Salvatore Barba, Ph.D.
Center for Complementary Medicine, Inc.
Seattle Office: 206-525-0750
cell: 360-929-5850

Patient's Name:		**Date of Birth:**
Mailing Address:		
Home Phone:	**Work Phone:**	**Social Security #:**
Marital Status: Single	Married Other	
If Patient is a minor child, parent's name:	Date of Birth:	**Social Security #:**
Does Patient have any allergies: Yes/No	If yes, please list	
Name of Employer/SCHOOL	**Address:**	**Business Phone:**
Primary Insurance Company Name:	**Address:**	**Phone:**
Subscriber's Name:	**Subscriber's ID #: (all letters and #s)**	**Subscriber's Date of Birth:**
Yearly Mental Health Benefit Limit:	$	# of sessions:
Set Copay Amount:	Deductible Amount:	Met for current year: Yes/No
Is authorization or referral required:		
Secondary Insurance Company Name:	**Address:**	**Phone:**
Subscriber's Name:	**Subscriber's ID #: (all letters and #s)**	**Subscriber's Date of Birth:**
Yearly Mental Health Benefit Limit:	$	# of sessions:
Set Copay Amount:	Deductible Amount:	Met for current year: Yes/No
Is authorization or referral required:		
Name of Person responsible for this account:		
Name of friend/relative not living with you:	Relationship to patient:	Phone:

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage including all copays and deductibles.

Patient, Parent, or Guardian's Signature: _____ Date: _____

FINANCIAL AGREEMENT POLICY

Consultation and therapy hours are by appointment only. The standard fee for each 50-minute therapy appointment is **$150.00**. Marital and family therapy are rated at $300.00 for a 50- minute therapy appointment. Initial evaluation appointments are set at $300.00 for a full hour.

We suggest that you contact your insurance company directly to clarify whether your insurance policy covers mental health services for your specific diagnosis, and if they require preauthorization or a referral by your primary care physician. It is important that you obtain information regarding your deductible as well as annual capitations on treatment. We will be happy to provide you with an insurance receipt (Super Bill) if needed to obtain reimbursement. However, please understand that you are solely responsible for knowing what your insurance benefits are so that you are not taken by surprise regarding uncovered services! **As the client, you are responsible for all professional fees that you incur**.

Dr. Barba is a preferred provider for several insurance companies, including Regence, and Premera Blue Cross, and Group Health Cooperative (GHC in Island County only). We will bill these insurance companies directly, and will honor your insurance company's contracted fees as indicated on the insurance EOB. Clients without insurance coverage for services rendered or with insurance co-pays and who have not yet met their deductible must remit all payments on the day of the appointment before the hour begins. **Please Note: All fees not covered by insurance must be paid on the day of the appointment before the hour begins!**

You are responsible for any extra charges for other services that are not covered by your insurance. This includes professional consultations with other health care professionals regarding your care, requested evaluation reports to agencies or other providers requested by you, as well as non-covered procedures and services. Telephone consultations exceeding 5-minutes are billed to you. You will be billed the standard hourly rate at $150.00. For reports that you request to be sent to your legal advisors or any services that require written preparation and my participation are set at $150.00 an hour with additional fees for court attendance.

Please note that we require 24 hours advanced notice if you must cancel and reschedule an appointment, or you will be charged in full for your scheduled appointment. Insurance companies will not pay for missed appointments. Missed or cancelled appointments are solely your responsibility.

I understand the above policy and agree to comply. I understand that I am responsible for charges associated with treatment and interventions related to my care, and missed appointments. I agree to pay my bills within thirty days from receipt of statement, unless other arrangements are made. I understand that bills unpaid beyond sixty-(60)-days accrue interest at a rate of 1% monthly (with a minimum billing charge of $5.00 monthly). I authorize Dr. Barba and ICCM to release information required to process my insurance claims. I further authorize my insurance benefits to be paid directly to Dr. Barba and ICCM.

Signature of Client
(Parent and or Guardian, if not an adult)

Date

Salvatore Barba, Ph.D.
Center for Complementary Medicine, Inc.

