Desoto Family Counseling
& Pediatric Therapy Center

FINDING SILVER LININGS SINCE 2001

6858 Swinnea Rd Bldg 6B
Southaven MS 38671
Phone:(662) 510-8444
Fax:(662) 470-7502

CASE HISTORY

Patient Information

Child's Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____

Mother's Name:_____ Age:_____ Occupation:_____
Phone: ( )_____ Work: (.)_____ Home: ( )_____
Father's Name:_____ Age:_____ Occupation:_____
Phone: ( )_____ Work: (.)_____ Home: ( )_____

Primary Insurance:_____ ID#:_____ Group#:_____
Provider or Customer Care#: _____ CoPay/CoIns: _____ Deductible Ind/Fam: _____
Secondary Insurance: _____ ID#:_____ Group#: _____
Provider or Customer Care#: _____ CoPay/CoIns: _____ Deductibe Ind/Fam: _____

Referred By:_____ Phone: ( )_____
Address: _____

Pediatrician:_____ Phone: ( )_____
Address: _____

Other Doctors: _____Phone: ( )_____
Address: _____

Brothers and Sisters (please include name and age):
_____
_____

Language Spoken in Home: _____ Child's Primary Language: _____

With whom does the child spend most of his/her time?_____

How does your child communicate? (gestures, single words, short phrases, sentences) _____
_____
_____

What are your concerns for your child's evaluation this date?_____
_____
_____

When was the problem first noticed? By whom?_____
_____

What do you think caused the problem?_____
_____

Has the problem changed since it was first noticed? If so, how?_____
_____

Is your child aware of the problem? If yes, explain how he/she feels about it._____
_____

Is your child (or in the past) seeing any specialist regarding this problem? (physicians, psychologists, special-ed teachers, speech language pathologist, occupational therapist, physical therapist) If yes, please include who, when, and their conclusions. _____
_____
_____

Does your family history include any problems related to the concerns of your child? If yes, please include details.
_____
_____

PRENATAL/BIRTH HISTORY

Length of Pregnancy:_____ Length of Labor:_____
General Condition:_____ Weight:_____ Length:_____
Type of Delivery: Vaginal (head first/feet first) Caesarean Breech Emergency C-Section
Mother's general health during pregnancy:_____
_____
Mother's age at Birth:_____ Length of hospital stay:_____
Did mom or baby receive any medications or treatments during hospitalization? _____
_____

MEDICAL HISTORY

Does your child suffer from any of the following? If so, provide age at which the child suffered from the illness or condition.

Allergies:____ Colds:____ Asthma:____ Dizziness:____ Encephalitis:____ Convulsions:____
High Fever:____ Measles:____ Mumps:____ Pneumonia:____ Tinnitus:____ Draining Ear:____
German Measles:____ Influenza:____ Meningitis:____ Seizures:____ Tonsilitis:____ Croup:____
Chicken Pox:____ Ear Infections:____ Headaches:____ Mastoiditis:____ Sinusitis:____
Autism/PDD NOS:_____ Emotional/Behavior Disorders:_____
Learning Disabilities:_____ Dyslexia:_____
Cleft Lip/Palate:_____ Hearing Impairments:_____
Genetic Syndrome:(please specify) _____
Other:_____
Past Surgeries:_____
_____
Major Accidents or Hospitalizations:_____
_____
Is the child currently taking any medications? If yes, explain. _____
_____
Has your child had a recent hearing test? If so, please include results._____
_____

DEVELOPMENTAL HISTORY

At what age did your child:
Grasp objects_____ Babble:_____ Use Single Words:_____ Combine words:_____
Name Objects:_____ Use Simple Questions:_____ Engage in Conversation:_____ Sit:_____
Stand:_____ Crawl:_____ Walk:_____ Run:_____ Jump:_____Feed Self:_____
Dress Self:_____ Draw Circles:_____ Use Toilet:_____

Does your child have difficulty walking, running, jumping, or participating in other activities? Is your child excessively clumsy, fall a lot, or bump into things? Please explain._____
_____
_____

Does your child require your assistance for self care tasks such as getting dressed, using the bathroom, feeding themselves, bathing/showering, etc? Please explain._____
_____
_____

Does your child have difficulty with drawing, coloring, cutting, fasteners (buttons or zippers), hand writing, or using two hands together? Please explain._____
_____
_____

