Alvin Butler, LMHC ♦ Harry Spears, LMHC
225 SW 7th Terrace • Gainesville, Florida 32601
352-379-2829 • 352-379-2843 Fax
www.itmflorida.com

INFORMATION FOR NEW CLIENTS

Effective communication between client and therapist is an important part of the therapy process. The following information covers many of the questions that may arise about therapy and includes a listing of the client's rights and responsibilities. Any questions you may have that are not covered in this notice should be brought to the attention of The ITM Group and Associates staff.

CLIENT RIGHTS

The following is not a list of legal rights, but rather is a statement of what you can reasonably expect from The ITM Group and our Clinicians. As a client receiving treatment at our office you are entitled to:

- Be treated with dignity, courtesy and respect
- Ask Questions relevant to your care.
- Know when your clinician is available to see you, or if not, how long the waiting period would be.
- Be informed about areas of specialization and limitations.
- Ask questions about written materials regarding your treatment.
- Actively participate in developing your treatment goals.
- Be informed regarding fees for treatment and method of payment, including insurance reimbursements.
- Discuss aspects of your treatment with others, including consulting with other clinicians.
- Request that a written report regarding services rendered to a qualified professional, or organization upon your written authorization.
- Request information about the Code of Ethics to which The ITM Group and their Clinicians adheres
- Terminate therapy at any time.
- Confidential communication in accordance with State and Federal law, and best practices of the profession (A copy of our Notice of Privacy Practices is kept in the waiting area)

EMERGENCY PROCEDURES

During after hours or weekends if you have an emergency or a life threatening situation please call the Alachua County Crisis Center (352) 264-6785 or 911.

TREATMENT METHODS

Counseling sessions are generally around 60 minutes in length. The frequency of sessions and the length of your treatment are aspects of therapy that you and your clinician will decide together based on your individual treatment needs and progress. Generally, various modalities of treatment are utilized for different problems. Please ask, if you have any questions about the nature of your treatment.

DISSATISFACTION WITH TREATMENT

Sometimes a client will not obtain the desired results or goals from therapy in the time period expected. This can result in frustration and dissatisfaction. During the process of therapy, emotional distress can arise as difficult issues are processed. Please discuss this with your clinician. If your concerns are not resolved, and adequate progress is not being made or if it becomes apparent that your clinician is not a good "fit" with you, your clinician may either make a referral for more specialized care, or discontinue therapy and assist with a referral to an appropriate therapist, health care professional or treatment program.

You may frequently have questions for our support staff. Jackie Piel manages the front desk and is often the person who schedules appointments and any questions related to insurance or billing just prior to seeing your clinician. The front desk staff will schedule follow up appointments as you leave the office. If there is already someone being served at the front desk, please wait in the waiting room to be served. This allows us to maintain a greater degree of confidentiality. As a service to you, the staff will usually call you the day prior to your appointment as a reminder, however, if they cannot call, THIS REMAINS YOUR RESPONSIBILITY to remember your appointments. We will send you a monthly statement for your records. If you would rather that we not send a statement to a particular address, or call you at a particular number, please let our staff know.

The staff is committed to providing you with care that is helpful. The ITM Group and our clinicians pursue excellence in a variety of clinical treatments. The ITM Group and our clinicians provide individual therapy with a wide population, and perform psychological evaluations. The ITM Group practices in a setting that includes many clinicians, therefore allowing easy referral to a professional that will likely meet your needs. We welcome any suggestions you may have about how we might improve the quality of services we provide.

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

FEDERAL LAW REQUIRES THE PROVISION OF THIS NOTICE

We are required by law to maintain the privacy of Protected Health Information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request. WE are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint. Or Privacy Officer is Alvin Butler, LMHC. You can contact the Privacy Officer by calling (352) 379-2829.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAY MAKE TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We may use information I your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital etc. For example, if we want an opinion about your condition from a specialist to obtain a consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may disclose information from your record to allow "health care operations". These operations include activities like reviewing records to see how care can be improved, contacting you with information about the treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

YOUR RIGHTS

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request for amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices. Including the actions of our staff with respect to the privacy of your health information. You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you five your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or claim under the policy even if you revoke the authorization.

USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE ARE REQUIRED TO MAKE WITHOUT YOUR PERMISSION:

In certain circumstances, we are required by law to make a disclosure of your health information. For example, State Law requires us to report suspected child abuse or neglect. Also, we must disclose information the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

We may use or disclose information from your record if we believe it is necessary to prevent or lesson a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE ARE ALLOWED TO MAKE WITHOUT YOUR PERMISSION:

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations. If you receive mental health care, including treatment for substance abuse, information relating to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or other. We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions and

product defects. We may assist health oversight activities, such as investigations of possible health care fraud, We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even If this is not ordered by a court. WE may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it. If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to saw enforcement officials.

We may use or disclose information from your record for research under certain conditions. Under certain conditions, we may disclose information for specialized government purposes, such as military, nation security and intelligence or the protection of the President.

The confidentiality of protected health information related to alcohol or drug abuse is protected by federal law regulations. Violations of the federal law and regulations is a crime and may be reported to appropriate authorities. We may not disclose any information about you unless you authorize the disclosure in writing, except as specified. We may disclose information about you if a court orders the disclosure. We may disclose information about you in a medical emergency, to permit you to receive needed treatment. We may disclose information about you for purposes of program evaluations, audits or research. We may disclose information about you if you commit a crime on our premises or against any person who work for us or if you threaten to commit such a crime. We are required to disclose information about you if we suspect child abuse or neglect. Except as stated in this Notice, you have the same rights and protections with respect to your health information as described in our general Notice of Privacy Practices.

We may contact you to provide appointment reminders as a courtesy. WE may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

____

Client Name

____

Client Signature

____

Date

PRELIMINARY EVALUATION INFORMATION

Identifying Information Date:________________

Name of Child____SS#________________
Address_____________________________________City______________State______Zip_________
Phone: (H)________________________(W)____________________Date of Birth_________________
Birthplace___________________________________Sex: Male Or Female (Circle One
Name (s) of person (s) completing this form:__________________________Relationship______________
Name (s) of person (s) having custody of child:_______________________Relationship______________

Who referred you to us:____

Presenting Problem

In the space below, describe as specifically as possible the problems which have led you to seek treatment or evaluation of your child.

____
____
____

What do you believe to be the most important factor(s) causing these problems?

____
____
____

At what ages did you first notice these problems?_______________________________________

Have there been any family changes or difficulties (new baby, death, divorce, family arguments, etc.) which may be related to these problems?_________ Please explain._________________________________
____

Has your child ever been treated for any behavioral and / or emotional problems? Yes_________ No__________

As an outpatient (clinic, private, etc.)

Name____Phone (____)________________
Address_____________________________________City______________State_____Zip__________
Name of doctor / therapist____
Reason for treatment____

Name____Phone (____)________________
Address_____________________________________City______________State_____Zip__________
Name of doctor / therapist____
Reason for treatment____

As an inpatient (in a hospital, residential treatment center, etc.)

Name____Phone (____)________________________
Address____City______________State_____Zip__________
For how long?_______________________________________Dates________________________________
Name of doctor / therapist____
Reason for admission____

Name____Phone (____)________________________
Address____City______________State_____Zip__________
For how long?_______________________________________Dates________________________________
Name of doctor / therapist____
Reason for admission____

(If more space is needed please list information on the last page)

Has your child experienced any of the following:

	Yes	No	Age	How often
Makes up stories excessively	____	____	____	________
Talks to imaginary companions	____	____	____	________
Sees or hears things that do not exist	____	____	____	________
Runs away or sneaks out	____	____	____	________
Sets fires	____	____	____	________
Problems with the law	____	____	____	________
Talked about or threatened to harm self	____	____	____	________
Has harmed self	____	____	____	________
Has excessive fears	____	____	____	________
Is hyperactive	____	____	____	________
Substance Abuse	____	____	____	________
Sadness or Depression	____	____	____	________
Aggression towards others	____	____	____	________
Temper tantrums	____	____	____	________
Overanxious	____	____	____	________
Sleeping problems	____	____	____	________
Bad dreams / nightmares	____	____	____	________
Lost interest in activities	____	____	____	________
Impulsive; acts without thinking	____	____	____	________
Sudden behavior or personality change	____	____	____	________
Inappropriate sexual behavior	____	____	____	________
Poor appetite	____	____	____	________
Problems with authority	____	____	____	________
Takes risks	____	____	____	________
Has companions which are negative influences	____	____	____	________
Destruction of property	____	____	____	________
Cruelty to animals	____	____	____	________

Has your child previously been evaluated with psychological tests, e.g. intelligence testing and / or personality assessments? Yes ______ No ______

If so, please provide us with the name and address of the psychologist or school, so that we may obtain a report or other pertinent data from this evaluation.