Seattle
360-929-5850
Oak Harbor
360.360-929-5850
Langley
360.221.7525

Notice of Mental Health Professional'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*" (formerly called a release of information) 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 reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the Washington Department of Social and Health Services. If I have reason to suspect that sexual or physical assault has occurred, I must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

- **Health Oversight:** If the Washington Department of Health subpoenas me as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state licensed mental health counselors, I must comply with its orders. This could include disclosing your relevant mental health information.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law. I will not release information without the written authorization from you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

- **Worker's Compensation:** With certain exceptions, if you file a worker's compensation claim, I must make available, at any stage of the proceedings, all mental health information in my possession relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

IV. Client's Rights and Psychotherapist's Duties

Client'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.

Psychotherapist'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 either send a revised notice to you in the mail or provide a copy for you during our next meeting.

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 Washington State Licensing Board.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

The contact information for these agencies is easily found online, and we can also supply it for you at your request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice has been in effect since April 14, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If this happens we will provide you with a revised notice by mail or during our next meeting.

Signature

I have read and understood the privacy policies described in the documents: "Notice of Mental Health Professional's Policies and Practices to Protect the Privacy of Your Health Information" and "Notice of Privacy Policies" of the Center for Complementary Medicine.

Signed_____ Dated_____

Relationship to Patient (if applicable)_____

Notice of Privacy Policies
issued 3/12/2014
Center For Complementary Medicine (ICCM, Inc., P.S)
206-525-0750

The information provided below illustrates the manner your protected health information (PHI) could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important.

Legal Responsibilities of provider: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure that you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and will be in effect until it is replaced. We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information (PHI) Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider at The Center for Complementary Medicine providing treatment to you. However, this information will not be provided to a third party, outside of our clinic, unless you have authorized it in writing.

Payment and Billing: Your protected health information may be used and disclosed to third party payers to obtain payment for services we have provided to you. This includes insurance billing, collection of funds in a manner you have authorized, as well as collection procedures for overdue accounts. Once we have been paid in full, we no longer have the authority to disclose you PHI regarding that particular procedure and date of service. Please keep in mind that checks you supply carry your name and address, and that this information is visible to bank employees and processors. Should you choose to pay by check or credit card, we are not responsible for the security of your personal information as it is processed by third parties (such as banks or credit card clearing houses). Should you choose to use these forms of payment, it is at your own discretion and risk. We are only responsible for protecting the information in our possession. If this concerns you, we can accept cash payment for services.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our health- care process. These processes include an assessment, improvement

activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation. Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization or as disclosed later in this document.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person with which you have a close personal relationship and who is involved in your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person access to your PHI.

Required By Law: Your PHI may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we will have to provide the necessary protected health information.

National Security and Disaster relief: Under some circumstances, the government, military, or aid agencies may require disclosure of healthcare information for disaster relief or for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, and disaster relief authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointments: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write send a thank you via first class mail or email to whomever referred you to his/her practice. **Both our office and our online scheduling service will communicate with you regarding**

your appointments with confirmation and reminder emails, unless you request in writing that we arrange appointments by some other means.

Search engines and Programs for making appointments belonging to other entities: Please note that if you choose to use programs available on the web to make appointments with us, provide payment, search for our practice information or communicate with us via contact forms or paperwork that they may supply, that we have no control over the safety and security of these sites and are not responsible for the safety or security of any information that you may supply to them. In addition, please note that the contact form available on our website is not secure. We ask that you not send any information that you desire to be private and protected by way of this form or any other electronic means of communication with us. **PLEASE EXERCISE CAUTION when transmitting data via the internet and email, as these means of communication are not secure. Your choice to do so is at your sole discretion and is not encouraged by us. When desiring secure communication, always contact our clinic directly, by phone or US mail. We will not read or respond to emails that contain information of a clinical or medical nature. You must contact us by phone to arrange to communicate with us regarding concerns of this nature.**

