Shoudt & Reilly Psychological Services, LLC.

6720 E. Perkiomen Avenue, Birdsboro, PA 19508
Telephone #: 610-404-1726
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Shoudtreillypsychologicalservices.com

BethAnn Shoudt, Psy.D.
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Susan O'Hayer, Psy.D.

Dear Parent:

In preparation for your child/adolescent's upcoming evaluation, we ask that you complete the enclosed forms and Client Information Questionnaire. We apologize that the form is quite lengthy. Please realize that collecting this information before the evaluation will help us to utilize the time available to your child's best advantage. Your child's clinician will ask you for these forms, as well as your insurance card and photo identification at the start of the session.

Often, useful clinical impressions can be generated at the very first meeting. Please be aware, however, particularly for children and adolescents that the evaluation process often entails several meetings before full diagnostic impressions are made.

The first session will involve some time for your child alone with the evaluator. You will also have some time, either with your child present or alone depending on the circumstances and flow of the evaluation, to discuss your concerns.

Sincerely,
Shoudt & Reilly Psychological Services

Clinician Name: _____

Initial Appointment: _____

Welcome to Shoudt & Reilly Psychological Services

What you can expect from Shoudt & Reilly Psychological Services:

- Please wait in our comfortable waiting room for your clinician to greet you.
- Before sessions begin, we will take care of all business matters, such as co-pays, scheduling, and insurance issues.
- We will assist you with all insurance issues, but ultimately it is the patient's responsibility to pay the bill for services rendered.
- Please feel free to contact our office with any questions, concerns, or other matters. We guarantee we will return your call within one business day (unless specified differently on our voice mail message). To contact your clinician for emergencies, call our answering service at 610-607-1751. For crisis or emergencies requiring immediate attention, and if you are unable to immediately reach us, please contact your psychiatrist, family doctor, the police, Service Access and Management at 610-236-0530, or go to your local emergency room.
- When your clinician is away, someone will cover their practice and assist you in emergencies.
- If you need to cancel an appointment, please give us 24 hours notice. Failure to give notice will result in the patient being billed a fee for this inconvenience. (We are understanding of illness, bad weather, or other life emergencies).
- All patient records are confidential; limits to this may include auditing by your insurance company.
- We will discuss all fees with you and assist in payment arrangements when necessary.
- For the comfort of others in the waiting room, we ask that you do not bring food into the waiting room.
- Most important to us is your comfort with the practice. We hope you find Shoudt & Reilly Psychological Services a supportive and enriching practice. We value you as our patient and respect you as a person or family.

Insurance Information and Demographics

Patient Information:

Name:_____ SSN:_____

Address:_____ DOB:_____

_____ Home Phone:_____

_____ Work Phone:_____

Mobile Phone:_____

Insurance Policy Holder: (If same as patient write same) **Relationship**:_____

Name:_____ SSN:_____

Address:_____ DOB:_____

_____ Home Phone:_____

_____ Work Phone:_____

Mobile Phone:_____

Employer:_____ Occupation:_____

Person Responsible for Bill: (If different from Insurance Policy Holder) **Relationship**: _____

Name:_____ SSN:_____

Address:_____ DOB:_____

_____ Home Phone:_____

_____ Work Phone:_____

Mobile Phone:_____

Primary Insurance Information:

Insurance Company:_____ ID#:_____

Claims Address:_____ Group#:_____

_____ Member services telephone number:

_____ _____

Mental Health Managed Care Company (If Applicable) _____

Mental Heath Managed Care telephone number: _____

EAP ID # (If Applicable):_____

EAP Authorization # (If Applicable):_____

Secondary Insurance Information: (If applicable)

Insurance Company:_____ ID#:_____

Claims Address:_____ Group#:_____

_____ Member services telephone number:

_____ _____

Mental Health Managed Care Company (If Applicable) _____

Mental Heath Managed Care telephone number: _____

I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Shoudt & Reilly Psychology Services. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature: _____ Date: _____

Consent to Treatment

I do hereby seek and consent to take part in behavioral health treatment services with Shoudt & Reilly Psychological Services, LLC. I understand that my clinician and I will collaborate to develop a treatment plan at the time of intake and that the treatment plan will be reviewed as often as indicated. I agree to pay for this treatment, and I understand the billing practices and the fee schedule. I understand that failure to pay for costs for which I am liable may ultimately result in my account being forwarded to the proper authority for collection.

