GINNY B. LIWANPO, PSY.D.
CLINICAL PSYCHOLOGY
PSY 20910

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OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

Patient Name: _____

OUTPATIENT SERVICES CONTRACT

The following information is provided herein about my professional services and business policies. Please carefully read and initial at the top of each page, indicating that you have read and agreed to my policies. **Your signature on this document will represent an agreement between us**.

GETTING TO KNOW ONE ANOTHER AND WHAT TO EXPECT

I view psychotherapy as a collaborative process that requires efforts from both therapist and patient. Successful outcomes can never be guaranteed. However, you can improve your changes of a satisfactory outcome through your active involvement, honesty, and openness in order to change your thoughts, feelings, and behaviors. It is also important that each of us feels that the relationship is a good fit. am committed to providing ethical, high quality care in a warm and safe professional relationship. Our first few sessions together will involve my conducting an in-depth psychological evaluation, including discussion of your history and current concerns or issues to establish mutually agreed upon treatment goals and recommendations. If at any time I determine, based upon my clinical judgment, that we are not a good fit, or that you would benefit from referrals to other providers or an alternative level of care, I will inform you of my decision and provide you with appropriate referrals. It is also important to tell me any concerns you may have regarding whether we are a good fit. Psychological treatment will consist of regular psychotherapy sessions, and may include the administration of psychological tests, the review of background records, and interviews with your consent of individuals who are familiar with you.

BENEFITS AND RISKS OF TREATMENT

Your participation in psychotherapy can result in a number of benefits, which may include a reduction of symptoms that have caused you to seek therapy, the resolution of specific concerns, greater insight and improvement in your interpersonal relationships. It is integral to challenge yourself to work on the things we talk about both during and between our sessions. There are also risks to participation in psychotherapy, such as: remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, anxiety, depression, insomnia, etc. I may challenge some of your assumptions, perceptions, or propose different ways of looking at, thinking about, or handling situations, that could cause you to feel angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to psychotherapy in the first place, such as personal or interpersonal relationships, may result in changes that were originally intended. Psychotherapy may result in decisions that affect you, including decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one person in a relationship can be viewed negatively by others affected by that relationship. Change may be easy and quick, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. It is important that if you have any questions about your progress or feelings of frustration, that you raise those questions with me.

Psychological services may also be provided primarily to prevent further deterioration of your mental or emotional status. This is considered maintenance treatment, which may be provided over an extended period. It is important to know that therapy is a time-consuming process and it is difficult to estimate exactly how long it will take. The length of treatment depends upon the goals of treatment and your own motivation, honesty and openness to creating change in your life. In my experience, the more a patient is invested and motivated to create and maintain daily change, the quicker and more effective therapy is.

PSYCHOTHERAPEUTIC APPROACH

Over the course of treatment, I will draw upon various psychological approaches based in part on the problem that is being treated and my professional assessment of what will best benefit you under the circumstances. These approaches may include cognitive-behavioral, mindfulness, family or play therapy, psychodynamic, and/or psycho-educational. There are times when I may recommend additional services, including: consultation with psychiatrist, specialist, or physician, marital sessions, conjoint parent/child sessions, and/or group psychotherapy. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments. You should evaluate this information along with your own opinions of whether you feel comfortable working with me.

From time to time, I may ask for your feedback regarding your psychotherapy and its progress. I hope that you will respond openly and honestly. Please bring up any questions that may arise about my procedures. Based on your feedback, I may adjust your treatment goals and the treatment approaches being used. You always have the right to ask about other treatments as well as their risks and benefits. If you are interested in treatment approaches that I do not provide, I will be happy to assist you in obtaining appropriate referrals.

The process of psychotherapy often involves a treatment team approach. If you are working with other providers, such as a psychiatrist or other physician, I may ask you to sign an *Authorization to Release Information* allowing me to communicate with other relevant providers to more fully assist you, and to gain another provider's perspective of the presenting issues and treatment plan. It may also be valuable from time to time, with your permission, for me to speak with other collateral sources, such as family members, or school personnel. If appropriate, I will discuss the benefits of such communication and request that you sign an Authorization allowing me to speak with any such individuals.

Termination

By agreeing to perform an initial psychological evaluation, I am not yet committing to an ongoing psychotherapeutic relationship with you. Our first few sessions together will help me assess whether I believe I can be of benefit to you. I do not accept patients who in my opinion I am unable to help. I reserve the right to terminate therapy at my discretion due to conflicts of interest, lack of progress or nonparticipation in therapy, nonpayment, or if your needs are outside the scope of my competence or practice. If at any point during treatment I assess that I am not effective in helping you reach your therapeutic goals, or I determine that you are not complying with treatment, such as by missing two or more consecutive appointments, or refusing to follow my treatment recommendations (including recommendations for a higher level of care), I will discuss my concern with you, and if appropriate, terminate treatment and assist you in finding an appropriate referral. You also have the right to terminate therapy at any time. However, it is important that such decisions not be made unilaterally, and it is my hope and expectation that you will let me know if you believe we are not a good fit or are not being effective, so that we can discuss it. If appropriate, I will provide you with referrals and assist you in transitioning care to another professional of your choosing. With your consent, I may also talk to the professional of your choice to help with the transition. Unless special arrangements have been made, a duration of 30 days or longer with no clinical activity is subject to having your chart closed.

Exclusionary Criteria

I will not see you for psychotherapy if I determine that you have arrived for psychotherapy under the influence of drugs and/or alcohol or if you are actively psychotic.

Confidentiality

All individually identifiable information, whether in electronic or physical form that is in the possession of or derived from information you share in confidence with me or this office regarding your medical or mental health history, a mental or physical condition, or mental or physical health treatment is confidential and may not be used or disclosed without your written authorization, except where disclosure is required or permitted by law.

When Disclosure is Required by Law

Some of the circumstances where disclosure is required by law are: where I reasonably suspect physical, emotional or sexual abuse, neglect or abandonment of a child, dependent adult or person 65 or older, or I have reason to believe that you may present a danger to yourself or others. Most of the provisions explaining when the law requires disclosure are described in *HIPAA Notice of Privacy Procedures and Policies and Limits of Confidentiality*. Note that I am required by law to report a sexual abuse of a child conduct that involves the creation of or streaming, downloading, storing, or transmitting electronic images sexually depicting a child.

