

## CONSENT TO OUTPATIENT THERAPY (MINOR)

This document contains important information about my professional services and policies. Please read it carefully and write down any questions you might have so that we can discuss them when we meet. When you sign this document, it will represent an agreement between us.

### PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, as well as the particular problems you bring forward. There are many different methods I may use to deal with the issues that you hope to address. Psychotherapy is not like a visit to your medical doctor. Instead, it requires a very active effort on your part. In order for therapy to be most successful, you will have to work on things that we discuss both during our sessions together and at home.

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

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

I normally conduct an **initial evaluation** that will last from 2 to 3 sessions. During this time, we can both decide if I am the best person to provide the services your child needs in order to meet your/their treatment goals. If psychotherapy is initiated, I will usually schedule one 45 to 50-minute session at a frequency that we agree upon.

### INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of my fees.** It is very important that you find out exactly what mental health services your insurance policy covers. If you do not have insurance, or I am not an in network provider, you will be expected to pay the full fee at the time services are delivered.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

### **CONTACTING ME**

I meet with clients throughout the day so I rarely answer the phone. I prefer to communicate via email and this is often the fastest means of getting in touch. If you **DO NOT** want to be contacted via email, please let me know. I can also be reached through voicemail and I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room.

### **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests (photocopying records, chart review).

### **MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

### **CONFIDENTIALITY**

Dr. Ruebel will not release information about you to another party unless:

- 1) You authorize him to do so in writing (you may revoke this at any time afterward).
- 2) He has reason to believe that you pose an imminent risk to your safety or the safety of an identifiable person(s).
- 3) You disclose that a child under the age of 18, an elderly person, or a disabled person is or has been physically or sexually abused by you or someone you know.
- 4) He is required by a court of law to disclose information (for example, if you use your mental health treatment as a defense in legal proceedings).

### **DIVORCE AND CUSTODY DISPUTES (FOR MINOR CLIENTS)**

Although my responsibility to your child(ren) may require my involvement in conflicts between you and your (ex) spouse, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child(ren). In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorney(s) not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if

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appropriate releases are signed or a court order is provided), but I will not make any recommendations about the final decision. Furthermore, if I am required to appear as a witness,

the party responsible for my participation agrees to reimburse me at the rate of \$250.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

By signing below, I attest that I have read the terms of this consent form and have been given an opportunity to ask questions.

\_\_\_\_\_  
Signature of client or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client

**Acknowledgement of receipt of Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information**

Your signature below acknowledges your receipt of the *Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information* (referred to as the "Notice") for the office of Jay Ruebel, Psy.D., PA.

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient

I hereby permit Dr. Jay Ruebel to release and furnish all medical and financial data related to my care that may be necessary for the collection of data for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO and PPO managed care organizations contracting with any of the above entities to perform such functions.

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient

*You have the right to request that Dr. Jay Ruebel restrict uses and disclosures of your health information; however, Dr. Ruebel is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that Dr. Ruebel has previously taken action in reliance to this consent. Your treatment is conditional in your signing this agreement.*

**INSURED/RESPONSIBLE PARTY INFORMATION**

*Please complete this section regardless of insurance coverage.*

Insurance Company name or Mental Health Network: \_\_\_\_\_

Phone number from insurance card: \_\_\_\_\_  
*(Please make sure to write down the number for mental health/substance abuse services)*

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Cardholder's Name: \_\_\_\_\_

Primary Cardholder's SS#: \_\_\_\_\_

Primary Cardholder's date of birth: \_\_\_\_\_

I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Authorization number (if you have one): \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

1. I authorize use of information on this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to Jay Ruebel, Psy.D., 1858 East Keller Parkway, Suite D, Keller, Texas 76248
5. I hereby permit a copy of this to be used in place of an original.
6. It is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by my insurance the day and time that services are provided.

