Insights

Colorado Assessment and Therapy, PC

Nancy Cason, Psy.D. 720-837-2159
Claire Dumke, Psy.D. 720-837-2158
899 Logan St. Suite 406
Denver, CO 80203
www.insightsdenver.com

Child/Adolescent
Diagnostic Assessment-Intake Information

Family Information

Client's Full Name: _____ Date of Birth: _____

Address: _____
City:_____State:_____Zip:_____

Primary Phone: _____ Email: _____

Parents are: ☐ In a relationship ☐ Married ☐ Separated ☐ Divorced

Parent #1 Full Name: _____

Address: _____
City:_____State:_____Zip:_____

Cell Phone: _____ Email: _____

Occupation:_____ Work Phone:_____

Parent #2 Full Name: _____

Address: _____
City:_____State:_____Zip:_____

Cell Phone: _____ Email: _____

Occupation:_____ Work Phone:_____

Custody arrangements if divorced or separated:_____

Current living arrangements are as follows: _____

List all others living in the household with your child

Name	Age	Gender	Relationship to child

Therapy Information

Has your child ever had a previous psychological evaluation? YES_____ NO _____

If so, when and where? _____

For what reason? _____

Previous Diagnoses: _____

_____

_____

Please list previous and current therapies and/or interventions, listing most current therapies first:

Therapy 1: _____

Name(s) of Service Provider**:**_____

Frequency and duration of therapy_____

Date Started:_____ Date Completed: _____

Reason for therapy: _____

Therapy 2: :_____

Name(s) of Service Provider**:**_____

Frequency and duration of therapy: _____

Date Started:_____ Date Completed: _____

Reason for therapy: _____

Therapy 3:_____

Name(s) of Service Provider**:**_____

Frequency and duration of therapy: _____

Date Started:_____ Date Completed: _____

Reason for therapy: _____

Please write any additional therapies, providers, dates of service and reasons for therapy on back.

Educational Background & Participation

Preschool

Name: _____ Dates Attended: _____

Services Received: _____

Kindergarten

Name: _____ Dates Attended: _____

Services Received: _____

Elementary School

Name: _____ Dates Attended: _____

Services Received: _____

Middle School

Name: _____ Dates Attended: _____

Services Received: _____

High School

Name: _____ Dates Attended: _____

Services Received: _____

Medical History, Diagnostic Testing & Assessments

Child's birth weight: _____ Length of pregnancy: _____

Were there any medical problems during pregnancy or birth? YES_____ NO _____

If so, what were they?_____

Were there any medical problems during the 1st year of your child's life? YES_____ NO_____

If so, please describe: _____

Medications

Please list any current medications or supplements (including medical marijuana) and prescribing doctor:

_____

_____

Family History

	Child's Mother	Child's Father	Child's Sibling	Child's Maternal Grandparent	Child's Paternal Grandparent	Other (specify)
Autism, Asperger's						
Hyperactivity/ADHD						
Motor delays						
Speech delays						
Learning disability						
Behavioral Disorder						
Seizure Disorder						
Mental Retardation						
Tic Disorder						
OCD						
Genetic Disorder						
Mood Disorder						
Depression						
Anxiety						
Hallucinations						
Suicidal Behavior						
Alcohol Abuse						
Drug Abuse						
Serious Medical Issues						

Additional family history: _____

Does your child have a history of any of the following? (Please mark X next to those that apply)

_____Hospitalization	_____Eating problems	_____ Hearing problems
_____ Head Injury	_____ Special diet	_____ Weight issues
_____ Seizure	_____Problems with ADLs (dressing, hygiene)	_____ Speech issues
_____ Many ear infections	_____ Motor Problems	_____ Stomach problems
_____Poisoning	_____ Dental issues	_____ Toileting problems
_____ Sleep disturbance	_____ Allergies	_____ Anxiety
_____ Sensory Issues	_____ Asthma	_____ Depression
_____ Poor coordination	_____ Vision problems	_____ Aggression

Please note all diagnostic testing previously conducted, including professional or organization that conducted the testing, date, and results.