When Disclosure May Be Required

Disclosure may be required pursuant to a legal proceeding by or against you. For example, if you place your mental status at issue in litigation, such as in a lawsuit seeking damages for severe emotional distress, the defendant may have the right to obtain your psychotherapy records and/or the testimony of your psychotherapist by issuing a subpoena. I will not release your protected health information in response to a subpoena without your written authorization or a court order except in cases where the records are sought for a workers' comp determination or proceeding, and even then, such release of information shall be reasonably limited to only that information necessary for the determination or proceeding.

Minors in Therapy

If you are under eighteen years of age, please be aware that the law may grant your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. In family and child therapy, I will reserve the right to use my professional judgment in determining what information would be pertinent for exchange or discussion between parents and their child(ren). This discretionary action on my part would be done in the best interests of every family member who is involved. It is also the policy of this office to request parents or guardians waive access to detailed information and/or access to your records. If they agree, I will provide them only with general information about our work together subject to your approval. If I feel it is important for them to know something to make sure that you and others around you are safe, I will encourage you to share the information with them, with your permission, in the context of a scheduled session. However, if I think it is clinically necessary, I will involve them even without your permission if I have reason to believe there is a risk of harm to yourself or if another is harming you in any way.

Parents/Guardians: Initial here to waive your access to your child's records/information _____

Health Insurance and Confidentiality

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP to process claims for payment. You have the right to withhold information regarding your treatment from your insurer, but that would mean that claims for reimbursement cannot be submitted, and you may be personally liable for payment. If you allow this office to share your confidential information for reimbursement purposes, only the minimum necessary information will be communicated. However, once shared, I have no control over what your insurance company or other third-party payor will do with the information and no control over who will have access to the information. Submitting an invoice for reimbursement of mental health treatment services carries a certain amount of risk to your confidentiality and to your future ability to obtain health or life insurance, and in some cases, even a job such as one that requires a high-level security clearance. Mental health information may be shared by your insurer with the Medical Insurance Bureau, which may make your information available through the use of codes to its member insurers. You may request a copy of your MIB Consumer File at: https://www.mib.com/request_your_record.html or by calling 1-866-692-6901.

Emergencies

Confidential treatment information may also be released in the rare event of a medical or psychological emergency, meaning a sudden change in condition that may result in physical or psychological harm to you if left untreated. In the case of an emergency, such as when necessary to keep you or another safe from harm, you authorize me to reach to the following emergency contact:

Name: _____

Address: _____

Phone: _____

Email: _____

Litigation Limitation

Due to the nature of mental health treatment, the relationship of trust involved, and the recognition that treatment often involves making a full disclosure with regard to matters that may be of a confidential and highly sensitive nature to maximize the effectiveness of treatment, and the harm that may result from involving your mental health provider in individual legal disputes with others, it is agreed that should there be a legal proceeding (such as divorce, custody proceedings, or lawsuits arising from personal injuries), neither you nor your attorney, nor anyone else acting on your behalf, will attempt to have me testify in any proceeding, nor will a disclosure of the psychotherapy records be requested without your discussing the risks of doing so with me.

Consultation

To provide high quality mental health services to you, I may consult from time to time with other psychotherapists regarding patients without disclosing patient identifying information so that your confidentiality is maintained.

Records and Your Right to Review Them

Both the law and the ethical standards of my profession require that I keep appropriate treatment records of each patient encounter for at least 7 years following the termination of treatment, or until a patient's 25th birthday, whichever is later. Unless otherwise agreed as clinically necessary, I will retain clinical records only as is mandated by California law. If you have concerns regarding your treatment records, please discuss them with me. As a patient, you have the right to review or receive a summary of your treatment records upon request and within a reasonable time, except in limited situations such as where I determine that releasing such information might be harmful to you. In such a case, I may provide the records to an appropriate mental health professional of your choice. When more than one patient is involved in treatment, such as in cases of couples and family psychotherapy, the release records must be authorized in writing by all participants who are capable of providing consent. You have the right to request that I amend the records I create and maintain regarding our sessions together. Such requests must be in writing and must state the reasons for your request. In general, I must respond in writing to your request within 60 days, and if denying the request, I will provide you with the reasons for the denial and an explanation of additional rights that you may have. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Communication via Email, Phone, or Text

Technology provides a convenient method for communicating brief messages. Text and e-mail communications particularly have become commonplace. However, communication using technology can also be problematic due to the risk of misinterpretation, the creation of a lasting record, unauthorized access and distribution of private information by others and other forms of abuse. Therefore, it is my policy that all substantive communication with me, such as discussions of symptoms, events or experiences, be limited to telephone or face-to-face discussion (either in person, or via secure synchronous audio and video technology) and that text, e-mail, and other electronic messaging technology be limited in their use to administrative communications. Such "administrative communications" might include requests for appointment changes, appointment confirmations, and notifications that you are late for an appointment. Communication with your psychotherapist should never be through social media.

No transmission system is perfect; internet, e-mail, cell phone, and other electronic communications should not be relied upon for the transmission of confidential protected health information, especially where time is of the essence. Risks potentially include the interception of wrongful access of confidential communications by authorized individuals. Unencrypted e-mails particularly are vulnerable to unauthorized access. Even with encryptions in place, such encryption protection may cease once you open the email on the receiving computer, thus leaving the communication open to others who may have access. If you communicate with me using an electronic device that is owned by a third party, such as an employer or public library, there can be no expectation that your individual private information will be protected since such devices are not owned or controlled by you. Faxes are also not always secure since they can be sent to the wrong number. While I will do my part to reasonably maintain the security of all electronic communications from me as set forth in my *Notice of Privacy Practices*, I cannot guarantee the security of information transmitted outside of our individual sessions via technology. Please notify me if you decide to avoid or limit the use of electronic communications such as e-mail, cell phones, text messages, or faxes. If you communicate confidential information to me via any electronic device, I may assume that you have made an informed decision to take the risk that such communication may be intercepted and may rely on your decision as your consent to communicate via the same method. E-mail, text messaging, and faxes should never be used for emergencies.