How does your child interact with other children?_____
_____

EDUCATION
School:_____ Grade:_____
Teacher:_____

How is your child performing academically? Please specify difficult subject areas if applicable. _____
_____
_____

Does your child receive special services or special education services?_____
_____

Has your child's teacher reported any concerns?_____
_____

SENSORY
Does your child dislike: (check all that apply)
Loud Noises_____ Hair brushing_____ Variety of food textures_____ Teeth brushing_____ Clothing tags_____ Being touched_____ Wearing socks/tight clothing_____
Taking on outings_____

Is/does your child: (check all that apply)
Overly active_____ Pay attention or play with toys for an age appropriate time_____
Less active_____ Hard to Calm_____ Restless when concentrating_____ Like movement_____

NUTRITION/FEEDING/SWALLOWING
Please describe any eating difficulties the child has, or had as well as other concerns (sucking, chewing, swallowing, choking/gagging, losing liquids through nose, stuffing mouth, etc):_____
_____
_____
_____
When did you first notice the problem? _____
What is your child's current diet?_____
What foods does your child refuse to eat?_____
_____
What foods are your child's favorite?_____
_____
How often are your child's feedings?_____

Current Weight:_____ Current Height:_____
Any difficulty gaining/maintaining weight? Please describe._____
_____

Any gastrointestinal issues? Please describe._____
_____
Any food allergies? Please list._____
_____

Has your child seen the a dentist/orthodontist? If yes, please describe. Provide any diagnosis of dental anomalies (underbite, overbite, tongue thrust, etc.)._____
_____
Does your child use a pacifier?_____ Digit/thumb suck?_____ When did he/she stop?_____
Does your child mouth objects such as rocks, dirt toys, etc.? Please describe._____
_____
ADDITIONAL INFORMATION
Please provide any additional information that might be helpful in the evaluation of the child's current problem._____
_____
_____
_____
_____
_____

Person completing this form:_____ Relationship to child:_____

Signature:_____ Date:_____

Please return this packet of information by mail, fax, or email (**nekki2@desotofamilycounseling.org**) prior to evaluation, if possible. If unable to return before evaluation, please bring to evaluation with the following information:

- Insurance Card and Information
- Parent ID
- Prescription from physician ordering the therapy evaluation (if MD did not fax prior to scheduling)
- Copy of evaluations done by specialists (psychologists, neurologists, etc.)
- Copy of Individualized Education Plan (IEP) if the child has one.

Regular and Customary Fee Schedule

Initial Consultation – by appointment	**$180.00 Hr.**
Individual Therapy	**$130.00 Therapy Hr.**
Play Therapy (Filial Therapy)	**$150.00 Therapy Hr.**
Family Therapy w/ Patient	**$150.00 Therapy Hr.**
Family Therapy w/o Patient	**$130.00 Therapy Hr.**
Group Therapy	**$75.00 Hr.**
Occupational Therapy Evaluation	**$100.00 Hr.**
Occupational Therapy Treatment	**$150.00 Therapy Hr.**
Speech Language Pathology Evaluation	**$220.00 Hr.**
Speech Language Treatment	**$150.00 Therapy Hr.**
Physical Therapy Evaluation	**$100.00 Hr.**
Physical Therapy Treatment	**$150.00 Therapy Hr.**
Applied Behavioral Analysis	**$80.00/session**
Medicinal Management (Psychiatric) Initial	**$130.00 to $175.00**
Medicinal Management Follow-Up	**$75.00 to $130.00**
Medical Records	**$25.00 up to 25 sheets**
Additional Sheets	**$5.00/10 sheets**
Basic Letters, including Short-Term Disability Paperwork	**$25.00**
No Show Fee	**$60.00**
Reports (Preparations), including insurance reports and evaluations.	**$180.00 Hr.**
Crisis Intervention or Weekend Services	**$180.00 Hr.**
Telephone Consultation	**$10.00/Ten Minutes**
Agency Consultation	**Per Contract (nego.)**
Consultation/Research (Attorney or Court Related)	**$180.00 Hr.**
Custody/Family Evaluations	**$180.00 Hr.**
Courtroom Testimony-half day	**$3700.00**
Courtroom Testimony-full day	**$5000.00**

****There will be an additional $1000 retainer fee for all court cases. This fee is to be paid in full for preparation of court.**

All fees are due and payable at times services are rendered. Methods of payment include personal check and cash. The cost for custody and/or family evaluations may be split by the parties involved but must be paid by the parties involved at the time of, or prior to the evaluation. Insurance claims can be filed individually or by this office. Fees not covered by insurance are due at time of service. All fees are subject to change without further notice.