Patient Rights Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in the format that you request, if we are able to. We will be able to fulfill your request by reproducing it for you in the format we have stored it, as long as it has not yet been destroyed. You may direct us to send copies of your protected information to third parties, but you assume the responsibility and risk for doing so, as we no longer have the ability to protect information we have disseminated to a third party or to you. Your request to obtain access to your information must be in writing. You may obtain an authorization to disclose protected health information form by using the contact information at the end of this notice. We may need to charge you a reasonable cost based fee for expenses including copies and staff time. You will be charged the cost of postage if you wish to have your information mailed by first class mail. If you request a different format, we will charge a cost based fee for that format. An explanation of applicable fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we disclose your protected health information for reasons other than treatment, payment, healthcare and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request that we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an exceptions cited in this document dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are

communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Specific Authorization regarding Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications by outside parties is prohibited without your written authorization. By signing below I authorize Center for Complementary Medicine to use my address, phone number, email address, and clinical records to contact me with birthday cards, holiday related cards, newsletters, and information about treatment opportunities and educational information within our clinic. You can opt out of these communications by supplying your notice to this effect in written form.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Contact for release of your PHI at Center for Complementary Medicine: Please call Deborah Houseworth, President: at 206-525-0750.

Questions and Complaints: If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, Please contact Deborah Houseworth at the Center for Complementary Medicine at 206-525-0750.

You may also make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request. Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

I have read and understood the privacy policies of ICCM, Inc. P.S. that have an issue date of 3/12/14.

Signed_____

Dated_____

Relationship to Patient, if applicable_____

Salvatore Barba, Ph.D. Center for Complementary Medicine, Inc., P.S.
Adult, Adolescent, Marital and Family Counseling and Neurofeedback
Cell Phone: 360-929-5850
Office Phone: 206-525-0750

CLIENT CONSENT TO TREATMENT, FINANCIAL AGREEMENT AND DISCLOSURE STATEMENT

I have read, had the opportunity to ask questions, and understand the Psychotherapist-Client Services Agreement and Disclosure Statement, Financial Agreement and Policy Statement, and Privacy Practices Statement that have been provided to me. I understand and agree to the description of confidentiality and its exceptions as described in these statements.

I understand that I have the responsibility to choose the provider and treatment modality that best meets my needs, and that I have the right to refuse treatment and terminate counseling at any time. I understand the that Salvatore Barba, PhD requests notice of termination at the beginning of a regularly scheduled appointment, so that the reasons for termination may be discussed with respect to my therapeutic issues. I agree to work with Doctor Barba regarding my reasons for seeking his counseling services and I consent to counseling under the terms described in the Psychotherapist-Client Services Agreement and Disclosure Statement.

My signature below indicates that I have received and read copies of the Psychotherapist-Client Services Agreement and Disclosure Statement and Financial Agreement and Policy Statement and that I agree to abide by the stated terms during my professional relationship with Doctor Barba, PhD.

Licensed Mental Health Counselors in Washington state are subject to RCW 18.130.180, regarding acts of unprofessional conduct. Unprofessional conduct can be reported to the Department of Health at HSQAcomplaintintake@DOH.WA.GOV or by calling: 360-236-4700. You can also address any correspondence to :
Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857

_____ _____
CLIENT NAME Date
(Please print clearly)
(For clients under the age of 13, consent must be given, and this form must be signed by a parent or legal guardian)

_____ _____
Parent and or Guardian (Pease Print) Date

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Salvatore Barba, PhD Date

Salvatore Barba, Ph.D., LMHP, BCN

Center for Complementary Medicine, Inc.
4649 Sunnyside Ave N., Suite 344
Seattle 98103

Direct Contact Number: 360-929-5850
Office/ business Number: 206-525-0750

WA state license LH00003885

2366 Eastlake Ave E., Suite 431,
Seattle 98102

220 First St (POB 299), Langley 98260-0299

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT AND DISCLOSURE STATEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA) and information required by Washington state law. HIPAA requires that I provide you with a Notice of Privacy Policies for use and disclosure of PHI for treatment, payment and health care operations. Our Notice of Privacy Policies, included in your intake packet, presents this in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about these procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy may be supplemented by Neurofeedback and Biofeedback interventions, as well as assessments such as QEEG's. These services would be discussed and agreed upon between the psychotherapist and the client with signed consent forms upon agreement to proceed with either of the mentioned interventions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should carefully consider your choice of therapist. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