I have been informed of my rights and responsibilities as a client of behavioral health services. I understand that I must call to cancel an appointment at least 24 hours in advance except in cases of emergency. I am aware that if an appointment is not cancelled in this time frame, I will be charged a no-show fee.

I understand that I have the right to terminate treatment at any time. I also understand that my clinician may terminate treatment at Shoudt & Reilly Psychological Services, LLC., if treatment at this office is not clinically appropriate. In these cases, referral to an appropriate service provider will be made.

My signature acknowledges that I have read and understand the consent to treatment form and agree with the same.

In cases of minors with divorced parents, both parents with legal custody must sign this consent form for treatment to begin.

_____	_____
Client Signature	Date
_____	_____
Parent/Legal Guardian Signature if child is Under 18	Date
_____	_____
Co-Parent Signature	Date
_____	_____
Therapist Signature	Date

Primary Care Doctor Notification

Patient Name: _____

Date of Birth: _____

Primary Care Doctor: _____
Address: _____
_____
_____
Telephone number: _____

_____I give permission to Shoudt & Reilly Psychological Services, LLC, to communicate with my Primary Care Doctor regarding my psychological treatment.

_____I DO NOT give permission to Shoudt & Reilly Psychological Services, LLC, to communicate with my Primary Care Doctor regarding my psychological treatment.

_____ _____
Signature of Client or their Personal Representative Date

_____ _____
Printed name of Client or Personal Representative Relationship to client

Consent to Use and Disclose your Health Information

This form is an agreement between you, _____ and Shoudt & Reilly Psychological Services, LLC. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI). We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We 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.

By signing this, you agree to let us use your information here and send it to others as necessary. The notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read that document before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of Client or their Personal Representative Date

_____ _____

Printed name of Client or Personal Representative Relationship to client

Insurance Billing Policy

Due to the increasingly lengthy process of submitting mental health insurance claims, Shoudt & Reilly Psychological Services requires your assistance in obtaining the following information. **In order to do this, please contact your insurance company and inquire about your behavioral health benefits.**

- Is there a Managed Care company that handles your insurance company's Behavioral Health benefit? ___ Yes ____ No
    - If Yes, Name of company:_____
- Is Pre-certification required?
    - If Yes, **call to obtain this within 24 hours of your first session**; If you fail to do this, your session may not be covered and you will be responsible for bill.
    - Authorization Number (if applicable): _____
    - Number of sessions authorized: _____
- Number of sessions allowed per calendar year? _____
- Is Shoudt & Reilly Psychological Services an In-Network provider? ___ Yes ___ No
    - If No, What is the Out-of-Network benefit? _____
- Do you have a deductible? ___ Yes ___ No; If Yes, Amount: _____
- What is your co-pay or co-insurance amount? _____

The primary focus of Shoudt & Reilly Psychological Services is to provide the highest quality behavioral health services possible. To that end, we have very limited time available for managing issues related to the large number of insurance companies utilized by our clients. Therefore, in order to maintain our standard of providing top quality clinical care, Shoudt & Reilly Psychological Services needs to make you, the client, responsible for contacting the insurance company directly to address any claim issues that may arise (including denied or returned claims). Although we are happy to submit claims to insurance companies for the benefit of our clients, ultimately, it is the responsibility of the client to provide payment for services.

We appreciate your attention to these matters!

I have read, understand, and accept the above stated policy.

Signature: _____ Date: _____

Notice of Privacy and 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.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). We are required also by law to do this. These laws are complicated, but we must provide you with important information.

We will use this information about your health, which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, or for some other business activities, which are called, in the law, health care operations. After you have read this Notice of Privacy and Practices (NPP), we will ask you to sign a consent form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety, or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. You may request information about these from your clinician.

Your Rights Regarding your Health Information:

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. There is an exception for psychotherapy notes, which you can discuss with your clinician. You can even get a copy of these records but we may charge you.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your PHI. You have to make this request in writing and include the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy.
6. You have the right to file a complaint if you believe your privacy right s have been violated. You can file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

The effective date of this notice is March 1, 2005

Please complete and sign the attached forms, and bring them with you to your first appointment.

Acknowledgement of Receipt of Notice of Privacy and Practices

Patient Name: _____

Date of Birth: _____

Maiden or other name (if applicable): _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Shoudt & Reilly Psychological Services, LLC, effective March 1, 2005.

