San Antonio Gifted and Talented
Shawn McKown, Psy.D.
Licensed Psychologist
P.O. Box 1452
Boerne, TX 78006
(210) 833-4788 info@sanantoniogt.com

CHILD AND FAMILY INFORMATION ASSESSMENT FORM

I. Identifying Information

Child's name: _____ Referred by: _____

Person completing this form: _____ Relationship to patient: _____

Home Address: _____

Home Phone#: _____ Work#: _____

Cell Phone#: _____ Email Address:_____

Child's date of birth: _____Age: ____ Sex: ____ Child's ethnic identification: _____

Mother's name: _____Father's name: _____
Stepparent's name (if applicable): _____

II. Reasons for Evaluation/Treatment

Please list the problems, concerns, or questions for which you want help for your child. Also, please specify when the problems were first noticed. Use back of form if needed.

1. _____When:_____
2. _____When:_____
3. _____When:_____

Please list anything you did to try to improve the problem.

_____
_____

Please describe any previous mental health treatment (including inpatient hospitalization) for your child, as well as your evaluation of the effectiveness of this treatment.

_____
_____

Has your child ever received formal psychological or academic testing? If so, please provide details (when, by whom, for what reason) and bring a copy of the report to your next session.

_____
_____

Please list any medications your child is currently taking:
_____
_____
_____

How do you hope that I may be able to help you and your child?
_____
_____
_____

III. Family/Environmental Factors

Please list members of the household with whom the child is currently living:

Name	Age	Relationship to child	How long (dates)

Are the child's biological parents: _____ Married _____ Divorced ____ Separated

If biological parents are divorced, who has legal custody? _____

Does the child visit the non-custodial parent? _____ If so, how often? _____

Who cared for the child during the first two years? _____

Describe any changes in your child's caretakers over the years. _____
_____

Was English the child's first language? Yes/No If not, what was the language and when did the child learn to speak English? _____

Did the child attend childcare? Yes/No If so, at what age? _____

Did the child attend preschool? Yes/No If so, at what age? _____

Who is currently involved in child's care? Mother Father Stepparent(s) other

If other, who? _____

What forms of discipline do you use? _____

Who usually disciplines the child? _____

Do both parents usually agree on the discipline? Yes/No If no, please elaborate:
_____
_____
_____

Is mother employed outside the home? Yes/No If so, where? _____
How many hours spent at work? _____

Is father employed outside the home? Yes/No If so, where?_____
How many hours spent at work? _____

Mother's occupation and education level: _____

Father's occupation and education level: _____

Who watches your child after school hours? _____

Does the child play outside in the neighborhood? _____

What activities does your child enjoy? _____

What kind of household responsibilities does your child have? _____
_____

Does child do them willingly? Yes/No Without prompting? Yes/No

What kind of activities do you do together as a family? _____
_____

Please list any significant stresses or family problems since your child has been born (e.g., moves, conflicts, family violence, deaths, financial problems, marital discord)
_____
_____

IV. Family History

Does anyone in the family have any of the following: (check all that apply, past or present)

Condition	Mother	Father	Sibling	Mother's Family	Father's Family
Learning problems					
Attention problems +/hyperactivity					
Mental Retardation					
Autism					
Aggressive or violent					
Depression or Suicide					
Anxiety Disorder/Panic attacks					
Manic depression /Bipolar disorder					
Psychiatric problems					
Psychosis or schizophrenia					
Obsessive-compulsive disorder					
Alcohol or drug abuse					
Legal problems (arrested; delinquency)					
Physical abuse					
Sexual abuse					
Behavior problems as child or teen					
Neurological problems					
Chronic medical illness					

V. Child's Educational History

School attending: _____Grade placement: _____
School Address:_____
City: _____ State: ____ Zip code: _____ Telephone: _____
School teacher's name: _____

Has your child ever been in special education? ____ If yes, please list years and services received.
_____
_____

Has your child ever been suspended or expelled from school? _____ If yes, please explain.
_____
_____

Has your child ever been retained or advanced in a grade? _____ If yes, please explain.
_____
_____

Please use this space to elaborate on school-related concerns:
_____
_____
_____
_____
_____
_____

Please check the column that best describes your child's school functioning:

Grade	Unable to pay attention, stay on task, or complete assignment	Problems with learning, low or failing grades	Problems with behavior at school
Preschool			
Kindergarten			
First			
Second			
Third			
Fourth			
Fifth			
Sixth			
Seventh-Ninth			
Tenth-Twelfth			

VI. Developmental History

Prenatal History

Were there any significant problems in the pregnancy? Yes/No If yes, please specify:_____
_____

Was alcohol consumed during pregnancy? Yes/No If so, how often and how much? _____
_____

What medications and/or street drugs were used during the pregnancy? _____
_____

Length of pregnancy: _____ Length of labor & delivery :_____

Medications during labor & delivery: _____

Were there any complications in the labor & delivery? Yes/No If yes, please specify:_____
_____