DOCTOR BARBA'S SCOPE OF TRAINING AND PRACTICE: I received my undergraduate degree in Psychology and Literature at Northeastern University in Chicago Illinois. Form 1978 to 1982 I worked at an inpatient psychiatric facility: Northwestern Institute of Psychiatry, serving children, adolescents and adults. Afterward, I pursued my graduate studies in Clinical Psychology at the Illinois School of Professional Psychology, and was a student in the Clinical Doctorate Program for two years before I relocated to the State of California and completed my Masters and Doctoral degree at the Institute of Transpersonal Psychology with an emphasis in Contemplative and Clinical Psychology. I interned at the International Focusing Institute in Chicago, and completed my residence and dissertation concurrent to attaining my hour requirements in clinical supervision. I received my doctorate in Transpersonal Psychology in 1990. I also worked at an residential facility for adolescents with chemical dependency, providing support to the patients and their families. I have developed clinical experience in a variety of mental health environments, and worked in Behavioral Medicine for many years, further attaining in depth experience in adolescent, adult, marital, family and group therapies. This training included study and practice in experiential psychotherapies, cognitive behavior therapies, mindfulness based therapies, hypnotherapy, and most recently, studies in the neurobiology of the brain, neuroscience and neurotherapy. I have well over 5,000 hours of client contact time in neurotherapy. I specialize in QEEG testing, QEEG guided (evidence based) Neurofeedback, Full Cap (20 Channel) Loreta Neurotherapy, and Z-Score surface training. I practice the Inversion method (Loreta: Low Resolution Brain Electromagnetic Tomography) of Neurotherapy (3-D brain Image). I am nationally board certified in EEG Biofeedback by the Biofeedback Certification Institute of America (BCIA). For 5 years I worked in Behavioral Medicine on the Adolescent Team at Group Health Cooperative. My focus is integrative and collaborative with other healthcare providers. I implement a variety of approaches in my work with adolescents, adults and couples suffering from clinical depression, PTSD, addiction, sleep disorders, anxiety, ADHD, Bi-Polar disorder, and stress related illnesses. I have trained in a variety of areas in Buddhist Psychology, and have offered retreats in this discipline. My work has been published in the International Folio, a journal with an emphasis in Focusing Oriented Psychotherapy. I have also facilitated seminars and retreats with the International Focusing Institute.
My professional licensure is as a Licensed Mental Health Counselor (under 18.225 RCW). I have been in the field of Psychology since 1978. **I am licensed in Washington state as a Licensed Mental Health Counselor with the license number: LH00003885.**

MEETINGS

The initial evaluation and first few sessions, provide both of us with the opportunity to decide if I am the best person to provide the services you need in order to meet your treatment goals. Once psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for missed sessions.**

PROFESSIONAL FEES

The fee for psychotherapy is $150.00 for a 50 minute session, with the initial evaluation (first appointment) costing $300.00. The cost family and marital therapy is: $300.00 for a 50 minute session. In addition to therapy sessions, I charge for other professional services you may need. I will break down the hourly cost if I work for periods of less than or more than one hour. Other services include report writing, telephone conversations lasting 15 minutes or longer, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Fee per hour for attendance at any legal proceeding will be discussed with you upon request for these services. The cost for preparing reports is $150.00 an hour. Neurofeedback, biofeedback, QEEG services and preparing written QEEG reports when requested are fees to be discussed at the time of requesting these services.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 10:00 AM and 6:00 PM, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by an answering system that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are in crisis, you can contact my office; however, in the case of an emergency, please call 911. (An emergency constitutes a life-threatening situation or situation in which you feel you or someone else are in danger--including a perceived or clear intent to harm yourself or others). Please have the emergency service or mental health professional follow-up with a call to my office to inform me of your situation.

Please remember that communication by email is not secure. Please do not send me emails with any information that you expect to be private and protected. I will not read emails with concerns of

a therapeutic nature. You must contact me by phone to discuss these issues and make an appointment.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychotherapist. The privacy policies in your intake packet discuss these issues in detail--please read them thoroughly. What follows is only a summary of some of the salient points.