Signature of client or Policyholder: \_\_\_\_\_

Date: \_\_\_\_\_

**PAYMENT POLICY**

Fee Schedule

Initial Consultation / Intake (60 minutes)	\$160.00
Therapy session (45-50 minutes)	\$140.00
Psychological Testing (includes test administration, scoring and interpreting tests, as well as report writing time)	\$150/hour
Interpretative session (review test results)	\$140.00/hour
Review of clinical records / Consultation	\$140/hour
School observation (includes travel time to and from)	\$150/hour
Court preparation (includes travel time to and from)	\$150.00/hour

1. **Full payment for each session is required at the time the service is rendered.** Payment may be made by cash, check, or debit/credit card. A co-payment of insurance will be accepted after insurance coverage is verified.
2. Filing of insurance is a courtesy provided by this office. If you prefer to file your own claim, a duplicate receipt will be provided.
3. There will be a **\$30.00 fee** for any **NSF check returned**.
4. Prior to psychological testing reports being released, full or partial payment of outstanding balance is required.
5. Any account that becomes delinquent may be subject to additional service charges and turned over to an outside agency.

**I have read, understand, and agree to abide by the above stated fee policy.**

Signature of patient or policyholder: \_\_\_\_\_

Printed name of patient or policyholder: \_\_\_\_\_

Date: \_\_\_\_\_

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**SCHEDULING POLICY**

I use an online scheduling program called **Schedulicity.com** that allows clients to view my schedule online and make appointments. This service will also send email reminders one day prior to your appointment.

**Schedulicity.com** is FREE to use and only requires that you create a profile with your email address and a password.

If you need to CANCEL or CHANGE existing appointments, you can use **Schedulicity.com** to view your existing appointments and make changes. If you make any changes, I will be notified via email and you DO NOT need to notify me.

If you do not have access to the internet or do not wish to use **Schedulicity.com**, please let me know and I will make appointments for you in the system.

**CANCELLATION POLICY**

The time you have reserved for a session is one for which you are financially accountable. As a courtesy, **Schedulicity.com** will provide email reminders of sessions one day prior to each session. If you do not wish to use email, please let me know and I will arrange to notify you by phone. If you should need to cancel or reschedule your appointment, please do so at least **24 in advance** of your appointment time. You can always use **Schedulicity.com** to view upcoming appointments as well as cancel or change your appointments.

If you fail to cancel an appointment and do not attend at the scheduled time, you will be financially responsible for **the full negotiated fee** for that session.

You will not be charged for missing a session due to emergencies or other events outside of your control.

Signature of client or policyholder: \_\_\_\_\_

Printed name of client or policyholder: \_\_\_\_\_

Date: \_\_\_\_\_

**Child/Adolescent Personal Information**

The purpose of this form is to obtain a detailed understanding of your child's growth and development. Please answer all of the questions below, to the best of your ability. If a question does not apply to your particular situation, write N/A.

**IDENTIFYING INFORMATION**

Child's name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_ Child's age: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ Zip code: \_\_\_\_\_ Contact email address: \_\_\_\_\_

**PRESENTING PROBLEM**

Why are you seeking this evaluation or treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did these problems begin? \_\_\_\_\_

\_\_\_\_\_

What are your goals for this evaluation or treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PARENTS, SIBLINGS, AND OTHERS IN HOME**

**Mother's name:** \_\_\_\_\_ **Mother's age:** \_\_\_\_\_

Lives with child: Y / N Phone #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Education/highest grade completed: \_\_\_\_\_

**Father's name:** \_\_\_\_\_ **Father's age:** \_\_\_\_\_

Lives with child: Y / N If not, address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Education/highest grade completed: \_\_\_\_\_

Does your child have stepparents? Y / N

If yes, please complete the following information:

Name(s): \_\_\_\_\_

Relationship(s) to child: \_\_\_\_\_

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Address(es)/phone #(s) \_\_\_\_\_

Is the child adopted or being raised by persons other than his/her biological parents? Y / N

If yes, explain: \_\_\_\_\_

Name of sibling	Age	Gender	Lives at home?	Relationship with child?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any others living in the home:

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**FAMILY CIRCUMSTANCES**

Who cares for the child when the parents or caregivers are at work or gone? \_\_\_\_\_  
\_\_\_\_\_

With whom does the child currently live? \_\_\_\_\_

Are the parents divorced or separated? Y / N If yes, for how long? \_\_\_\_\_

If yes, who has custody? \_\_\_\_\_

How often does the noncustodial parent see the child? \_\_\_\_\_

Family's religious affiliation (optional): \_\_\_\_\_

How frequently does the child see grandparents? \_\_\_\_\_

Has the family recently experienced any unusual or stressful events? \_\_\_\_\_  
\_\_\_\_\_

**PREGNANCY**

Did the mother receive prenatal care? Y / N If yes, what kind? \_\_\_\_\_

\_\_\_\_\_ Length of pregnancy: \_\_\_\_\_

Did the mother experience any emotional or medical difficulties during the pregnancy? Y / N

If yes, explain: \_\_\_\_\_

Length of labor: \_\_\_\_ hours    Apgar scores: \_\_\_\_\_ Birth weight \_\_\_\_ lbs. \_\_\_\_ oz. Length: \_\_\_\_\_

**DEVELOPMENT**

Was the child breast-fed or bottle-fed? \_\_\_\_\_ Age weaned: \_\_\_\_\_

Did the child experience any of the following problems during infancy or toddler hood? If yes, explain.

Colic	Y / N	_____
Excessive crying	Y / N	_____
Delayed language development	Y / N	_____
Unclear speech	Y / N	_____
Eating problems	Y / N	_____
Delayed fine motor skills	Y / N	_____
Delayed gross motor skills	Y / N	_____

At what approximate age did your child begin exhibiting the following behaviors ?

Crawled: \_\_\_\_\_ Sat alone: \_\_\_\_\_

Walked independently: \_\_\_\_\_ Spoke first words: \_\_\_\_\_

Spoke in sentences: \_\_\_\_\_ Was toilet trained: \_\_\_\_\_

For adolescents, please indicate the following:

Age at onset of puberty: \_\_\_\_\_ Age at first menstruation: \_\_\_\_\_

Which hand does your child use for writing? \_\_\_\_\_ Eating? \_\_\_\_\_

Has your child been the victim of abuse? Y / N If yes, please explain: \_\_\_\_\_

**MEDICAL AND PSYCHIATRIC HISTORY**

Name of primary care physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of most recent physical exam: \_\_\_\_\_ Results: \_\_\_\_\_

Date of most recent dental exam: \_\_\_\_\_ Results: \_\_\_\_\_

Date of most recent vision exam: \_\_\_\_\_ Results: \_\_\_\_\_

Date of most recent hearing exam: \_\_\_\_\_ Results: \_\_\_\_\_

Has the child experienced any of the following medical problems? If yes, please explain:

Frequent colds	Y / N	_____
Frequent ear infections	Y / N	_____
Asthma	Y / N	_____
Gastrointestinal problems	Y / N	_____
Muscle pain	Y / N	_____
Skin problems	Y / N	_____
Repetitive behaviors	Y / N	_____
Allergies	Y / N	_____

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Vision problems	Y / N	_____
Wears glasses?	Y / N	_____
Hearing problems	Y / N	_____
Cerebral palsy	Y / N	_____
Lead poisoning	Y / N	_____
Seizures	Y / N	_____
Congenital problems	Y / N	_____

Other health concerns: \_\_\_\_\_

***Medication***

Is your child currently taking any kind of medication? Y / N If yes, please indicate:

Name / dose / reason for medication: \_\_\_\_\_

Is your child experiencing any side effects from medications? \_\_\_\_\_

***Alcohol or Drug Use***

Does your child use alcohol or drugs? Y / N If yes, how do you know and how much do they use?

***Previous Evaluations***

Has your child ever had any of the following evaluations? If yes, indicate name of examiner, date of examination, and reason for the exam.