Scheduled appointment times are reserved for you. Therefore, 24 hours' notice is required to cancel appointments. Missed sessions and sessions cancelled without appropriate notice will be billed at the customary rate and must be paid by the responsible party.

Fees for courtroom testimony are due and payable prior to the day of court or hearing. Retainers are required in case and must be paid for in advance. Fees for deposition and/or courtroom testimony are based on time away from the Center, including travel time. Expenses for meals, travel, and lodging (when applicable) are itemized and billed separately. Time spent in preparation for court, research, and contact times with the attorneys are billed separately.

-Therapy sessions typically last 45 minutes with initial intakes lasting 60 minutes.

_____ _____

Signature **Date**

Authorization To Process Third Party Payments

I authorize the release of any medical or other necessary information to Desoto Family Counseling Center, PLLC to process third party reimbursement. I also request payment of government benefits either to myself or to the party who accepts assignments.

I understand that I am responsible for any portion of the bill not paid by the insurance company.
I understand that any benefits explained to me by Desoto Family Counseling Center, PLLC does not guarantee payment.

_____ _____
Signed Date

Appointment Policy

Please confirm or reschedule appointments by 1:00 pm the day prior to your appointment time. If you do not confirm your appointment, you may risk losing your scheduled appointment time.
Please cancel appointments by 1:00 PM the day before your scheduled session. Cancellations at the time of the appointment or less than an hour in advance to the appointment will be considered a NO SHOW. If you cancel or reschedule the day prior to your appointment, it allows us time to fill that appointment for someone else in need. All future appointments on the schedule will be automatically cancelled when you NO SHOW an appointment, this includes cancellations outlined above. Also, you may incur a NO SHOW fee of $60. If you would like to dispute a NS fee or cancellations of your appointments, please consult with your therapist, not the front office staff.

Three consecutive NO SHOWS will result in termination of services at this agency and you will be referred to the mental health agency for your area.

_____ _____
Client Signature/Guardian Signature Date

_____ _____
Witness Signature Date

Do you authorize the use of text or email as a mode of communication?

YES NO

Text Number: _____

Email: _____

By signing below I acknowledge that there is a risk to my confidentiality with texting and email. Desoto Family Counseling Center, PLLC does not use a secure email server. I also release Desoto Family Counseling Center, PLLC from any liability associated with the use of texts or emails.

_____
Signature and Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ CAREFULLY! Desoto Family Counseling Center, PLLC has adopted the following policies and procedures for protection of the privacy to the people we serve.

OUR OBLIGATION TO YOU:
We at Desoto Family Counseling Center, PLLC respect your privacy. This is part of our code of ethics. We are required by law to maintain the privacy of "protected health information" about you, to notify you of our legal duties and your legal rights, and to follow the privacy policies described in this notice. "Protected health information," means any information that we create or receive that identifies you and relates to your health or payment for services to you.

USE AND DISCLOSURE OF INFORMATION ABOUT YOU:
Use and disclosure for treatment, payment and health care operations.
We will use your protected health information and disclose it to others as necessary to provide treatment to you. Here are some examples:

- Various members of our staff may see your clinical record in the course of our care for you. This includes clinical assistant, accounting, physicians, and other therapists.
- We may provide information to your health plan or another treatment provider in order to arrange for a referral or clinical consultation.
- We may contact you to remind you of appointments.
- We may contact you to tell you about treatment services that we offer.
- We may contact you regarding insurance benefits.

We will use or disclose your protected health information as needed to arrange for payment for service to you. For example, information about your diagnosis and the service we render is included in the bills that we submit to your health plan. Your health plan may require health information in order to confirm that the service rendered is covered by your benefit program and medically necessary. A health care provider that delivers service to you, such as an accounts payable representative, may need information about you in order to arrange for payment for its services.

It may also be necessary to use or disclose protected health information for our health care operations or those of another organization that has a relationship with you. For example, our quality assurance staff reviews records to be sure that we deliver appropriate treatment of high quality. Your health plan may wish to review your records to be sure that we meet national standards for quality of care.