In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA. With your signature on a proper Authorization form, I may disclose information in the following situations:

- I may occasionally consult other health and mental health professionals about your case. If I consult with a professional who is or is not involved in your treatment, I will discuss the use of a consult, and request an authorization from you in order to discuss your clinical issues. These professionals are legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information).

- Disclosures required by health insurers to process insurance claims or by my office to collect overdue fees.

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the therapist-client privilege law. I cannot provide any information without your written authorization or that of your legal representative. However, if I am served with a court order or subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, or a court order, the privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

There are some additional situations where I am permitted or required to disclose information without either your consent or Authorization:

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

- If a client files a worker's compensation claim, and the services I am providing are relevant to the injury for which the claim was made, I must, upon appropriate request, provide a copy of the client's record to the client's employer and the Department of Labor and Industries.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have reasonable cause to believe that a child has suffered abuse or neglect, the law requires that I file a report with the appropriate government agency, usually the Department of Social and Health Services. Once such a report is filed, I may be required to provide additional information.

- If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate government agency, usually the Department of Social and Health Services. Once such a report is filed, I may be required to provide additional information.

- If I reasonably believe that there is an imminent danger to the health or safety of the client or any other individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the client, or contacting family members or others who can help provide protection.
-

If such a situation arises, I will make every effort to discuss it fully with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You may examine and/or

receive a copy of your Clinical Record, if you request it in writing, except in 1) the unusual circumstance that I conclude disclosure could reasonably be expected to cause danger to the life or safety of the client or any other individual or 2) that disclosure could reasonably be expected to lead to the client's identification of the person who provided information to the me in confidence under circumstances where confidentiality is appropriate, Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee and clerical fees per Washington state law. I may withhold your Record until the fees are paid. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
In addition, I also keep a set of psychotherapy notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record. These psychotherapy notes are kept separate from your clinical record. While insurance companies can request and receive a copy of your clinical record, they cannot receive a copy of your psychotherapy notes without your signed, written authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your psychotherapy notes unless I determine that 1) knowledge of the health care information would be injurious to your health or the health of another person, or 2) could reasonably be expected to lead to your identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate, or 3) they contain information that was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes, or is otherwise prohibited by law.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Since privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is usually my policy to request an

agreement from the parents that they consent to give up access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else. In either case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. (In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.)
If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, its costs will be included in the claim.) In order to make an appointment your account must not be delinquent.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.
You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions.
You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as

treatment plans or summaries, reports that may include elements from our sessions together, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

Psychotherapist-Client Services Agreement and Disclosure Signature Statement

My signature below states that I have received and read the information stated in Doctor Sal Barba's Psychotherapist-Client Services Agreement and Disclosure Statement and that I understand the content of this document, as well as the terms that are outlined in it. My signature attests that I understand its content, and agree to abide by its terms during my professional relationship with him.

_____, _____.

Client Signature Date

_____, _____

Signature of parent or guardian (if patient is a minor) Date

Rev. 3/2014: Psychotherapist-Client Services Agreement and Disclosure Signature Statement Form.

MEDICAL DEVELOPMENTAL QUESTIONNAIRE

Today's Date _____ Completed By: _____
Youth's Name _____ Sex: M____ F____
Date of Birth _____ Age: _____ Adopted: Yes____ No____
Household Address _____
_____
Home Phone _____
Work Phones (Mom) _____ (Dad) _____ (Teen) _____

Parent Address (if different) Phone: _____
_____
_____

Youth's Physician/Clinic _____
Address: _____
_____
Phone Number: _____

FAMILY INFORMATION:

	Living in Household	Date of Birth	Ethnic Origin	Religion	Education	Occupation
BIOLOGICAL MOTHER FULL NAME: _____	Yes__ No__	_____	_____	_____	_____	_____
BIOLOGICAL FATHER FULL NAME: _____	Yes__ No__	_____	_____	_____	_____	_____
SIBLING FULL NAME: _____	Yes__ No__	_____	_____	_____	_____	_____
SIBLING FULL NAME: _____	Yes__ No__	_____	_____	_____	_____	_____
SIBLING FULL NAME: _____	Yes__ No__	_____	_____	_____	_____	_____