Neonatal History:

Baby's Apgar Score (if known): _____ Baby's Birthweight: _____
Were there any significant problems for the child at birth or in the newborn phase? Yes/No
If yes, specify:_____

_____
_____

Infancy (0 to 12 months):

Circle any significant problems, delays and/or difficulties your child had in the first year:

Feeding Sleeping Breathing Bowel and/or Urinary habits
Colic Inability to be consoled Sitting unassisted Crawling
Intolerance of affection Emotional responsiveness
Other: _____

Toddler (12 to 36 months):

Circle any significant problems, delays and/or difficulties your child experienced during this time:

Walking unassisted Feeding self First words
Using sentences Severe temper tantrums Over-activity
Entertaining self Stranger anxiety Other:_____

Childhood (3 to 11 years)

Circle any significant problems, delays and/or difficulties your child has displayed during this time:

Impulsive	Very shy	Aggressive
Nervous/fearful	Completing tasks/chores	Over-activity
Short attention span	Severe temper tantrums	Uncoordinated
Bowel/urinary habits	Obeying others	Math skills
Reading skills	Writing skills	Peer Relations
Destroying property	Prolonged sadness or irritability	Academic failure

Other: _____

Adolescence (12 to 18 years)

Circle any significant problems, delays and/or difficulties you child has displayed during this time:

Prolonged sadness or irritability	Delinquency	Truancy
Aggressive	"Gang" membership	Impulsive
Academic failure	Social isolation	Pregnancy
Sexually active	Running away	Fighting
Drug/Alcohol use	Temper outbursts	

Allergies:

List all of your child's allergies. Please be sure to include medication allergies: _____

_____

Medical problems:

List all past and present medical problems as well as any surgery or accidents, also give age when they occurred: _____

_____

Hospitalizations (please list reason for the hospitalization, the place & date):

Medical _____

_____

Psychiatric_____

Please use the following space for any other information you may want Dr. McKown to know about your child or your situation prior to being seen:

_____

_____

What are your goals for your child's treatment here?_____

_____

_____

Parent signature:_____ Date: ____/____/_____

Therapist's signature: _____ Date: ____/____/_____

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OFFICE POLICIES AND PROCEDURES

Below are listed some important facts related to treatment. Please read this carefully and feel free to ask any questions. Please keep this information for your records.

Session Duration: Therapy sessions are generally 45-50 minutes. If you are late for a session, the time will be lost in that session. Arrangements can be made to schedule longer sessions when they are appropriate for your needs. Testing sessions may be two hours or longer, depending on the child. Multiple sessions may need to be scheduled in order to complete all testing.
Scheduling Policy: Appointments can be made by calling Dr. McKown at 210-833-4788. Please note, Dr. McKown's schedule fills up quickly. In order to avoid unexpected gaps between sessions, I will be happy to schedule several appointments ahead for you if you wish. Please note the cancellation policy below, however.
Cancellation/No-Show Policy: If you need to cancel or reschedule an appointment, please notify me as soon as possible, at 210-833-4788. Do not use e-mail to make or cancel appointments.
Appointments that are not kept (no-shows) or which are cancelled without 24 hour notification will be billed at a rate of $50. If you no-show for two consecutive appointments, I reserve the right to cancel any additional scheduled sessions and you must contact me to make arrangements to bring your account current before additional sessions can be scheduled.
Office Hours: Sessions are scheduled by appointment only. If you need to reach me between regularly scheduled appointments, you can leave a message at 210-833-4788. Please note that I am not available for extended telephone consultation. In addition, I may be unable to return your call the same day that I receive it.
Emergency/On-call Services: Please note that Dr. McKown provides non-emergency face-to-face psychological services by scheduled appointment. If the situation warrants immediate medical attention, please dial 911 or proceed directly to an emergency room. If you believe that you will need frequent emergency contact between sessions, please discuss this with me immediately so that I may refer you to a provider more able to serve your needs.
Confidentiality: All information and records will be kept confidential, and will be held in accordance with state laws regarding the confidentiality of such records and information. Currently, both law and professional ethics require psychologists to maintain complete confidentiality in the vast majority of cases. In these cases, the psychologist cannot release any information about you or your family without your express permission. Records and/or information will be released regardless of consent under the following circumstances:
Limits to Confidentiality:
If the therapist has reason to believe that a health care professional has engaged in professional misconduct;
If the patient introduces his or her mental condition as a defense in a legal proceeding;
If the patient/family initiates legal action against the therapist;
If a judge orders the therapist to release patient information related to legal proceedings;
According to state and local laws, therapists must report all cases of suspected physical and sexual abuse or neglect of minors, elderly or handicapped to the appropriate agencies;
According to state and local laws, therapists may report all cases in which there exists a danger to self or others to the appropriate people or agencies.
If your account is delinquent and you have not made appropriate arrangements with me, confidentiality would be breached by giving your name to a collection agency.