It is our policy to obtain a general written permission to use and disclose you protected health information for treatment, payment or health care operations purposes, you will be asked to sign a consent form to permit all such uses and disclosures of your information at the time of Intake.

Emergencies: If there is an emergency, we will disclose your protected health information as needed to enable people to care for you.

Disclosure to your family and friends: If you are an adult, you have the right to control disclosure of information about you to any other person, including family members or friends. If you ask us to keep your information confidential, we will respect your wishes. But if you do not object, we will share information with family members or friends involved in your care as need to enable them to help you. You will be required to sign a Release of Information for each individual.

Disclosure to health oversight agencies: We are legally obligated to disclose protected health information to certain government agencies, including the federal Department of Health and Human Services.

Disclosures to child protection agencies: We will disclose protected health information as needed to comply with state law requiring reports of suspected incidents of child abuse or neglect.

Other disclosures without written permission: There are other circumstances in which we may be required by law to disclose protected health information without your permission. They include disclosures made:

Pursuant to court order, To public health authorities, To law enforcement officials in some circumstance, To correctional institutions regarding inmates, To federal officials for lawful military or intelligence activities, To coroners, medical examiners and funeral directors, To researchers involved in approved research projects, and as otherwise required by law.
Other disclosures: We will follow the provisions of 42 CFR Part 2 governing disclosure of protected health information. Except for the circumstances described above, we will not disclose protected health information to a third party without your written permission or a court order. If a request for disclosure of your patient record is received, you will be contacted and asked whether you wish to authorize disclosure. If you refuse to authorize disclosure, or it is not possible for us to contact you personally, we will not disclose your information without a court order.

Disclosures with your permission: No other disclosure of protected health information will be made unless you give written authorization for the specific disclosure.

YOUR LEGAL RIGHTS

Right to request confidential communications: You may request that communications to you, such as appointment reminders, bills, or explanation of health benefits be made in a confidential manner. We will accommodate any such request, as long as you provide a means for us to process payment transactions.

Right to request restrictions on use and disclosure of your information. You have the right to request restrictions on our use of your protected health information for particular purposes, or our disclosure of that information to certain parties. We are not obligated to agree to a requested restriction, but we will consider your request.

Right to revoke a Consent or Authorization: You may revoke a written Consent or Authorization for us to use or disclose your protected health information. The revocation will not affect any previous use or disclosure of your information.

Right to review and copy record: You have the right to see records used to make decisions about you. We will allow you to review your record unless a clinical professional determines that the review would create a substantial risk of physical harm to you or someone else. If another person provided information about you to our clinical staff in confidence, that information may be removed from the record before it is shared with you. We will also delete any protected health information about other people.
At your request, we will make a copy of your record for you. **We will charge a reasonable fee for this service.**

Right to "amend" record: If you believe your records contain an error, you may ask us to amend it. If it is amended, you will be told and allowed the opportunity to add a short statement to the record explaining why you believe the record is inaccurate. This information will be included as part of the total record and shared with others if it might affect decisions they make about you.
Right to an accounting: You have the right to an accounting of some disclosures of your protected health information to third parties. This does not include disclosures that you authorize, or disclosures that occur in the context of treatment, accounting of other disclosures made in the preceding six years. If requested by law enforcement authorities that are conducting a criminal investigation, we will suspend accounting of disclosures made to them.

Questions about our policies and procedures, requests to exercise individual rights, and complaints should be directed to our contact person. Our contact person is Anthony J. Wood. The contact person can be reached at 662-772-5937.

Personal Representatives: A "personal representative" of a patient may act on their behalf on exercising their privacy rights. This includes the parent or legal guardian or a minor. In some cases, adolescents who are "mature minors" may make their own decisions about receiving treatment and disclosure of protected health information about them. If an adult were incapable of acting on his or her own behalf, the personal representative would ordinarily be family. An individual can also grant another person the right to act as his or her personal representative in an advance directive or living will.

Disclosure of protected health information to personal representative may be limited in cases of domestic or child abuse.

COMPLAINTS

If you have any complaints or concerns about our privacy policies or practices, please submit a complaint to our contact person. If you wish, the contact person will give you a form that you can use to submit a complaint.

CIVIL RIGHTS COMPLIANCE

Nondiscrimination Policy
As a recipient of federal financial assistance, Desoto Family Counseling Center does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by Desoto Family Counseling Center directly or through a contractor or any other entity with whom Desoto Family Counseling Center arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.)