Telephone & Emergency Procedures

I do not operate an emergency-based practice. I am often not immediately available by telephone, as I do not take calls when I am in session with a patient. If you need to contact me, please leave a message on my confidential voicemail (949) 491-6135, and provide at least 2 to 3 times when you will be available. I check my voicemail periodically throughout the day, and will make every effort to return your call as soon as reasonably practical but within 24 to 48 hours -- with the exception of weekends, holidays, and periods when I am out of town. If I will be unavailable for any extended period of time, the contact information for a covering colleague will be provided. If at any time, you believe you are having a medical or psychiatric emergency, call 911 or go to the nearest emergency room. You may also use the following resources:

- National Suicide Prevention Lifeline: (800) 273-8255
- Orange County Crisis Line: (877) 727-4747

Financial Policies

I offer a free 15-minute initial phone consultation in the process of determining if we are a good fit. During the initial period of evaluation, we can both decide whether I am the best person to provide the services you need for meeting your treatment goals. If you decide to continue treatment, one 45-minute session is scheduled each week at a time we agree upon, although some sessions may be longer or more frequent. Detailed below are fees for professional services that are rendered:

FEE	PROFESSIONAL SERVICE	SERVICE DESCRIPTION
$290	Initial Evaluation	60 minutes. Diagnosis of symptoms and issues; treatment planning. Up to 3 evaluation sessions depending on symptom severity.
$260	Child/Family Therapy	45 minutes. Interactive therapeutic techniques (e.g., art, play, narrative modalities).
$210	Individual Therapy	45 minutes. Psychotherapy.
$190	Collateral/Family Session	45 minutes. Meeting with family member(s) without patient present.
$150	Parent Consultation	30 minutes. Consultation on parenting issues relevant for treatment.
$130 $200	Telehealth Session • Telehealth 30 minutes • Telehealth 45 minutes	Telehealth psychotherapy via phone or video platform. Symptom and/or treatment progress monitoring. May be reimbursable by insurance.
$25	Phone Consultation • Phone 15 minutes	A quick check-in or follow-up on wellbeing. NO clinical therapy is conducted. NOT reimbursable by insurance. Phone conversations longer than 15 minutes and extended sessions will be charged on a prorated basis.

You are financially responsible for all the fees and expenses related to your treatment. Patients are expected to pay according to the abovementioned fee schedule at the end of each session unless other arrangements have been made.

Every January I increase my fee according to the previous year's rate of inflation, regardless of when you began treatment. We will review your fee annually to negotiate any increase in fee, considering any financial hardships and/or gains. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments. In certain situations of unusual hardship, a sliding scale may be arranged; we can discuss this further at your request and work to make your therapy affordable. If continued treatment is clinically indicated at the time and alternative payment arrangements cannot be agreed upon, I will provide you with referrals for other providers offering reduced fees.

Billing & Payments

Payment in the form of bank transfer, cash, or check is due at the time of the session unless we agree otherwise, or unless you have insurance coverage that requires another arrangement. Credit cards are stored on file to set up appointments and may be considered an option to be used for no-show, late cancellations, and/or outstanding balances beyond 60 days. Checks should be made out to Ginny Liwanpo, Psy.D., preferably prior to the start of a session to make the most efficient use of our time. If a check is returned due to insufficient funds, you may be liable for any bank charges or processing fees incurred.

While I will work with you to resolve any overdue and unpaid charges, you understand and agree that I may use any lawful means such as collection agencies, small claims courts, and binding arbitration to obtain payment of any overdue amounts. You further agree that I may disclose such personally identifiable information regarding your treatment as is necessary to collect overdue amounts. Such information may include dates and times of service, the general nature of the services provided, and communications between us regarding efforts to resolve your debt.

Insurance Reimbursement

I accept a limited range of health insurance in my practice; I am not a Medicare provider. As insurance coverage varies for each patient's circumstances, and does not necessarily apply to all treatment, it is your responsibility to verify the specifics of your coverage. Please contact your insurance company prior to your first visit to inquire about the rate they will reimburse you. Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance companies. Payment in full for all services including those that are not covered by your insurer and those for which your insurer provides only partial payment is your responsibility. For patients whose insurance is accepted in my practice, co-payments and deductible must be paid at the time services are rendered. Your insurance is billed as a courtesy, but you remain personally responsible for the fee should it not be covered by insurance. If you are not eligible at the time services are rendered, you are responsible for full payment.

Unless agreed upon differently, I will provide a copy of your receipt, which you can then submit to your insurance company for reimbursement if you so choose. Most insurance companies provide partial reimbursement when you use out-of-network providers. I cannot guarantee payment of your claims. You are responsible for the payment of your bill regardless of the status of your insurance claim. If your insurance company pays only a portion of the bill or rejects your claim entirely, an explanation should be made to you as the insured. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation for the psychological services that have been rendered.

As was indicated in the above section *Health Insurance & Confidentiality* -- you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. Most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide them with additional clinical information (e.g., treatment plan, summaries). This record will become part of the insurance company files and stored in a computer. All insurance companies claim to keep such information confidential. Once we have all the information about your insurance coverage, we will discuss what may be accomplished with the available benefits and what will happen if they run out before you feel ready to end our sessions.

It's important to remember that you always have the right to pay for my services yourself to avoid the problems described above. There are certain advantages to consider when paying out of pocket, which include:

1) Freedom to begin treatment quickly without waiting for approval from your insurance company.
2) Ability to select the therapist of your choice.
3) You and your therapist decide the length of your treatment without insurance policy limits.
4) Increased privacy with no personal information shared without your consent.

Cancellation Policy

Your appointment is a reservation of time specifically for you to the exclusion of others, and a minimum of one business day (24 hours) notice is required for rescheduling or cancelling your appointment. Otherwise, there is a cancellation fee of **$100**, regardless of the reason for the cancellation or no-show unless waived in my sole discretion (reserved for bona fide emergencies). If you are late to your appointment, we will still need to end at our regular time so that I can respect the appointment times of other patients. Payment of any late cancellation charges will be your responsibility as health insurance generally does not reimburse for missed appointments. A bill will be sent directly to patients who do not show up for or cancel an appointment.

Mediation & Arbitration

All disputes arising out of or in relation to this agreement to provide psychotherapy, including disputes related to non-payment of fees in excess of the Small Claims jurisdictional amount and claims arising from the provision of professional services shall be referred first to mediation, and then if unsuccessful, to binding arbitration. The mediator shall be a neutral third party unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement or care arising from this agreement shall be submitted to and settled by binding arbitration in the county in which the professional services described herein are provided in accordance with the rules of JAMS (dispute resolution services) which are in effect at the time the demand for arbitration is filed. The prevailing party in any proceeding shall be entitled to recover reasonable attorneys' fees.

