSN		Subscribers Birth Date / /		Co-Payment Amount	
Insurance Company Name, Phone Number & Address (on card):					
Occupation	Employer	Employer Address			Employer Phone No. ()
Patient's Relationship to Subscriber	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

I realize that it is **solely** my responsibility to pay for services as well as to determine what my insurance coverage, benefits and limits are. I request that The Sullivan Center for Children provide clinical services and I agree to be financially responsible for these costs. The Sullivan Center will bill my insurance, but regardless of any insurance billing assistance provided to me by the Center, I will be responsible for my account. I authorize insurance payments be paid directly to the Sullivan Center. By signing this *Financial Agreement* I consent to the release of information to my insurance company as required for validation, billing, reimbursement and related services. I understand that this account may be subject to finance charges of 1.5% per month (18% per annum) of the unpaid balance after 90 days. If the account becomes delinquent and referred to an attorney or collection agency, I will be held responsible for actual attorney fees and collection expenses. If you have health insurance it may cover a part of the cost of your treatment here, and to determine whether it will, we need the above information. Please advise office if you have secondary insurance coverage. **Please provide office with copies of insurance card and driver's license.**

Signature of Patient or Financial Guarantor

Date

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Health and Background Questionnaire

Check if you have any symptoms in the following areas, and briefly explain.														
<input type="checkbox"/> Seizures _____ <input type="checkbox"/> Head/Neck Injury _____ <input type="checkbox"/> Ear/Nose/Throat _____ <input type="checkbox"/> Headaches _____ <input type="checkbox"/> Skin _____ <input type="checkbox"/> Lungs _____	<input type="checkbox"/> Chest/Heart _____ <input type="checkbox"/> Back _____ <input type="checkbox"/> Intestinal _____ <input type="checkbox"/> Bladder _____ <input type="checkbox"/> Bowel _____ <input type="checkbox"/> Circulation _____	Any Recent Changes In: <input type="checkbox"/> Weight <input type="checkbox"/> Energy Level <input type="checkbox"/> Ability to Sleep <input type="checkbox"/> Mood <input type="checkbox"/> Appetite <input type="checkbox"/> Sexual Energy <input type="checkbox"/> Other Pain/Discomfort, Describe: _____												
Childhood Illnesses: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio														
Immunizations : <input type="checkbox"/> Tetanus <input type="checkbox"/> Pneumonia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Chickenpox <input type="checkbox"/> Influenza <input type="checkbox"/> MMR														
List Any Medical Problems, Allergies or Conditions (Include Diagnosis & Diagnosing Doctors Name if Known): _____ _____ _____														
List Any Medications you are using (Include Prescribing Doctor and Dosages if known): _____ _____ _____														
Describe any family history of Mental Illness or Physical Illness: _____ _____ _____														
Surgeries/Hospitalizations or Serious Accidents/Injuries <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Year</th> <th style="width: 55%;">Reason</th> <th style="width: 30%;">Hospital</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			Year	Reason	Hospital									
Year	Reason	Hospital												
Exercise <input type="checkbox"/> Sedentary <input type="checkbox"/> Mild Exercise <input type="checkbox"/> Occasional Vigorous Exercise <input type="checkbox"/> Regular Vigorous Exercise														
Diet: Are you dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is this a physician prescribed diet? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimate Salt Intake: <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low Estimate Fat Intake: <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low Estimate Sugar Intake <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low Estimate Caffeine Intake <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low														
Military: If you have previously served in the military, please list division and highest rank achieved:														
Legal History: <i>If you check yes to the following questions please provide details on the reverse side of this paper</i> Are you currently involved in any current litigation such as criminal, civil or divorce proceedings? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been arrested/convicted of inappropriate sexual or criminal behavior involving a minor? <input type="checkbox"/> Yes <input type="checkbox"/> No														

Current Psychotherapist or Psychiatrist:	Address:	Dates Seen
Previous Therapists:	Address:	Dates Seen
Previous Psychiatrists:	Address:	Dates Seen
Primary Care Physician:	Address:	Dates Seen
Previous Psychological Testing/Educational Testing:	Address:	Dates Seen
Previous Mental Health Agencies Involved:	Facility:	Therapist
Previous Residential Mental Health or Hospital Mental Health Services:	Facility:	Therapist

Sullivan Center Mental Health Symptom Checklist

- Yes Any history of a seizure or epileptic attack?
- Yes Any history of drug or alcohol abuse?
- Yes Any misuse of over-the-counter or prescription drugs?
- Yes Any history of head injury or black-outs?
- Yes Decreased academic or work performance?
- Yes Difficulty eating, excessive eating, or forced vomiting?
- Yes Difficulty sleeping, falling asleep, or difficulty waking up in morning?
- Yes Do you have access to guns, rifles, weapons or explosives?
- Yes Do you wears glasses, contact lenses, hearing aid or a prosthesis?
- Yes Ever been in the car during a serious car accident?
- Yes Ever made a serious threat or attempt to cause serious injury to another person?
- Yes Excessive shakiness, arm or leg tremors?
- Yes Experiencing frequent panic, terror or nervousness?
- Yes Feeling depressed, unusually lethargic, tired, bored, or apathetic?
- Yes Frequent or disturbing nightmares? Night sweats/terror?
- Yes Hallucinations: visual, auditory or olfactory (smell)
- Yes Have you ever attempted or threatened to attempt suicide?
- Yes Have you previously been to a counselor or therapist?
- Yes Increased difficulties with eye and hand coordination?
- Yes Increased difficulty in concentration or attention?
- Yes Increased moodiness or irritability?
- Yes Loss of simple movement of various body parts, such as paralysis or numbness?
- Yes Preoccupied with death, dying or morbid thoughts?
- Yes Problems with over-eating or poor appetite?
- Yes Recent changes in vision, balance, hearing or coordination?
- Yes Recent dizziness spells?
- Yes Recent surgery or hospitalizations?
- Yes Threatened, attempted or engaged in serious destruction of property, including fire setting?

Please circle if any of the following apply to you...

Distractible	Phobic	Listless/Fatigued	Impulsive	Hostile	Stomach Aches
Domestic Violence	Strange thoughts	Sexual Difficulty	Tired	Self-mutilation	Anorexic
Fearful	Clumsy	Overactive	Difficulty Concentrating	Easily Distracted	Nightmares
Legal Problems	Family Problems	Poor Social Life	Drug or Alcohol Abuse	Difficulty at work	Academic Problems
Over-eating	Poor Appetite	Excessive Worry	Pessimistic	Agitated	Forgetful
Socially Isolated	Hyperactive	Frequently Ill	Headaches	Body Pains	Nervousness
Suicidal Thoughts	Marital Problems	Parenting Worries	Financial Problems	Crying Episodes	Recent Death/Loss
Very unhappy	Irritable	Frequently Angry	Withdrawn	Difficulty Sleeping	Hallucinating

What services you are seeking and what are your expectations for treatment?