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact Courtney Parrish, LCSW at 662-772-5937.

Limited English Proficiency

We contact local hospitals, charitable organizations, or the Department of Human Services in instances where limited language, proficiency clients are concerned. Limited English Proficiency Policy form is available upon request.

Sensory Impairment
We maintain contact with individuals who are proficient in Sign Language to assist our hearing-impaired clients. Procedure for communicating information to persons with sensory impairments is available upon request.

Accessibility
Desoto Family Counseling Center and all of its programs and activities are accessible to and usable by disabled persons, including persons with impaired hearing and vision. Access features include:

- Convenient off-street parking designated specifically for disabled persons.
- Curb cuts and ramps between parking areas and buildings.
- Fully accessible offices, meeting rooms, bathrooms, public waiting areas, patient treatment areas, including examining rooms and patient wards.
- A full range of assistive and communication aids provided to persons with impaired hearing, vision, speech, or manual skills, without additional charge for such aids.

If you require any of the aids listed above, please let the receptionist or your therapist know.

Effective Date: These policies and procedures were approved May 1, 2016.

I have read, fully understand, and approve of the aforementioned terms, as well as the Notice of Privacy Practices that was received. I understand that I am entitled to receive a paper copy of the Notice of Privacy Practices and may ask for a copy of this notice at any time.

_____ _____

Signature Date

Authorization To Release Patient Information

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's signature or guardian's signature and date signed or if it is expired as described below. This authorization maybe revoked by the patient at any time.

I hereby authorize [name of provider/address]: _____

_____

_____

P _____ F _____

To disclose from the health records of:

Name: (Last, First, MI): _____

DOB: _____ SS#: _____

Covering the periods of healthcare (Date(s) of service):

From (date): _____ to (date): _____

The following information may be released:

□ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____

□ Other Information: _____

To disclose healthcare records to [name of facility/address/fax]:

Desoto Family Counseling Center, PLLC
6858 Swinnea Rd, Bldg 4
Southaven, MS 38671
Fax (662) 772-5940

Affirmation of Release

I give _____ or the named provider permission to release/receive only the information I have selected on this form to the provider (s) that I have named and only for the purposes I have checked. I understand that this release is valid up to the expiration date stated below and I may refuse to sign this authorization or revoke this authorization at anytime. I also understand that there may be a minimum of a $25.00 fee associated with a copy of the records.

_____ _____

Signature of Patient/Guardian and Relationship to patient **Date Signed**

Expiration Date: _____ _____

Witness Signature/Date

Communication Release and Authorization Form

Will anyone else other than yourself be involved in client's (child/ward) transportation to and from Desoto Family Counseling Center, or need to communicate with the therapist or staff at Desoto Family Counseling Center? If so, please complete below.

I/We authorize the following persons to transport my child/ward to and from Desoto Family Counseling Center, or to otherwise be involved in my child's/ward's treatment by way of communication with the therapist:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

I/We authorize Desoto Family Counseling Center staff and/or personnel to communicate with me via the following methods:

___Text Message ___Voicemail

___Telephone ___Email

RELEASE: I/We understand that Desoto Family Counseling Center should not be held responsible for any personal information that may be accessed by third parties via the above approved methods of communication. Accordingly, for myself/ourselves and/or as natural parent(s) or guardian(s) of Client, I/we hereby release Desoto Family Counseling Center, its owners, employees, contractors and agents from any liability which may arise on account of any personal information accessed by third parties through the approved methods of communication.

Effective on dates:_____ to _____

_____ _____
Signature of Client/Guardian Date

_____ _____
Signature of Client/Guardian Date

_____ _____
Signature of Witness Date

The Decision to Terminate

At DeSoto Family Counseling, we strive to provide you with the best therapeutic services that you, your family, or your child may need. However, the therapist is in charge of the therapeutic relationship and may deem it appropriate to terminate services. Reasons to terminate may include, untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy including two consecutive no shows or three consecutive late cancellations (not within 24 hour notice). The therapist may also see that the client could benefit from another therapist that would be more clinically appropriate to meet their needs. The therapist will discuss the decision to terminate with the client or send a letter notifying of the decision to terminate and referral options.
The client also has the right to terminate services during the therapy process. The client may also request referral options as well.

I, _____, have read and agreed to the terms of the decision to terminate.

_____
Patient/Guardian Signature/Date

_____
Therapist Signature/Date