DENISE R. NELSON, PH.D.

CLINICAL PSYCHOLOGIST ▪ PSY 18659

CHILD/ADOLESCENT REGISTRATION

Child's Name ______________________________Today's Date______________

Address_____________________________________City__________________

State_________________ Zip_______________ Child Cell_________________

Home Telephone______________________Age________Birthdate______________

Grade level_______________ School Attended______________________________

Sibilings in the home and their ages_______________________________________

Name (and relation) of anyone else living in the home __________________________

Mother's Name____

Father's Name ____

Parent's Marital Status____

Parent's address (if different from child's)___________________________________

Mother's Occupation ______________________ Mother's Cell _________________

Father's Occupation _______________________Father's Cell __________________

Pediatrician's Name____

Phone #________________________________ Last Examination Date_____________

Is your child taking any medications or experiencing any health problems? Yes__ No__

If yes, please describe____

____

Please turn page over...

10780 SANTA MONICA BLVD. ▪ SUITE 250 ▪LOS ANGELES, CA 90025 ▪ (310) 963-4891

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Person to contact in case of an emergency________________________________

Telephone #_____________________ Relationship_______________________

Who suggested that you contact me?______________________________

Is your child currently seeing any other psychotherapist? Yes___ No___

Name of therapist________________________ Phone #____________________

Date of Treatment_______________________ Reason_____________________

Has your child ever been in psychotherapy? Yes___ No___

If yes, please list dates of treatment_______________________________

Reason ____

Unless I have your consent to release information, no information regarding you or your child will be shared with anyone – except under certain legally defined situations where the safety of your child, yourself, or another person is at risk.

Please note that my services require a 48-hour notice of cancellation. Failure to give 48-hour notice of cancellation will result in the full session fee being charged.

All of the information I have written above is accurate to the best of my knowledge. I have been given a copy of the Office Policy and the California Notice Form. I have read, understood, and agree to the conditions stated in both the Office Policy and California Notice Form.

Signature______________________________________ Date_______________

Name (printed) ________________________________

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OFFICE POLICY

Welcome to my office. I find that communication with my patients regarding my office policies assists me in providing the best service. Therefore, I have taken the time to answer some of the most commonly asked questions. If you have more questions, please feel free to ask.

Payment for Sessions: Payment is required at the time services are rendered. Any other services you ask me to provide (such as report or letter writing) will be charged at the same hourly session rate, unless otherwise indicated. I do not bill insurance companies. I will provide you with a receipt that can be submitted to your insurance company; the insurance company should then reimburse you directly for services that are covered. I suggest you contact your insurance company to determine what is covered. Please note that you are responsible for the entire payment regardless of the amount the insurance company pays. For those in more extended treatment, I reserve the right to periodically adjust this fee.

Accounts are considered delinquent after two sessions are unpaid. At this point, if payment arrangements have not been made, routine appointments will cease until the situation is addressed. If you are having financial troubles that may affect your ability to pay for therapy, please let me know so that it is possible to make arrangements. Non-therapeutic information may be disclosed to collect unpaid treatment fees. I will attempt to contact you directly for payment; however, if your account remains delinquent, I may utilize the services of an outside collection agency, retain an attorney, or small claims court action may be taken.

Cancellation Policy: A scheduled appointment means that time is reserved only for you. If you are unable to keep an appointment you have scheduled, I need 48 hours notice to allow another patient to use the time that has been set aside for your visit. *Failure to inform me of your cancellation 48 hours in advance will result in a charge to you for the full time set aside for your visit.* Please note that insurance companies typically do not reimburse for missed/cancelled sessions.

General Phone Accessibility & Phone Consultations: There will always be a therapist or confidential voicemail system to take your message. Your message will typically be returned within 24 hours. If you leave a message after 5PM, your call will usually be returned the next business day. If you leave a message on the weekend, your call will be returned on the following Monday or on the next business day. I'll return your urgent message as soon as possible. Please note that I will likely return your call by cell phone. On your message, please leave your name, message, and phone number.

If you need a lengthier telephone consultation, past 10 minutes, you'll be charged a prorated fee based on your 50-minute session fee. At your request and with your written authorization, I may communicate with people other than you. If any of these calls exceed 10 minutes, you will be billed on a prorated fee based on your 50-minute session fee. Insurance companies will not be billed for telephone time.