Please list anyone else currently living in your household (include name, age, sex, and relationship to teen):

_____
_____

Parents: Single Yes ___ No ___ Deceased Yes ___ No ___
Separated Yes ___ No ___ Divorced Yes ___ No ___
* If yes, custody arrangements _____
Remarried Mother Yes___ No____ Father Yes___ No___
* Step-parent's name (if not in household)
_____

Describe your main concerns regarding your adolescent: _____

_____

_____

_____

_____

Has there been prior evaluations or treatment: Yes _____ No _____

If yes, please explain _____

_____

_____

FAMILY HEALTH HISTORY: Blood relations

(include yourself, your siblings and your parents)

Mother: Age now ____ or at death ____ Number of Brothers _____ Number of Sisters _____

Father: Age now ____ or at death ____ Number of Brothers _____ Number of Sisters _____

Has any family member had: (indicate paternal with P, maternal with M, e.g.: P uncle, M uncle, etc.)

	Who		Who
ADD/ADHD	_____	High Blood Pressure	_____
Alcoholism	_____	High Cholesterol	_____
Anemia	_____	HIV/AIDS	_____
Bedwetting	_____	Learning Disabilities	_____
Birth Defects	_____	Mental Illness	_____
Breast Cancer	_____	Neurological Problems	_____
Cancer	_____	Seizure Disorder	_____
Depression	_____	Sickle Cell	_____
Developmental Delay/ Mental Retardation	_____	STD (sexually transmitted diseases)	_____
Diabetes	_____	Stroke	_____
Drug Problem	_____	Suicide	_____
Eating Disorders	_____	Thyroid Problems	_____
Headaches	_____	Tics	_____
Heart Attack	_____	Tourettes	_____
age _____		Tuberculosis	_____
Hepatitis	_____	Other Illnesses	(please describe)

_____

_____

PRENATAL HISTORY:

Was there difficulty in conception? Yes ____ No ____

Mother was under a doctor's care during pregnancy? Yes ____ No ____

While pregnant, did the mother have: ( ) Anema ( ) Elevated Blood Pressure ( ) Toxemia ( ) Swollen Ankles ( ) Kidney Diseases ( ) Heart Disease ( ) Bleeding ( ) Measles ( ) German Measles ( ) Flu ( ) Other Virus ( ) Vomiting ( ) Injury ( ) Infection ( ) Medication ( ) Emotional Problems ( ) Threatened Miscarriage or Early Contractions ( ) Other Illness ( ) Any Alcohol, Drug, Caffeine, or Nicotine Intake ( ) Previous Miscarriage

Please describe _____

_____

_____

Other problems encountered in pregnancy? Yes ____ No ____
Explain _____
Were there medications taken during pregnancy? Yes ____ No ____
If yes, what medications? _____

ADOLESCENT PERINATAL HISTORY:
How many hours from first contractions to birth? _____

Where was the baby delivered? Home _____ Hospital _____
Birthing Center _____ Other _____

Was natural childbirth used? Yes ____ No ____

Was the mother under anesthesia during childbirth? Yes ____ No ____

Was the labor induced? Yes ____ No ____
Was induced labor planned? Yes ____ No ____

What type of delivery was used? Vaginal _____ C-section _____

Who delivered the baby? Doctor _____ Midwife _____ Other _____

Is the patient a twin? Yes ____ No ____
Who was born first? _____

Did the baby have breathing problems? Yes ____ No ____

Did the baby have a cord around the neck? Yes ____ No ____

Was the baby's cry delayed? Yes ____ No ____

Was the baby's color abnormal? Yes ____ No ____

Was oxygen used for the baby? Yes ____ No ____

Was the baby premature? Yes ____ No ____
How many weeks: _____

What was the baby's birth weight? _____ lbs _____ ozs

What was the apgar score? _____

What problems did the mother experience at delivery or just afterward? _____
_____

What problems did the baby have after birth? _____
_____

When did the baby leave the nursery? _____

Was the baby normally active? Yes ____ No ____

ADOLESCENT DEVELOPMENTAL HISTORY:

If you can't recall exact age, then in comparison to siblings or other children, indicate whether skills developed early, normal, or late.