Name:____Phone (___) ____________
Address_____________________________________City______________State_____Zip_______

SCHOOL INFORMATION

What schools has your child attended? (Begin with present school)

School and Address	Grade	Special Education

Has your child ever repeated a grade? Yes _____ No _____ if yes, please explain.
Grade Repeated __________ Reason ______________________________
Grade Repeated __________ Reason ______________________________

Estimate grade average for each year for school subjects:
K ________ 1st________ 2nd ________ 3rd ________ 4th ________ 5th ________ 6th ________ 7th ________
8th ________ 9th ________ 10th ________ 11th ________ 12th ________

Has your child experienced any of the following problems in school?

	Yes	No	How often?
Getting along with other children	Yes _____	No ______	________
Short attention span	Yes _____	No ______	________
Overactive	Yes _____	No ______	________
Reading	Yes _____	No ______	________
Writing letters or numbers	Yes _____	No ______	________
Spelling	Yes _____	No ______	________
Math	Yes _____	No ______	________
Finishing work in class	Yes _____	No ______	________
Homework	Yes _____	No ______	________
Frequent absences due to illness	Yes _____	No ______	________
Skipping school	Yes _____	No ______	________
Behavior / conduct problems	Yes _____	No ______	________

Please rate your child=s effort in school:
Maximum ______________ High ________________Average______________ Low ________________

What are your child=s usual conduct grades?
Grade: K-2 ________________ 3-5 ________________ 6-8 ________________ 9-12 ________________

Please estimate your child=s intelligence level: Below Average Average Above Average

Name of teacher (s) we can contact for information regarding your child=s school performance:________________
____

Name of school:____Phone # ________________________

MEDICAL HISTORY

Name of child=s pediatrician or family doctor ______________________________ Phone #________________

Has your child ever been in the hospital for medical problems: Yes ________ No ________

Dates	Names of Hospital, City & State	Reason for Hospitalization
________	______________________________	______________________________
________	______________________________	______________________________
________	______________________________	______________________________

Does your child have any physical or medical problems or handicaps? (e.g., diabetes, asthma, heart condition, etc.)? Yes ________ No ________, If yes, please explain:____
____

Is your child taking any medications? Yes ________ No ________ If yes, what is it, who prescribed it and how long has he / she been taking it?

Medication	Prescribed by	How Long
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________

Does your child have any allergies? Yes ________ No ________ If yes, describe what they________________

Has your child experienced any of the following?

Soiling or lack of bowel control.. Yes ______ No ________
Wetting or lack of bladder control... Yes ______ No ________
Urinary infections... Yes ______No ________
Convulsions.. Yes ______ No ________
Loss of consciousness.. Yes ______ No ________
Eye examination (give date) .... Yes ______ No ______ Date:_____
Ear examination (give date) .... Yes______No_______Date:_____
Corrected hearing.. Yes ______ No ________
Persistent headaches requiring treatment.. Yes ______ No ________
Abnormal weight loss or gain (please circle which).. Yes ______ No ________
Frequent colds / respiratory conditions .... Yes ______ No ________
Any known heart conditions... Yes ______ No ________
Unusual muscular weakness... Yes ______ No ________
Rocking, head banging... Yes ______ No ________
Thumb sucking.. Yes ______ No ________
Preoccupation with physical complaints.. Yes ______ No ________

If there were any other difficulties, please explain:____
____

What childhood illnesses has your child had?

Illness	Age at time
____	______________

Did your child suffer any complications of these illnesses (high fever, convulsions, coma, etc.)? Yes ____ No _____
If yes, please describe the circumstances:

Has your child been injured in any accidents or falls at any time? Yes ______ No ______ Please describe.