Dual/Multiple Relationships

The term "Dual Relationship" refers to having a treatment relationship with a Psychologist while involved in some other relationship with that same Psychologist. Romantic relationships between a patient and her/his psychotherapist are inappropriate as is any other relationship that may be reasonably expected to impair the psychotherapist's clinical judgment or that potentially exploits the patient. Dual roles can occur through mutual acquaintances or having similar social interests or frequenting the same places. While not all dual relationships are unethical or even avoidable, they can detract from the quality of the treatment relationship. Therefore, I will attempt to avoid being in a relationship with you outside of our therapy together. It is possible that you may see me out in the community. Please do not be offended if I do not acknowledge you. This is in part to protect your confidentiality and the proper limits of our relationship. However, I will respond to you if you address me first. I ask that if you do encounter me outside of treatment, do not attempt to discuss treatment with me. If you become aware that a dual relationship exists, such as finding that you and I participate in the same organization, it is your responsibility to notify me and communicate whether the dual relationship may be or has become uncomfortable for you in any way. I will listen carefully and respond to your feedback and will discontinue the dual relationship if in my judgment it potentially interferes with the effectiveness of psychotherapy or your welfare and the relationship cannot otherwise be limited.

Office Policies & General Information Agreement for Psychotherapy Services

Your signature below indicates that you have read the information in this document, provided accurate information, and agree to abide by the terms during our professional relationship.

I have carefully read the Office Policies and Information Agreement, and have had the opportunity to have any questions I have explained to me to my complete satisfaction. I have initialed at the top of each page, which indicates that I understand the terms in this document and agree to comply with them. By signing below, I voluntarily agree to participate in psychotherapy and agree to comply with what has been outlined above.

_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date

_____ _____

Additional Patient Signature (Spouse/Partner/Family Member/Friend) Date

_____ _____

Signature of Psychological Services Provider Date

Patient Financial Responsibility Agreement

You will be financially responsible for any fees that are not covered by your insurance plan. These often include, but are not limited to:

1) Have not met deductible or are not current with your insurance premiums
2) Provider is not in-network
3) Number of sessions exceeds approved sessions
4) Pre-authorization required and not obtained
5) Failure to give adequate notification of at least 24 hours prior to scheduled appointment for cancellations or rescheduling

Date _____

_____

Patient Name

_____

Patient Signature (Patient's Parent/Guardian if under 18)

Patient's Initials: _____

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CONSENT FOR MENTAL HEALTH TREATMENT & LIMITS OF CONFIDENTIALITY

I hereby authorize and request Ginny Liwanpo, Psy.D. (PSY 20910) to carry out mental health assessment and/or treatment services which now or during the course of my care as a patient are advisable. I have the following rights and may discuss these at any time:

1. I can discuss any questions or suggested interventions I have about the course, purpose, and direction of psychotherapy.
2. I have the option to explore any other possible treatments or alternatives to therapy.
3. I have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those I've incurred.
4. I understand no guarantees can be promised regarding the outcome of psychotherapy. I will be informed of possible outcomes.
5. I have the right to know the content of my treatment records, which may be provided to me in written summary. If I choose to review the content of my records, I must submit a written request to my therapist.

The provider has explained to me the proposed treatment plan, general nature and extent of the benefits and risks involved in treatment, and alternative treatment options, if any. However, treatment will not be delayed if any emergency exists (e.g., patient presents as a danger to self or other or reports being in danger). This consent is only for the services checked below and can be revoked at any time by written notification. **Consent granted for:**

☐ Individual Psychotherapy ☐ Family Psychotherapy ☐ Psychological Testing ☐ Medication Management

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a patient cannot be shared with another party without the written consent of the patient. I am legally the holder of privilege, and understand the following noted exceptions to this privilege:

Duty to Warn & Protect: The right to confidentiality is forfeited if the patient becomes a danger to self or others. When the patient discloses intentions or a plan to harm another person, the mental health professional is mandated to warn the intended victim and report this information to legal authorities. If the patient discloses or implies a plan for suicide, and/or a high suicide risk is assessed, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the patient's family. Hospitalization may occur as an attempt to protect the patient.

Abuse of Children and Vulnerable Adults: If the patient reports and/or there is reasonable suspicion of child abuse or neglect, the mental health professional must report that to Department of Children & Family Services and/or legal authorities.

Prenatal Exposure to Controlled Substances: Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access clients' records.

Insurance Providers (when applicable): Insurance companies and third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Court (when applicable): If mental health records are subpoenaed by a court order, the patient's records can be disclosed.

I have read, fully understand, and agree to the above Consent for Treatment and Limits of Confidentiality. I understand their meanings and ramifications.

Date _____ _____
Patient Name

_____
Patient Signature (Patient's Parent/Guardian if under 18)

Date _____ _____
Therapist Signature

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PAYMENT AUTHORIZATION

➔ It is the policy of this practice for all patients to store a valid credit/debit card on file in order to set up appointments; it may be an option to be used for no-show, late cancellations, and/or outstanding balances beyond 60 days. Charges will appear on your credit card statement as: "Ginny Liwanpo, Psy.D."

Please indicate the card you wish to store on file, on a secure and encrypted server for this practice:

Patient Name: _____ **Date of Birth:** ___/___/___

Name on Card: _____

Credit/Debit Card #: _____ **Expiration Date:** _____

Type of card: ☐ Debit ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER **CVV Code:** _____

Cardholder's Zip Code: _____ **Cardholder's Email Address:** _____

➔ You will elect to pay your fees for copayments and/or services rendered by: check or bank transfer (e.g., Apple Pay or Zelle).

Payment Method for copayment and/or services rendered -- I agree to pay for my services using one of the following:

☐ *Option 1*: Payment transfer via Apple Pay

Account holder Email: _____ Phone #: _____

☐ *Option 2*: Payment transfer via Zelle

Account holder Email: _____ Phone #: _____

☐ *Option 3*: Check Payment

As indicated above, the payment method you choose will be used for copayments and/or services rendered. The card on file may be used for the following when there are outstanding balances beyond 60 days. Please note:

- Any copays, coinsurance, and/or deductible amounts as specified by my insurance plan that were not paid at the time of service.
- Any late cancellation or missed appointment fees I have incurred. **A missed session fee is $100**.
- The amount my insurance reimburses me directly on an out-of-network basis for our sessions, if and when I have not forwarded the check or amount to this practice within two weeks of receipt.
- Bank fees or charges associated with bounced or returned checks, which will incur the check amount plus a returned-check fee of $30. Any charge back fees when credit card is declined. These must be paid within 7 days of being notified of such charges.
- Telephone contact in excess of that usually associated with services, prorated at my regular hourly rate, with prior notice given before any charges are incurred. This may include phone contact of 10 minutes or completing documents related to treatment.

Please read and initial the following statements:

_____ It is my responsibility to update my records should my card be cancelled or expire.

_____ This authorization becomes a permanent part of my records and will be treated with privacy, confidentiality, and the utmost financial safeguards for the length of time my records are required by law to be retained (up to 7 years).