WHEN DID

the baby turn over? _____ Early _____ Normal _____ Late _____

the baby sit alone if placed in this position? _____
Early _____ Normal _____ Late _____

the baby get to a sitting position unaided? _____
Early _____ Normal _____ Late _____

the baby crawl? _____ Early _____ Normal _____ Late _____

the child stand? _____ Early _____ Normal _____ Late _____

the child walk? _____ Early _____ Normal _____ Late _____

Did he/she walk on his/her toes to a conspicuous degree? Yes ____ No ____
Does he/she still do this? Yes ____ No ____

What other walking or running problems have been present? _____
_____

WHEN DID

the child feed himself? Early _____ Normal _____ Late _____
with their fingers Early _____ Normal _____ Late _____
with utensils Early _____ Normal _____ Late _____

they drink from a cup? Early _____ Normal _____ Late _____

he/she learn to undress Early _____ Normal _____ Late _____
put on outer garments Early _____ Normal _____ Late _____
manage buttons Early _____ Normal _____ Late _____
zip zippers Early _____ Normal _____ Late _____
lace laces Early _____ Normal _____ Late _____
tie shoes Early _____ Normal _____ Late _____

When was the child toilet trained?

Bladder day _____ Early _____ Normal _____ Late _____
Bladder night _____ Early _____ Normal _____ Late _____
Bowel day _____ Early _____ Normal _____ Late _____
Bowel night _____ Early _____ Normal _____ Late _____

What difficulties were encountered in these areas of training?

_____
_____

Is your adolescent Right handed _____ Left handed _____ Both _____

When did your child

use single words _____ Early _____ Normal _____ Late _____

phrases _____ Early _____ Normal _____ Late _____

sentences _____ Early _____ Normal _____ Late _____

How clear or well formed was speech as a child? _____

How clear and well utilized is speech now? _____

PAST MEDICAL HISTORY OF ADOLESCENT:

Did the baby have colic? Yes ____ No ____

Were feeding problems encountered in the past? Yes ____ No ____

If yes, what _____

Are there eating difficulties? Yes ____ No ____

If yes, explain _____

_____

Did the adolescent have: (check those that apply and note age)

ADD/AHD	_____	Hypoglycemia	_____
Alcohol Problems	_____	Lead Poisoning	_____
Anemia	_____	Learning Disabilities	_____
Arthritis	_____	Measles	_____
Asthma	_____	Meningitis	_____
Bed Wetting	_____	Mumps	_____
Blood Transfusion	_____	Overdose	_____
Cancer	_____	Pneumonia	_____
Constipation	_____	Poisoning	_____
Depression	_____	Polio	_____
Diabetes	_____	Psychiatric Problem	_____
Diphtheria	_____	Rheumatic Fever	_____
Drug Problems	_____	Scarlet Fever	_____
Ear Infections	_____	Seizures/Epilepsy	_____
Encephalitis	_____	Syphillis	_____
German Measles	_____	Thyroid	_____
Head Injuries	_____	Tics	_____
Heart Disease	_____	Tourettes	_____
Hepatitis	_____	Tuberculosis	_____
Herpes	_____	Urinary or Kidney	_____
High Fever	_____	Whooping Cough	_____

Other _____

_____

Are there any allergies? Yes ____ No ____

If yes, please list: _____

How did the adolescent sleep as a child? _____

How do they sleep now? _____

_____

Does hearing seem adequate by the parents' standards? Yes ___ No ___

Has anyone else questioned the adolescent's hearing ability? _____
If yes, who and how: _____

Has the adolescent worn glasses? Yes ___ No ___
Have there been any eye problems? Yes ___ No ___
Are there any eye problems now? Yes ___ No ___

Has the adolescent taken any medicine longer than 3 weeks? _____
If yes, for what and what were the results? _____

Has the patient shown any unusual reaction to medication? _____
e.g., has the child been excited by medications which would normally be sedative in nature?
If yes, explain _____

What other physical complaints does the adolescent have?