If I am out of town or on vacation, there will always be someone covering for me. I will notify you of the name and phone number of the covering therapist before leaving town (typically at our previous session); this information will also be on my voicemail message.

If you choose to email me, please be aware that in this age of ever-expanding technology, no guarantees can be made about the absolute privacy of this communication.

Please turn the page over…

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Emergency Treatment: If you have a life-threatening emergency, please call 911 or go to the nearest emergency room. I am not able to provide immediate or 24-hour availability.

Confidentiality: Sessions between a psychologist and patient are strictly confidential, except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances: suspicion of child/elder abuse or otherwise dependent individuals, if I believe that you present a danger to yourself or others, if a credible third person communicates that you represent a serious threat of bodily injury to others; when court ordered to release information, to collect unpaid balances on your account (identifying and balance information will be given, not information about the therapy sessions themselves) or when disclosure is otherwise required by law.

In the event of my death or incapacitation, a professional colleague will have access to your personal file in order to notify you and help arrange for continued mental health care.

Consultation: I often consult with other professionals. In such cases, neither your name nor any identifying information about you will be revealed.

Litigation Charges: If I am required to attend a deposition, hearing or other legal proceeding in the capacity as your current or past therapist, you will be billed at $400 per hour for my time, including preparation, telephone time, and travel time as well as the time I spend at the legal proceeding.

Treatment &Termination: After the first few meetings, I will assess if the type of therapy I provide can benefit you. If I feel I cannot help you, I will give you several referrals that you can contact. At any point during therapy, if I feel I can not be effective in helping you reach the therapeutic goals, I will discuss this with you and, if appropriate, terminate treatment and provide you with qualified referrals. Termination will also be considered if: you fail to comply with my treatment recommendations, a conflict of interest develops, you fail to pay my fee on a timely basis, or you or I believe it is in your best interest.

Risks & Benefits: Therapy can cause initial distress – especially as the patient encounters situations or thoughts/feelings that have been avoided due to the discomfort they cause. This can cause a corresponding disruption in functioning. However, with repeated work on these anxiety-provoking triggers, typically overall anxiety is reduced or eliminated. I will continue with therapy if I believe I can be effective in helping you reach your treatment goals. However, please be aware that therapeutic outcomes vary and there are no guarantees regarding outcome.

Duration of Treatment and Associated Cost: Duration of treatment, and associated cost, is extremely variable. Typically, this depends on the severity of symptoms/degree of functional impairment at the outset of treatment, how much support a person requires to engage in the treatment plan, if the person takes large or small steps toward feared/avoided situations, and how motivated a person is to pursue treatment goals. Because payment is made at the time of each session, there are never mounting costs leading to one large bill that can take someone by surprise.

I have read and fully understand the above information. I understand that I will be responsible for the full fee if I do not cancel appointments 48 hours in advance. I have been given the opportunity to clarify any questions and have received a copy of this office policy.

Signature________________________________ Date_______________

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Acknowledgement of Receipt of Notice of Privacy Practices

Client's Name:____________________________ Date of Birth:______________

Parent/Guardian's Name (if client is a minor): _____________________________

By signing below, I hereby acknowledge receipt of Dr. Denise Nelson's Notice of Privacy Practices.

_________________________________ _________________

Signature of Client (or Parent/Guardian) Date

____

Name (printed)

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CONSENT FOR TELEHEALTH SERVICES

I understand that telehealth services (video conferencing or phone) are not the same as a direct client/health care provider visit. Due to the fact that we are unable to be in the same room, non-verbal communication can be missed and the interaction can feel more artificial than in person.

Potential benefits: Easier assess to care. Convenience and eliminates commuting time.

Potential risks: Interruptions, unauthorized access, and technical difficulties.

My health care provider or I can discontinue telehealth visits if it is felt that this format is not adequate for the situation.

To maximize benefits and minimize risks, I agree to:

1. Be prepared to have the telehealth session in a quiet, private space where I feel comfortable speaking freely and where I will not be interrupted.
2. Have a back-up device available (e.g., phone in the case of video conference) or landline phone (e.g., if a cell phone is primarily used).
3. Use a secure internet connection – rather than a public/free Wi-Fi.
4. Confirm with my insurance company that telehealth sessions will be reimbursed; if they are not reimbursed, I am responsible for the full payment.

I have had an opportunity to ask my provider about any questions I have about using telehealth.

By signing below, I am indicating that I have read, understood, and agree to the information contained in this document.

_______________________________ _______________________

Signature Date