_____ _____

Signature of Client or their Personal Representative Date

_____ _____

Printed name of Client or Personal Representative Relationship to client

Notice to Parents Regarding Custody Issues

It is the strict policy of Shoudt & Reilly Psychology Services, LLC not to get involved in custody or legal issues of our child/adolescent patients. This policy is based on both ethical and clinical decisions. It is not in the best interest of our patient, your child, for us to be involved in legal proceedings. Doing this would constitute a dual relationship with your child that could potentially damage the therapeutic relationship. Your child needs to trust and believe that what is discussed in treatment is confidential and will not be part of court proceedings. Likewise, for a therapist to become involved in legal proceedings could be perceived by a child/adolescent as the therapist siding with one parent over another. This dynamic could potentially risk your child feeling "caught in the middle" of their parents' problems.

It is in each parent's best interest and your child's best interest that evaluations and opinions be given by an independent evaluator. This professional can either be court appointed or your child's therapist may be able to make recommendations.

Signing below indicates your understanding of this policy and agreement to honor your child's relationship with their therapist as independent of all court proceedings. Both parents' signatures are required for this document.

_____ _____

Parent signature Date

_____ _____

Co-parent signature Date

CLIENT INFORMATION QUESTIONNAIRE

ALL INFORMATION CONFIDENTIAL

General Information Date: _____

Child's Name:_____ Age:_____ Sex: _____DOB:_____

Address:_____ City: _____ Zip:_____

Child's Legal Custodian: _____ Home Phone:_____

Name of person completing this form: _____

Relationship to child: _____

Referred by: _____ Phone:_____

Father's Name: _____Relationship if not biological: _____

Mother's Name: _____ Relationship if not biological: _____

Biological father's address (if not living with child):

_____

Phone Number: _____ Frequency of Contact:_____

Biological mother's address (if not living with child):

_____

Phone Number: _____ Frequency of Contact:_____

Please list name & address of your child's primary care physician & any other physicians involved in their
care:_____
_____

List family members & all others in the home:
Name: Age Relationship Occupation

_____
_____
_____
_____
_____
_____

Describe how you feel your child relates to the rest of the family:
_____
_____
_____

If parents are divorced/separated, how old was child at time of separation?
_____

List any other siblings (along with age & relationship) not in the home:

_____
_____
_____

Please describe your child's current medical, behaviors and emotional problems. Include age at which problems started and any recent stressors:
_____
_____
_____
_____
_____
_____
_____
_____

What seems to help?

_____
_____
_____
_____

Circle any of the following if they have been problems for your child:

Speech or language	Fearful	Slow learner
Coordination	Wets bed	Sad
Prefers to be alone	Bites nails	Stomach troubles
Fights w/ siblings	Sucks thumb	Angry
Fights w/ peers	Tantrums	Can't relax
Fights w/ adults	Nightmares	Lonely
Physically aggressive	Sleep	Feels inferior
Destroys property	Rocking	Suicidal Thoughts
Cruel to animals	Head banging	Trouble w/ friends
Steals	Holds breathe	Indecisive
Shy/timid	Poor appetite	Depressed
Reckless behaviors	Stubborn/willful	Nervous
Self injury	Overactive	Bowel Problems
Odd habits/mannerisms	Impulsive	Obsessive
Lack of friends	Frequent visits to nurse	Frequent visits to Guidance office

Developmental History:

Age of mother during pregnancy _____ Mother's health: □ good □ fair □ poor

List medications during pregnancy _____

Did mother smoke, drink alcohol or use substances during pregnancy? _____
Specify amounts, types and frequency _____
_____
_____

Any illness during or complications of pregnancy?_____

Length of pregnancy _____weeks Labor _____hours

Birth Weight _____ Type of Delivery □ vaginal □ C-section

Any instruments/forceps? (Specify) _____

Any complications of delivery or birth defects? _____

Was mother depressed or down after delivery? _____

Please describe child as an infant: □ pleasant □ fussy □ calm □ colicky
□ irritable □hard to manage

Any problems with sleep or feeding (describe) _____
_____

Developmental Milestones:

To the best of your recollection, please fill in the age at which your child began each of these behaviors:
(If you cannot remember ages, specify if the event was early, on time, or late)

Showed response to parent _____

Rolled over _____

Sat alone _____

Crawled _____

Walked alone _____

Babbled _____

Put several words together _____

Dressed self _____

Toilet trained: Bladder _____ Bowel _____

Dry at night _____

Fed self _____

Rode tricycle _____

Spoke single words _____

Have there been any caregivers other than parent prior to kindergarten?