What neurologic complaints are present? _____
headaches _____, vomiting _____, poor balance _____, numbness _____
double vision _____, dizziness _____, weakness _____, other _____

ADOLESCENT PSYCHOSOCIAL HISTORY:

What difficulty do parents have in managing the adolescent now?

In the past? _____

Does the adolescent demonstrate any problems in relating to his or her siblings, now? _____

In the past? _____

Has the adolescent ever lived outside the home? Yes ___ No ___
Foster Care _____, other family members _____, friends _____,
With whom and when? _____

Has there ever been CPS (Child Protective Services) or FRS (Family Reconciliation Services) intervention in the home? _____
If yes, please explain _____

What problems does the teen have in relating to and playing with peers, now? _____

In the past? _____

Peer's parents' complaints have been: _____

Does the adolescent demonstrate poor anger control? Yes ____ No ____
If yes, explain _____

What makes him/her angry? _____

What does the teen enjoy doing the most? _____

What is his/her capability in varied leisure activities involving gross motor control? e.g, sports, running, etc. _____

What is his/her capability in leisure activities requiring fine motor control? e.g., drawing, models, etc. _____

Is attention span short? Yes ____ No ____
If yes, describe _____

Does he/she seem unduly impulsive? Yes ____ No ____
If yes, describe: _____

Does he/she lack self-control? Yes ____ No ____
How? _____

When? _____

Is he/she overly active? Yes ____ No ____
If yes, describe: _____

Does he/she react out of proportion when faced with problems? _____
Explain: _____

PARENT/TEEN DRUG/ALCOHOL AND BEHAVIORAL HISTORY:

How often have you thought that your son/daughter has come home intoxicated or stoned?

Has your adolescent made any significant changes in his/her peer groups that you have noticed? Yes ___ No ___
If yes, when

Has your adolescent been missing school?
If yes, explain Yes ___ No ___

Have you and your teen had more arguments/disagreements lately? Yes ___ No ___
If yes, explain

Has your adolescent withdrawn from school, sport, work, club, or fun activities in which she/he was once active? Yes ___ No ___
If yes, describe:

Is your teen spending more time at home in his/her room than usual? Yes ___ No ___
or spending more time away from home than before? Yes ___ No ___
If yes, describe:

Have you ever found any drug paraphenalia or alcohol amongst your teen's belongings? Yes ___ No ___
If yes, what?

Is your teen spending more money with little to show for it? Yes ___ No ___

Have you found that any money, jewelry, alcohol or other household items have been missing? Yes ___ No ___
If yes, explain:

Do you think that your teen is caring for herself/himself less than before in terms of dress or health? Yes ___ No ___
If yes, describe:

Has your teen had any legal problems? Yes ___ No ___
If yes, describe:

If there any family history of alcohol or drug use? Yes ___ No ___
If yes, explain:

EDUCATIONAL HISTORY:

Current School _____ Grade _____

Address _____

_____

Principal/Director/Counselor _____

Ever repeated a grade? Yes _____ No _____ Which? _____

Special Classes Yes _____ No _____ Which? _____

Learning Disability Yes _____ No _____ If yes, please specify _____

_____

Testing/Assessment other than routine Yes ____ No ____

If yes, please provide a copy of the results and/or reports

Did the child go to preschool? Yes ____ No ____

If yes, how many years? _____

Were there any problems encountered in preschool? Yes ____ No ____

If yes, describe: _____

_____

Were their problems noted in grade school? Yes ____ No ____

If yes, describe: _____

_____

Does he/she have difficulty with handwriting? Yes ____ No ____

If yes, describe: _____

_____

Did/do other parents or teachers complain about your child's behavior? Yes ____ No ____

If yes, explain: _____

_____

Prior school evaluations or special interventions? Yes ____ No ____

If yes, explain: _____

_____

Has he/she seen the school psychologist or other special educational personnel?

Yes ____ No ____

If yes, explain: _____

_____

How does the adolescent react to going to school, now? _____

_____

In the past? _____

_____