By signing this form, I certify that I am the cardholder and am authorized to agree to the above terms on behalf of the patient listed above. My signature grants my permission for Ginny Liwanpo, Psy.D. to bill my credit/debit card to charge my credit card for the conditions listed above, and attests that I will not dispute those conditions. I further authorize Dr. Liwanpo to disclose information regarding my attendance/cancellation to my credit card company if I dispute a charge.

Cardholder's Signature: _____ **Date:** _____

GINNY B. LIWANPO, PSY.D.
PSY 20910

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. The privacy of your health information is important to this office. Please review it carefully.

HIPAA stands for Health Insurance Portability and Accountability Act. It was designed to help contain the ever-rising health care costs by streamlining the system through the adoption of standards for transmitting electronic health care claims. HIPAA regulations also establish standards for protecting the privacy of medical records.

LEGALLY DEFINED DUTY

This office is required by law to protect the privacy of your health information. This protected health information (PHI) is defined as health information that can be used to identify you, has been created by this office, or has been received from another office or entity. It applies to past, present, and future health or condition, your treatment, payment for services, insurance claims, or other payment information that this office maintains related to your care. This office has the duty to provide you with this notice, which describes how your health information will be used and disclosed for purposes of treatment, payment, and other health practices. The use of this information applies to the sharing, utilization, examination, or analysis of this information within this treatment facility. Your health information is disclosed when it is released or transferred out to another party or entity.

USE & DISCLOSURE OF YOUR HEALTH INFORMATION

This office may use or disclose your protected health information (PHI) for the purposes of providing treatment, payment for services rendered, and healthcare operations (i.e., accounting and billing). This office will not share your PHI with any requested agency or person unless you sign an authorization form allowing us to do so. This gives you control over the distribution of your PHI. You have the right to request restrictions in our use or disclosure of your PHI for treatment, payment, or healthcare operations.

USE OF YOUR PHI IN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your PHI without consent; however, we will attempt to contact you in advance when the situation allows:

1. **Health and Safety: Emergency Situations:** When there is serious threat to your health and safety or that of another individual or the public. In this case, your PHI would be shared with any person or organization that might be able to prevent/reduce the threat. This office may also use and disclose your health information to emergency personnel in case a situation warrants such treatment.
2. **Treatment:** This office may use and disclose your health information to a physician, psychiatrist, or other mental health clinicians who provide treatment to you. The purpose of this disclosure is for coordination of your treatment.
3. **Federal, State, Local, or Administrative Law:** This office may use or disclose your health information when mandated by law. This includes reporting child/elder/dependent abuse, harm to self or others, when required by government agencies such as a county coroner or workers compensation laws.
4. **Healthcare Operations:** This office may disclose and use your health information for the purpose of maintaining and running this office. This includes quality assessment protocols reviewing the competence of clinicians providing treatment, or conducting training, certification or licensing activities.
5. **Payment:** This office may use and disclose your health information to obtain payment for services provided to you. The disclosure may be to your health insurance company or health plan. If this office uses a third party for billing services, we will make sure they comply with the safe management of your PHI.
6. **Law Enforcement/Military/National Security:** We may be required by law to disclose PHI: (a) to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, missing person, complying with a court order, warrant, grand jury subpoena, and other law enforcement purposes.; (b) if you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities; (c) to federal officials for intelligence and national security activities authorized by law. We may also be required to disclose your PHI to officials to protect the President, other officials, or foreign heads of state, or to conduct investigations.
7. **Social Security Administration:** If you are referred to this office for a disability determination evaluation, all personal information SSA collects is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by provisions which are mandated by HIPAA.
8. **Authorization:** This office may obtain your written authorization for use or disclosure of your PHI for situations not listed above. You may give this office your written authorization for use of your health information or to disclose it to anyone for any purpose as defined by the written *Authorization for Use or Disclosure of PHI*. You may revoke your authorization in writing at any time.
9. **Family, Friends, or Others Involved in Your Healthcare:** This office may provide your health information to persons who are involved in your care or payment for your care, such as family members, friends, or other individual(s) designated by you as being involved in your healthcare or for the payment of your healthcare, unless you object. Any such disclosure will be limited to information directly related to the person's involvement in your care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. **Right to Request Restrictions:** You have the right to request restrictions on certain users and disclosures of your PHI. This office will review your request and may choose not to accept it. If your request is accepted, a written format will be included in your records and this office will abide by the request. The request may not interfere with the legally defined uses and disclosures of your health information.
2. **Right to Access:** You have the right to examine or obtain copies of your health information, with some exceptions. The request must be made in writing, and this office will attempt to comply with the requested format within 30 days of receiving your written request. This office may choose to provide you with a summary or synopsis of your health information if you agree. Please note there are specific laws governing psychotherapy session notes because these notes are intended to assist the psychotherapist only, and have the potential to be misinterpreted by others. The office may deny your request under limited circumstances, if we believe it would be reasonably likely to cause you substantial harm. Should this office deny your request, you will be provided a reason in writing and an explanation of your rights to initiate a review of the denial. The office may charge a reasonable administrative fee to reimburse us for the time and supplies required to provide you with your PHI.
3. **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You may request that health information be sent to you at a specific location and by specific means such as E-mail. This office will attempt to comply as long as it is feasible.
4. **Right to an Accounting:** You have the right to request an accounting of disclosures. This is a list of certain non-routine disclosures your therapist has made of your PHI. Non-routine disclosures include disclosures made for purposes other than treatment, payment collection, or healthcare operations. You may make one such request every year. The office may charge a reasonable administrative fee to reimburse for time and supplies required to provide the accounting of disclosures.
5. **Right to an Amend:** You have the right to request an amendment or correction to your PHI for as long as the PHI is maintained in the record. The request must be made in writing and include a reason. This office must respond to your request within 60 days of the request, which will be granted or denied. If your request is granted, the appropriate changes will be made, you will be informed of the changes made, and third parties needing to know about the changes will be notified. This office may deny your request if the information in the record is, in our opinion: (a) accurate and complete, (b) not part of the PHI kept by or for your therapist, (c) not part of the PHI which youwould be permitted to inspect and copy; or (d) not created by your therapist. You will receive a written statement stating the reason for the denial.
6. **Right to a Paper Copy:** You have the right to receive this notice by email or in written format upon request.

This office reserves the right to change the terms of privacy practices as described in this NOTICE and will inform you by mail or email of any changes.

COMPLAINTS

Should you believe that this office has violated your privacy rights, you may file a complaint with this office by sending a written complaint to:

Dr. Ginny Liwanpo
1101 Dove Street, #155
Newport Beach, CA 92660

You may also submit a written complaint to the United States Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C., 20201.