Age Setting Child's reactions/behavior

_____
_____
_____
_____

Medical History:

Please circle any of the following conditions your child has had & list age of occurrence

Measles	_____	Whooping Cough	_____
German measles	_____	Meningitis	_____
Mumps	_____	Encephalitis	_____
Chicken pox	_____	Seizures	_____
Rheumatic fever	_____	Head injury	_____
Broken bones	_____	Diabetes	_____
Visual problems	_____	Cancer	_____
Hearing problems	_____	Bleeding problems	_____
Paralysis	_____	Frequent nosebleeds	_____
Severe/frequent headaches	_____	Skin conditions	_____
Extreme fatigue	_____	Suicide attempt	_____
Anemia	_____	Bowel problems	_____
Memory problems	_____	Eating problems	_____
Tuberculosis	_____	Loss of consciousness	_____
Fever above 105	_____	Dizziness/fainting	_____

Is your child on a special diet? □ No □ Yes
Describe_____

Does your child take any medications currently? □ No □ Yes
Please include any over the counter medications, herbal supplements or remedies.

Drug Dose Frequency Duration Reason Prescribed by
_____
_____
_____
_____
In the past, has your child ever been on medication for anxiety, depression, behavior problems, etc.?

Drug Dose Frequency Effectiveness Side Effects Why discontinued
_____
_____
_____

Does your child have any drug allergies or sensitivities? □ No □ Yes

Drug Symptoms
_____
_____

Does your child have any other allergies or sensitivities (environmental, food, dye, latex, etc.)?
□ No □ Yes, describe _____

Caffeine consumption: (soda, tea, iced tea, coffee, etc.) amount _____ per day/week

Sexual Development:

Has your child started developing sexual characteristics such as pubic hair or breast change?
□ No □ Yes

If yes, at what age & what was your child's attitude toward this?
_____
_____

If applicable, age at first menstruation: _____

Any menstrual irregularities, cramps or other physical discomfort? □ No □ Yes

Psychiatric History:

Has your child ever received any mental health and/or substance abuse treatment?

□ No □ In-patient □ Out-patient

Place/Provider Dates Reason Outcome

_____

_____

_____

When was your child last seen by a mental health professional? _____

Significant Events – please check & describe:

Event	Date	Describe
Loss of someone close		
Loss of pet		
Trouble with the law		
Living/placement away from home		
Incest/sexual abuse		
Physical abuse or neglect		
Emotional abuse		
Held back in school		
Moves		
Significant health problems of self or family member		

Child's Education Grade _____

Name and address of school child presently attends:

_____ Phone: _____
_____ Contact person: _____

Please check what you feel describes your child in the following areas:

Attendance: □ Rarely absent □ Sometimes absent □ Often absent

Ability: □ Above average □ Average □ Below average

Relationship with peers: □ Above average □ Average □ Below Average

Behavior: □ Above average □ Average □ Below average
Has your child ever been suspended or expelled? □ No □ Yes
If yes, describe _____

Any difficulty with: □ Reading □ Math □ Spelling □ Writing
Other_____

What, if any, special services have been provided for your child in school (speech/language, remedial reading, special classes, counseling, groups, occupational therapy)?

_____
_____
_____

Does your child have an IEP? □ No □ Yes

Any school refusal or avoidance? □ No □ Yes

Social/Extracurricular activities (list & comment):
_____
_____
_____
_____

Family History:

Is there a family history of any of the following disorders – if so, please check and list family members on adjacent line:

□Depression_____
□Manic-Depression _____
□Anxiety Disorders_____
□Suicide Attempt _____
□Autism _____
□Attention Deficit/Hyperactivity_____
□Tics _____
□Learning Disorders _____
□Mental Retardation _____
□Alcoholism _____
□Drug Abuse _____

Any family history of medical problems, including diabetes, heart disease, cancer, seizures, Alzheimer's, asthma, etc.? □No □Yes
Describe
_____
_____

Parents' current marital status:
□ Married & living together □ Separated □ Widowed □ Mother remarried
□ Single, never married □ Divorced □ Living together □ Father remarried

How would you describe the relationship between you and your child's co-parent?
□ No difficulties □ Occasional difficulties □ Frequent difficulties