Psychological or psychiatric evaluation? \_\_\_\_\_

Neuropsychological evaluation? \_\_\_\_\_

Neurological evaluation? \_\_\_\_\_

***Treatment History***

Has your child ever received counseling or psychiatric treatment? Y / N

If yes, include dates, name of treating professional, reason for treatment, and effectiveness of treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family's Health**

Mother's present health: \_\_\_\_\_

Father's present health: \_\_\_\_\_

Has anyone in your family experienced a mental, psychological, or academic problem such as mental retardation, learning disabilities, depression, schizophrenia, epilepsy, or bipolar disorder? Y / N

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

How does your child relate to other children? \_\_\_\_\_

\_\_\_\_\_

Does your child prefer to play with younger or older children? Y / N

If yes, explain: \_\_\_\_\_

Does your child have a best friend? Y / N

How many friends does your child have? \_\_\_\_\_

**RECREATIONAL INTERESTS**

Does your child participate in sports or recreational activities outside of school? Y / N

If yes, describe: \_\_\_\_\_

What does your child like to do in his/her free time? \_\_\_\_\_

\_\_\_\_\_

Have the child's interests in these activities changed recently? Y / N

If yes, please explain: \_\_\_\_\_

What are your family's favorite activities? \_\_\_\_\_

**BEHAVIORAL SYMPTOMS**

Does your child have difficulty with any of the following problems? If yes, please explain in space below.

- |  |       |
|--|-------|
| Has trouble meeting new people; is shy or withdrawn                | Y / N |
| Is overly anxious  | Y / N |
| Seems sad or depressed   | Y / N |
| Has thoughts of suicide  | Y / N |
| Refuses to comply with adults' requests or violates parental rules | Y / N |
| Has conduct problems   | Y / N |
| Is physically cruel to people or animals                           | Y / N |
| Is inattentive   | Y / N |
| Problems concentrating   | Y / N |

Is restless	Y / N
Makes careless mistakes	Y / N
Has trouble playing quietly	Y / N
Has frequent mood shifts	Y / N
Frustrates easily	Y / N
Has difficulty managing anger	Y / N
Has eating problems	Y / N
Has fears/phobias	Y / N
Has hallucinations	Y / N
Has experienced trauma	Y / N

Explanations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child experienced difficulty with the law? Y / N

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

## EDUCATIONAL STATUS AND HISTORY

### *Current Status*

Name of current school: \_\_\_\_\_ Grade: \_\_\_\_\_

Type of school: Public \_\_\_\_ Private \_\_\_\_ Home Schooled \_\_\_\_ Other \_\_\_\_\_

Teacher(s): \_\_\_\_\_

\_\_\_\_\_

Does your child currently receive any special education services? Y / N

If yes, please specify: \_\_\_\_\_

What grades does your child currently earn? \_\_\_\_\_

\_\_\_\_\_

Is this a change from previous years? Y / N

If so, explain: \_\_\_\_\_

### *School History*

Preschool: At what age? \_\_\_\_\_ For how many days/hours per week? \_\_\_\_\_

Any problems? \_\_\_\_\_

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Did the child have difficulty or receive any special education services in any of the following grades? If so, please explain.

Kindergarten \_\_\_\_\_

\_\_\_\_\_

Grades 1-3 \_\_\_\_\_

\_\_\_\_\_

Grades 4-6 \_\_\_\_\_

\_\_\_\_\_

Grades 7-8 \_\_\_\_\_

\_\_\_\_\_

High School \_\_\_\_\_

\_\_\_\_\_

Does your child like going to school? Y / N Please explain: \_\_\_\_\_

\_\_\_\_\_

What are your child's favorite subjects? \_\_\_\_\_

Least favorite subjects? \_\_\_\_\_

What is your child's approach to schoolwork (organized/disorganized; responsible/irresponsible)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WORK HISTORY**

Does your child have a job, or is your child involved in a vocational program? \_\_\_\_\_

\_\_\_\_\_

Child's position: \_\_\_\_\_

Hours per week: \_\_\_\_\_

Has your child ever been fired/terminated from a work/volunteer position? \_\_\_\_\_

\_\_\_\_\_