You have specific rights under the Privacy Rule, which are protected and will not affect the services that you receive, if you exercise your right to file a complaint. The effective date of this NOTICE is April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

You have the right to refuse to sign this document

I, _____ have read and received a copy of this office's HIPAA Notice of Privacy Practices.
Patient Name (parent/guardian if patient is under 18)

Signature: _____ Date: _____
(parent/guardian if patient is under 18)

FOR OFFICE USE ONLY

This office attempted to obtain written acknowledgement of receipt of the NOTICE of Privacy Practices. However, this office was unable to obtain it because:

_____ The patient refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented this office from obtaining the acknowledgement

GINNY B. LIWANPO, PSY.D.
PSY 20910

CHILD / ADOLESCENT INTAKE FORM

CONFIDENTIAL PATIENT INFORMATION

Patient Name _____ DOB: _____ AGE: _____

Primary Language(s): _____ Ethnicity: _____

Patient's Assigned Sex: _____ Patient's Gender Identity: _____

Parents/guardians (for minor): _____

Phone number (where message can be left): * _____

Cell phone: * _____ Email: * _____

Home address: * _____

INSURANCE COVERAGE: Yes / No HMO / PPO Effective Date: _____

Insurance Company: _____ Phone: _____ Annual Deductible Met ? Yes / No

Name of Policy Holder: _____ DOB: _____ SS#: _____

ID/Policy #: _____ Group #: _____ Plan #: _____

Billing Address: _____ CoPay Amount: _____

Emergency contact name & number(s): _____

School: _____ Grade: _____

Patient living with (name/relationship/age): _____

Financially responsible party: _____

Relationship to patient: _____

Address and phone (if different from above): _____

Referred by: _____

Primary care physician & address/phone number: _____

Psychiatrist, if any (name & phone number) _____

Current medications: _____

Presenting Problems (*What are you seeking help with for your child?*): Duration (months):

_____ _____

_____ _____

_____ _____

*** By providing the phone number where messages may be left, cell phone, and email contact information above, you agree to have this office use such contact information to provide you with information related to scheduling and treatment.**

CURRENT SYMPTOM CHECKLIST (*Rate intensity of symptoms currently present for at least **PAST 2 WEEKS***)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe
APPETITE				
Bingeing/Purging	[ ]	[ ]	[ ]	[ ]
Change in appetite	[ ]	[ ]	[ ]	[ ]
Laxative/Diuretic abuse	[ ]	[ ]	[ ]	[ ]
Self-induced Vomiting	[ ]	[ ]	[ ]	[ ]
Significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
ANXIETY				
Excessive worrying	[ ]	[ ]	[ ]	[ ]
Flashbacks	[ ]	[ ]	[ ]	[ ]
Nervous/anxious	[ ]	[ ]	[ ]	[ ]
Panic attacks	[ ]	[ ]	[ ]	[ ]
Intrusive traumatic memories	[ ]	[ ]	[ ]	[ ]
FOCUS				
Easily distracted	[ ]	[ ]	[ ]	[ ]
Dissociative states	[ ]	[ ]	[ ]	[ ]
Trouble completing tasks	[ ]	[ ]	[ ]	[ ]
Trouble concentrating	[ ]	[ ]	[ ]	[ ]
Trouble following directions	[ ]	[ ]	[ ]	[ ]
Trouble paying attention	[ ]	[ ]	[ ]	[ ]

	None	Mild	Moderate	Severe
IMPULSE				
Impulsive	[ ]	[ ]	[ ]	[ ]
Need to repeat behaviors	[ ]	[ ]	[ ]	[ ]
Self-mutilation	[ ]	[ ]	[ ]	[ ]
MOOD				
Agitation	[ ]	[ ]	[ ]	[ ]
Angers easily	[ ]	[ ]	[ ]	[ ]
Elevated mood	[ ]	[ ]	[ ]	[ ]
Irritability	[ ]	[ ]	[ ]	[ ]
Lack of energy/fatigue	[ ]	[ ]	[ ]	[ ]
Mood swings	[ ]	[ ]	[ ]	[ ]
Physical complaints	[ ]	[ ]	[ ]	[ ]
Tearfulness/ Emotional	[ ]	[ ]	[ ]	[ ]
THOUGHTS				
Delusions	[ ]	[ ]	[ ]	[ ]
Hallucinations	[ ]	[ ]	[ ]	[ ]
Homicidal Ideas	[ ]	[ ]	[ ]	[ ]
Paranoid Ideas	[ ]	[ ]	[ ]	[ ]
Racing Thoughts	[ ]	[ ]	[ ]	[ ]
Suicidal Ideas	[ ]	[ ]	[ ]	[ ]

	None	Mild	Moderate	Severe
CONTROL				
Aggressive Behaviors	[ ]	[ ]	[ ]	[ ]
Get stuck with thoughts	[ ]	[ ]	[ ]	[ ]
Hyperactive/fidgety	[ ]	[ ]	[ ]	[ ]
Fear of particular things	[ ]	[ ]	[ ]	[ ]
Feeling worthless	[ ]	[ ]	[ ]	[ ]
Few or no friends	[ ]	[ ]	[ ]	[ ]
Grief/loss	[ ]	[ ]	[ ]	[ ]
Hopelessness	[ ]	[ ]	[ ]	[ ]
Insomnia	[ ]	[ ]	[ ]	[ ]
NO menstrual cycle	[ ]	[ ]	[ ]	[ ]
Low self-esteem	[ ]	[ ]	[ ]	[ ]
Medical condition	[ ]	[ ]	[ ]	[ ]
Motor/Vocal Tics	[ ]	[ ]	[ ]	[ ]
Nightmares	[ ]	[ ]	[ ]	[ ]
Oversleeping	[ ]	[ ]	[ ]	[ ]
Physical/sexual abuse	[ ]	[ ]	[ ]	[ ]
Poor body image	[ ]	[ ]	[ ]	[ ]
Sleep disturbance	[ ]	[ ]	[ ]	[ ]
Sexual Dysfunction	[ ]	[ ]	[ ]	[ ]
Substance use	[ ]	[ ]	[ ]	[ ]
Withdrawn/ Social isolation	[ ]	[ ]	[ ]	[ ]

SUBSTANCE USE HISTORY (*check all that apply for patient*)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used: (complete all that apply)

	First use age	Last use age	Current Use: Yes/No	Current Use: Frequency	Current Use: Amount
[ ] alcohol					
[ ] amphetamines/speed					
[ ] barbiturates/owners					
[ ] caffeine					
[ ] cocaine					
[ ] crack cocaine					
[ ] hallucinogens (e.g., LSD)					
[ ] inhalants (e.g., glue, gas)					
[ ] marijuana or hashish					
[ ] nicotine/cigarettes					
[ ] PCP					
[ ] prescription _____					
[ ] Other _____					

Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____)

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used. [ ] relationship conflicts
[ ] other _____

GINNY B. LIWANPO, PSY.D.
PSY 20910

DEVELOPMENTAL QUESTIONNAIRE FOR CHILDREN

(to be completed by both parents or guardians together)

Please complete the following items to the best of your recollection. Not all sections may be applicable to your situation, so feel free to add additional pages as needed. Having this information in advance will better prepare your psychologist for your initial meeting, and you will be able to elaborate further on any of these points, if you wish, and some of this information may be covered again during your meeting.