Describe significant marital problems and how both spouses view them:

Mother's View:
_____
_____

Father's View:
_____
_____

Any marital counseling? □ No □Yes

Parent's History:

Biological Mother:
Name: _____ Age: _____
Highest Level of Education: _____
Please describe any problems growing up – particularly those involving relationships/family:
_____
_____
_____

Biological Father:
Name: _____ Age: _____
Highest Level of Education: _____
Please describe any problems growing up – particularly those involving relationships/family:
_____
_____
_____

Adoptive or Stepmother:
Name: _____ Age: _____
Occupation: _____ Highest Level of Education: _____
Please describe any problems growing up – particularly those involving relationships/family:
_____
_____
_____
How did this child adjust to his/her stepmother?
_____
_____
_____

Adoptive or Stepfather:
Name: _____ Age: _____
Occupation: _____ Highest Level of Education: _____
Please describe any problems growing up – particularly those involving relationships/family:
_____
_____
_____
How did this child adjust to his/her stepfather?
_____
_____
_____

Optional:

Some managed care companies require we ask the following questions regarding cultural/spiritual issues. You may choose to respond or not respond.
With what ethnic/cultural /racial group do you identify?_____
What is your religious affiliation?_____
What role does your religion/spirituality play in your life? _____
_____
Are there any spiritual or cultural issues that you feel need to be taken into account in your child's treatment? □No □Yes, Please explain _____
_____

Please list any additional comments or concerns:
_____
_____
_____
_____
_____
_____
_____
_____

Fee Schedule

Procedure	BethAnn Shoudt, Psy.D Melissa E.D. Reilly, Psy.D. Katie Castille Nerney, Psy.D. Christine A. Jenkins, Psy.D. Susan O'Hayer, M.A.
Initial Evaluation	$185
Individual Psychotherapy	$150
Family Psychotherapy	$150
Couples Psychotherapy	$150
Interactive Individual Psychotherapy	$150
Copy of Records	$25
Letters to providers	$25
Insurance Company Appeals, Lengthy Claims Forms/Reports	$25
Telephone Consult	$25 per 10 minutes
School/ IEP Meetings	$150 per hour
No Show or Cancel in less then 24 hours	$40
Re-Bill charge for payments not received within 30 days	$5

Directions to Shoudt & Reilly Psychological Services, LLC.

From 422 going West

Route 422 (Benjamin Franklin Highway) turns into Perkiomen Avenue once you cross Route 82. At the traffic light at the intersection of Sunset Manor Drive on the left and Pineland Rd on the right (there is a Sheetz Gas station on your left) make a left onto Sunset Manor. Make a left (the third left) onto Allen Rd which curves to the left and turns into Donna Dr., then make a right back onto Perkiomen Avenue going East. You will pass a shed retailer on the right. On the right you will see Egan's Auto Mall Car Wash and Garage. Shoudt and Reilly Psychological Services are located inside the large Stone building next to the highway. Turn right into our shared entrance with the Egan's Auto Mall Car Wash and Garage. Turn left at the rear of the stone building into the Shoudt & Reilly Psychological Services parking lot. Please enter using the door off the parking lot.

From 422 going East

You will pass the Wal-Mart store, Service Electric and come to the light at the Sheetz Gas station on your left. After the Sheetz, on the right, there is a shed retailer, and then Egan's Auto Mall Car Wash and Garage. Shoudt and Reilly Psychological Services are located inside the large Stone building next to the highway. Turn right into our shared entrance with the Egan's Auto Mall Car Wash and Garage. Turn left at the rear of the stone building into the Shoudt & Reilly Psychological Services parking lot. Please enter using the door off the parking lot.

From 724 Coming West:

You will pass a Turkey Hill, shortly after you will turn left onto Gibralter Road (there is a playground). Follow Gibralter until you have to bear right. Follow Gibralter to the right. This will bring you to Perkiomen Avenue. Turn Right.

You will pass the Wal-Mart store, Service Electric and come to the light at the Sheetz Gas station on your left. After the Sheetz, on the right, there is a shed retailer, and then Egan's Auto Mall Car Wash and Garage. Shoudt and Reilly Psychological Services are located inside the large Stone building next to the highway. Turn right into our shared entrance with the Egan's Auto Mall Car Wash and Garage. Turn left at the rear of the stone building into the Shoudt & Reilly Psychological Services parking lot. Please enter using the door off the parking lot.