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OFFICE POLICIES AND PROCEDURES

Limits to Confidentiality (cont.)
Professionals may consult on a case with another professional without identification of the client whose case is the subject of consultation.
If a child is 16-18 years old, and if treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical, or emotional abuse, the law provides that parents may not access their child's records.

Recordkeeping San Antonio Gifted and Talented provides testing, assessment, education, support and therapy for the gifted and their families. The gifted child or adult will be the identified patient. As such, office records will be kept only on that identified individual. Although families may be seen for therapy, it will be in the context of treating the child and no records will be kept on either parent. Therapy notes will be documented only in the child's file. If a sibling of the identified gifted child is subsequently seen for testing or individual therapy, separate documentation will be initiated and a separate chart maintained.

San Antonio Gifted and Talented and Dr. McKown do not perform child custody evaluations. If you need a referral for this service, I can provide one. No records on either parent will be kept.
When a child is seen for testing and assessment, the parents will receive a copy of the assessment report. They are then free to make this available to whomever they choose: school personnel, physicians, tutors, etc. If the parent chooses to make the report available to others, confidentiality may not be maintained by those entities.
When a release of information consent form is signed as part of a request to have records sent elsewhere, be advised that Dr. McKown does not send or receive records electronically. Records will be sent via USPS. If you provide records to Dr. McKown, please either hand carry them to your next session or ask that they be copied and sent via USPS to the address above.

Most psychological testing performed by Dr. McKown is based on paper and pencil tests which are hand-scored and interpreted; however, some tests require that data be sent electronically to a second party in order to be scored.
Please do not e-mail confidential information to me. Although the e-mail service of San Antonio Gifted and Talented is as secure as any other, there can be no guarantee of privacy prior to my receipt of the message.

I indicate by my signature that I consent to mental health treatment and that I understand and consent to the conditions described above. I also know that I may ask questions at any time.

Signature: _____ Date: _____

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Financial Policy and Payment Arrangements

Payment of fees: Payment is expected at each visit. San Antonio Gifted and Talented is a fee for service clinic. You may pay by cash or check. If you wish to file to your insurance company for reimbursement, I will fill out forms that you provide. The focus of this practice is services to the gifted; few insurance companies will pay for services not associated with a mental health diagnosis. If checks for services do not clear the bank, this office reserves the right to utilize an outside collection agency to collect delinquent accounts.

Cancellation Policy: If you need to cancel an appointment, please notify Dr. McKown by phone as soon as possible. **Do not e-mail with a notice of cancellation. Without at least 24 hours' notice, a missed appointment will be charged to you at $50.** You are responsible for this fee.

A MISSED APPOINTMENT WITHOUT 24 HOUR NOTIFICATION WILL BE CHARGED $50.

Fee Schedule:

Initial Intake (First Session)	$175.00
Individual Psychotherapy	$125.00
Family Therapy	$125.00
Intellectual Assessment	$550.00
With Academic Assessment	$800.00

Assessment includes an initial intake with the child, an initial intake with the child's parents, review of previous records, administration, scoring and interpretation of tests, report writing, a final session with the child and parents to review the results and implications of the assessment and recommendations, and a copy of the report. Depending on the number of tests given and presenting diagnostic questions, the fee may vary somewhat.

I understand that payment in full is made at each session.

I understand that my fee for services will be:_____

My signature below indicates that I have read and agree with the Financial Policy and Payment Arrangements as described above.

_____ _____
Signature Date

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CONSENT FOR TREATMENT OF A MINOR CHILD

CHILD'S NAME:_____

PARENT/GUARDIAN:_____

I, _____, attest that I am the parent or legal guardian of, and I have the legal right to authorize psychological evaluation and/or treatment for, my minor child _____.

I give permission to Dr. Shawn McKown, Licensed Psychologist, and San Antonio Gifted and Talented to provide psychological services to my child. These services may include an initial intake interview, as well as agreed upon evaluation and/or psychotherapy with Dr. McKown, including family therapy.

_____ _____
Signature Date

I (we) have submitted legal documentation of custody arrangements if divorced.

_____ _____
Signature Date

Dr. McKown is a licensed psychologist in the state of Texas. If you wish to file a complaint with the licensing board, contact:
Texas State Board of Examiners of Psychologists
333 Guadalupe
Tower 2 Room 450
Austin, TX 78701
1-(800)-821-3205

TEXAS NOTICE FORM (HIPAA)

Notice of Psychologist's 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 office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"*Disclosure*" applies to activities outside of my office, 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 Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
Health Oversight: If a complaint is filed against me with the Texas State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, 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**.**

Serious Threat to Health or Safety: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

Worker's Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

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 make available a revised copy in the office and provide you with a copy upon request.

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, you may contact the Texas State Board of Examiners of Psychologists at 512-305-7400. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date: This notice will go into effect immediately.

_____ _____

Signature Date