Today's date: _____

Child's name: _____ DOB: _____

Name(s) of person(s) completing this form, and relationship to the child:

_____

Parent information: **Mother** **Father**

Name: _____ _____

Contact Phone: _____ _____

Age at child's birth: _____ _____

Highest level of education: _____ _____

Occupation: _____ _____

General Health: _____ _____

Family History

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

_____

Parents' current marital status:

[ ] married to each other
[ ] separated for _____ years
[ ] divorced for _____ years
[ ] mother remarried _____ times
[ ] father remarried _____ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for _____ years
(age of patient at mother's death _____)
[ ] father deceased for _____ years
(age of patient at father's death _____)

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse
[ ] experienced physical/verbal/sexual abuse

Age of emancipation from home: _____ Circumstances: _____

_____

Any other special circumstances in childhood: _____

_____

_____

Describe any past or current significant issues in other immediate family relationships: _____

_____

_____

_____

For parents who are divorced and remarried or in significant live-in relationships:

Nature of the divorce (amicable, contentious, on-going conflict, etc.): _____

_____

Step-parent's/significant live-in other's name: _____

Highest level of education: _____ _____

Occupation: _____ _____

Arrangements for visitation and custody: _____

_____

Sibling information (please add additional page as needed):

Name	Age	full/half/step-sib	Where living if not home?

In cases of adoption:

Age of child when s/he moved in your home/age when adopted: _____ / _____

Any information about the biological parents: _____

_____

Any pertinent information about the initial adjustment and family reactions: _____

_____

_____

Pregnancy and Regarding Mother of child (MOC):

Did MOC receive prenatal care? Any complications during pregnancy? _____

_____

Full term? _____ C-section? _____

During the pregnancy:	Yes	No		Yes	No
Did MOC use drugs?	_____	_____	Did MOC smoke cigarettes?	_____	_____
Did MOC drink alcohol?	_____	_____	Any depression/anxiety?	_____	_____
Any medical problems?	_____	_____	Any accidents or falls?	_____	_____
Any trauma or losses?	_____	_____			

Please describe in detail any items you checked "yes":

_____

_____

Delivery:

Birth weight: _____

Did the baby have any problems after the delivery that needed medical attention (e.g., trouble breathing, jaundice, seizures, paralysis)?

Describe: _____

Did MOC suffer from post-partum depression? Describe: _____

_____

Infancy and early childhood:

Any health problems? _____

Baby's temperament (e.g., happy, smiling, laughing, cuddly, whiney, fussy, seemed in pain, sad, "old," hard to engage)?

Describe: _____

Activity level during infancy and early childhood:

_____ High level of activity, such as squirming, wiggling, kicking, and moving about

_____ Low level of physical activity, not showing much increase in movement, interest, or response

_____ Showed vigorous activity when awake and when played with but equally often observed playing quietly and generally relaxed

During baby's first year was there anything (even if it had nothing to do with the baby) that caused unhappiness or anxiety in the family or placed the mother or father under special strain?

Describe: _____

What is your child's current sleep arrangement? _____

Developmental milestones:

As best you can remember, designate the age at which your child:

Age (months)

_____ Speak first words

_____ Potty trained

Age (months)

_____ Use 2-word sentences

_____ Walk alone

Did your child have difficulties in separating from you when left with others? How did s/he respond when you returned?

_____

Did your child have any delays or difficulties (If so, describe and give ages):

_____ In motor coordination? _____

_____ In speech? _____

Did your child have any toilet accidents at this time? Describe: _____

Attachment:

Does the child have a closer attachment to one parent than the other? If so, describe how this is shown. _____

_____

Did the child strongly attach to any other people? Describe when and whom: _____

Does your child prefer playing with children who are:

_____ his/her own age _____ older _____ younger _____ with one or two friends _____ many friends?

Has your child ever had difficulties in making and keeping friendships? Describe: _____

Did your child ever lose anyone with whom s/he was close? _____

How would you describe your child's personality? (circle those that apply)

happy/sad	outgoing/introverted	flexible/stubborn	underachiever/overachiever
optimistic/pessimistic	calm/high-strung	leader/follower	lackadaisical/perfectionist

Discipline:

What methods (e.g., spanking, time-outs, ignoring, withholding of privileges, withholding of approval and affection) did you use in disciplining your child and how did s/he respond? _____

_____

What were major areas that required discipline? _____

Who usually applied the discipline? _____

Problems and concerns:

Have any of these areas been of concern to you? (Check those that apply and star those of current concern)

ACADEMIC:
_____ Difficulty with math
_____ Difficulty with spelling & reading

ANXIETY:
_____ Excessive worrying
_____ Difficulty separating from caregiver
_____ Nervous/anxious
_____ Overly dependent
_____ Unusual fears or phobias

APPETITE:
_____ Bingeing/Purging
_____ Change in appetite
_____ Self-induced Vomiting
_____ Significant weight gain/loss

CONTROL:
_____ Bullying, threatening others
_____ Difficulty with change
_____ Impulsive
_____ Restless, trouble sitting still

FOCUS:
_____ Difficulty following directions
_____ Difficulty paying attention
_____ Easily distracted

IMPULSE:
_____ Cruelty to animals
_____ Destroying property
_____ Fire-setting
_____ Getting into fights
_____ Lying
_____ Oppositional, defiant behaviors
_____ Running away from home
_____ Self-injurious behavior
_____ Sexual acting out
_____ Substance use
_____ Stealing

LANGUAGE:
_____ Difficulty expressing what s/he wants to say
_____ Difficulty understanding what is said

MOOD:
_____ Depression
_____ Irritability
_____ Mood swings
_____ Often angry and resentful
_____ Tearfulness/emotional

SENSORY:
_____ Avoidance of certain textures
_____ Overly sensitive to sounds
_____ Difficulty manipulating small objects
_____ Restricted, repetitive interests
_____ Restricted, repetitive motor mannerisms
_____ Trouble with balance