Incident	Age	Injury

Was your child ever unconscious, in a comma, or had a concussion as a result of illness or injury? Yes _____ No _____
If yes, please explain:

DEVELOPMENTAL INFORMATION

Where there any physical or emotional difficulties during pregnancy with this child Yes ______ No ______ If yes, please describe:

Was this child premature or full term: ________________ If premature, give number of weeks early: __________

Were there any of the following complaints? Mother taking medication or drugs (specify): ____________________ Long labor ________ Forceps delivery _________ Breech birth ________ Eclampsia __________
Caesarean Section __________
Other

Were there any immediate complications following delivery? Yes ______ No ______ if yes, please describe: _________

Please list the age at which your child:		Any Problems?	
Walked	Age: ______	Yes ______	No ______
Talked (words)	Age: ______	Yes ______	No ______
Talked (sentences)	Age: ______	Yes ______	No ______
Weaned	Age: ______	Yes ______	No ______
Toilet trained	Age: ______	Yes ______	No ______
Began puberty	Age: ______	Yes ______	No ______

If there were any difficulties, please explain:

PERSONAL INFORMATION ABOUT CHILD

What are your child=s strengths

What activities or special treats does your child find rewarding?

What does your child spend most of his / her free time doing?______________________________

____

NUTRITIONAL INFORMATION

Has your child had an eating problem? Yes ______ No ______ Please explain: (include dates)______________

____

Has your child ever been on a special diet? Yes ______ No ______ if yes, please explain.______________

____

Are there any other dietary habits that should be noted? Yes ____ No ____ if yes, please explain______________

____

FAMILY INFORMATION

Biological Father ______________________________ Date of birth ______________
Occupation____
Address______________________________City______________State____Zip________
Home Phone (____)____________________Work Phone (____)________________Ext______
Schooling______________________________Social Security #________________
Marital Status____________________________Number of marriages______________

Biological Mother ______________________________ Date of birth ______________
Occupation____
Address______________________________City______________State____Zip________
Home Phone (____)____________________Work Phone (____)________________Ext______
Schooling______________________________Social Security #________________
Marital Status____________________________Number of marriages______________

Stepfather______________________________ Date of birth ______________
Occupation____
Address______________________________City______________State____Zip________
Home Phone (____)____________________Work Phone (____)________________Ext______
Schooling______________________________Social Security #________________
Marital Status____________________________Number of marriages______________

Stepmother______________________________ Date of birth ______________
Occupation____
Address______________________________City______________State____Zip________
Home Phone (____)____________________Work Phone (____)________________Ext______
Schooling______________________________Social Security #________________
Marital Status____________________________Number of marriages______________

Adoptive father______________________________ Date of birth ______________
Occupation____
Address______________________________City______________State____Zip________
Home Phone (____)____________________Work Phone (____)________________Ext______
Schooling______________________________Social Security #________________
Marital Status____________________________Number of marriages______________

Adoptive mother______________________________ Date of birth ______________
Occupation____
Address______________________________City______________State____Zip________
Home Phone (____)____________________Work Phone (____)________________Ext______
Schooling______________________________Social Security #________________

Marital Status________________________________ Number of marriages____________________________

Please list all brothers and sisters (include half-siblings):

Name	Date of birth	Sex	Present Health	Living at home

Others at home:

Name	Date of birth	Sex	Relationship

Has your child ever lived with anyone else for any period? Yes_____ No _____ If yes, when (give dates), with whom and why:

When?	With whom?	Why?

Has anyone in the family (brother, sister, mother, father, grandparents, aunt / uncle, siblings, etc.) Ever had any of the following problems?

			Relationship
Epilepsy..	Yes_____	No _____	____________________
Diabetes..	Yes_____	No _____	____________________
Mental illness requiring hospitalization...	Yes_____	No _____	____________________
Outpatient treatment for emotional problems....................................	Yes_____	No _____	____________________
Allergies..	Yes_____	No _____	____________________
Excessive use of alcohol..	Yes_____	No _____	____________________
Excessive use of drugs or medication..	Yes_____	No _____	____________________
Suicide..	Yes_____	No _____	____________________
Serious legal difficulties (prison sentence)..	Yes_____	No _____	____________________

What kinds of things do **ALL** members of the family do together?_________________________________

____

Have the mother and father ever been separated for a period of time (armed services, illness, marital problems, etc.)?
Yes______ No ______ Why?____

Religion of child__________________________

I understand that this information will be used in the evaluation of my child and will be included in his / her records.

Signed ____Date_____________________
Parent / Legal Guardian