SLEEP:
_____ Insomnia
_____ Nightmares
_____ Oversleeping
_____ Sleep disturbance

TEMPERAMENT:
_____ Awkward / Clumsy
_____ Overly anxious
_____ Shy
_____ Lack of social skills

THOUGHT:
_____ Delusions
_____ Hallucinations
_____ Lost in fantasy, daydreaming
_____ Preoccupation with violence
_____ Often blaming of others or circumstances
_____ Suicidal Ideas

_____ Other _____

Did your child have any frightening experiences? Describe: _____

_____

Describe your child's strengths with regards to abilities, behaviors, etc.: _____

_____

Spirituality:

Describe religious/spiritual practices of your family, if any: _____

Education:

Child's academic strengths: _____

Child's academic weaknesses: _____

Behavior problems at school: _____

Extracurricular activities: _____

Grades:	_____ above average	_____ average	_____ below average
Ability:	_____ above average	_____ average	_____ below average
Attendance:	_____ usually present	_____ often excused absences	_____ truant
Relations with peers:	_____ excellent	_____ usually gets along	_____ problems
Relations with teachers:	_____ excellent	_____ usually gets along	_____ problems

Do you feel that schools have adequately dealt with your child's problems? Explain:

_____

Has your child received any special help in the schools (tutoring, special ed, therapy, etc.)?
Describe when, whom, what: _____

_____

Has your child repeated or skipped any grades? _____

Health:

List major illnesses/surgeries that your child has had. _____

_____

Any significant medical, mental health, and learning problems in the immediate and extended family: _____

_____

Emotional/Psychiatric History

[ ] [ ] Prior outpatient psychotherapy?
No Yes If yes, on _____ occasions. Longest treatment by _____for ____ sessions from _____ /_____ to _____ / _____
Provider Name Month / Year Month / Year

Prior provider name	City/State	Phone	Diagnosis	*Beneficial*?

[ ] [ ] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?
No Yes If yes, on _____ occasions. Longest treatment at _____ from _____ / _____ to _____ /_____
Name of facility Month / Year Month / Year

Hospital facility name	City/State	Phone	Diagnosis	*Beneficial*?

[ ] [ ] Prior or current psychotropic medication usage? If yes:
No Yes

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	*Beneficial*?

[ ] [ ] Any inpatient/outpatient treatment for a psychiatric/substance use disorder or psychotropic medications in family history?
No Yes _____

_____

GINNY B. LIWANPO, PSY.D.
PSY 20910

PATIENT QUESTIONNAIRE

(to be completed by the patient, with parents' help only if necessary)

Today's date: _____

Your name: _____ Age: _____ Date of Birth: _____

Whose idea was it for you to come today? _____ Mine _____ Parent(s) _____ Other: _____

If it wasn't your idea, are you OK with it? _____ Yes _____ No _____ Not sure _____

For what problems are you seeking help today? _____

_____

Have you ever seen a therapist/counselor in the past? _____ Yes _____ No

If yes, who did you see? _____

When and for how long did you see the therapist/counselor? _____

For what reason? _____

Was it helpful? Why/why not? _____

_____

Who lives at home with you? _____

Please check all appropriate boxes.

Describe your family	Mom	Dad	Step-mom	Step-dad	Brother	Sister	Other
Likes me							
Kind							
Pleasant							
Understanding							
Easygoing							
Rarely home							
Strict							
Mean							
Harsh							
Critical							
Negative							
Angry							
Uses drugs							
Uses alcohol							
Verbally abusive							
Physically abusive							

Please check all appropriate boxes.

Kinds of punishment	Mom	Dad	Step-mom	Step-dad	Brother	Sister	Other
Sends you to your room							
Takes away privileges							
Restricts/Grounds you							
Spanks/Hits you							
Other: explain							

Do you have, or have you ever had, any significant medical problems or been hospitalized?

_____

Are you on any medications? _____

_____

I identify my gender as (fill in the blank): _____

For girls: Have you started your period? _____ Yes _____ No If yes, when? _____

Are you, or have you been, pregnant? _____ Yes _____ No

Have you ever drunk alcohol? _____ Yes _____ No

If yes, do you still drink? _____ Yes _____ No How often? _____

If yes, is this a problem for you? _____ Yes _____ No

Have you ever used drugs? _____ Yes _____ No What? _____

If yes, do you still use? _____ Yes _____ No How often? _____

If yes, is this a problem for you? _____ Yes _____ No

Have you ever had police/court involvement? _____ Yes _____ No

If yes, describe: _____

Check all that apply to you:

_____ Prefer to be alone
_____ Problem getting along with others
_____ Don't get along with my brothers and sisters
_____ Family member, relative, or friend tried to kill him/herself
_____ I have a best friend
_____ I have a boyfriend/girlfriend (age: _____)
_____ I am/was sexually abused
_____ I get picked on by others
_____ I don't get along with my teachers
_____ Alone a lot but don't like it
_____ Shy
_____ Conflict with parents/step-parents
_____ I have a lot of friends
_____ I am/was physically abused
_____ I feel neglected
_____ I ditch school
_____ I've been suspended/expelled
_____ My grades are low

Have you ever experienced any of these symptoms? Please check all that apply.

	Current	Past		Current	Past		Current	Past
Restless/unable to sit still			Acting without thinking			Difficulty paying attention		
Low motivation			Easily frustrated			Easily distracted		
Daydream; fantasize a lot			Temper outbursts			Uncooperative		
Back talk			Don't like to admit mistakes			Argue a lot		
Enjoy "bugging" others			Easily annoyed by others			Rebellious		
Damage property			Steal things			Want to run away from home		
Run away from home			Hurt animals			Hurt people		
Sexual problems			Set fires			Nervous/can't relax		
Worry more than others			Worry about past behaviors			Worry about the future		
Fears or phobias			Panic			Afraid of germs or getting sick		
Repeat acts over and over			Feel confused a lot			Can't control body movement		
Feel odd or different than others			Speech problems			Restrict eating even when hungry		
Vomit food intentionally			Eat too much at once			Hear voices or see things others don't		
Headaches			Stomachaches			Sad, crying, or depressed		
Hard to make decisions			Irritable/angry a lot			Keep away from others		
Trouble concentrating			Trouble going to sleep			Trouble staying asleep		
Memory problems			Nightmares			Nothing is fun anymore		
Cutting or injuring myself			Sleep too much			Feeling tired all the time		
Unexplained weight gain or loss			Feel suicidal			Low self-esteem		