☐ Head Injury: _____

Provider/Date(s):_____

☐ Seizures**:** _____

Provider/Date(s):_____

☐ Sensory/Motor:_____

Provider/Date (s):_____

☐ Speech/Language: _____

Provider/Date(s):_____

☐ Allergy: _____

Provider/Date (s):_____

☐ Hearing: _____

Provider/Date (s):_____

☐ Vision: _____

Provider/Date (s):_____

☐ Genetic Testing: _____

Provider/Date (s):_____

☐ Immunological: _____

Provider/Date (s):_____

☐ Hospitalization(s)/Surgery: _____

Provider/Date (s):_____

☐ Other: _____

Provider/Date (s):_____

Additional Information…

Strengths_____

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Struggles_____

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Insights, PC

CLIENT NAME:_____ DATE:_____

CONSENT TO TREATMENT

The information on this page is made available so that you will be fully aware of some important matters concerning the psychologist-patient relationship and Insights policies. A "psychologist-patient" or "treatment" relationship does not exist until after an initial assessment is completed and we have decided to move ahead as evidenced by your signature on this form. It is important that we agree that we will be able to successfully work together to accomplish your goals. We will discuss this during the first visit and decide whether or not to proceed, and whether we need to continue the assessment for one or more subsequent visits.

CONFIDENTIALITY AND HIPAA

Generally speaking, the information provided by and to the patient during the assessment and any subsequent treatment, is legally confidential and cannot be released without the patient's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 and the Notice of Privacy Rights that can be provided to you in full upon your request as well as other exceptions to Colorado and Federal Law. For example, mental health professional are required to report child abuse to authorities. If a legal exception to psychologist-patient arises, if feasible, you will be informed accordingly.

DIAGNOSTIC ASSESSMENT

Diagnostic Assessment is a process that requires involvement from the patient, family, and, at times, other caregivers, such as teachers or therapists. These services require face-to-face contact for interviewing and testing. They also include the psychologists' time required for the reading of records, consultations with other professionals, scoring of tests, interpreting of results, report writing, and any activities to support these services.

INSURANCE

We will be glad to provide invoices to help in filing insurance claims. However, you will be responsible for the full fee at the time of service unless we make other arrangements. If you are insured by a carrier with whom we contract with part of your evaluation may be covered by insurance. In these cases, you are still responsible at the time of service for any co-payment, co-insurance, and deductible depending on your plan. Additionally, if your insurance carrier will be reimbursing us, you will still be responsible in the event that the insurance company denies a claim or you have additional co-insurance or have not met your deductible. In the event that your insurance company does not pay, for whatever reason, it is your responsibility to pay the balance due. It is also your responsibility to then seek reimbursement from your insurance; Insights does not pursue denied claims on your behalf. As the insured, you are ultimately responsible for determining which services are covered by your insurance company. While we are providers for certain insurance companies, it is not the responsibility of Insights to know what your plan does and does not cover; plan coverage varies greatly. It is also your responsibility to alert us that you will be going through your insurance for services rendered at the outset of therapy. We are not able to back date claims or reimburse for sessions already paid for. If you have questions, about the payment process, please ask.

Initials:_____

AGREEMENT FOR FINANCIAL RESPONSIBILITY

The estimated cost of the evaluation will be discussed before the initial appointment. Half of the total cost of the evaluation must be received with your intake paperwork at the initial appointment. At the time of your final appointment and before receipt of the diagnostic report, the remainder of your balance is due in full. Cash, money order, check, MasterCard, or Visa are accepted. Insights will provide an itemized receipt of your payment, upon request, at the final meeting.

OTHER FEES

In the event that it is determined that Insights owes you a refund (example: insurance covered more than anticipated), Insights will issue you reimbursement. Please note that if a payment was made by credit card, there will be a 5% fee deducted from the refund. This fee can be avoided by paying with check or cash.

Insights will not agree to court appearances or other legal involvements unless the matter has been discussed and it is agreed that such involvement is within our range of competence and will not interfere with the treatment relationship. Professional fees for court appearances, depositions and attorney consultations are $300.00 per hour (two hour minimum) plus travel and waiting time, are non-discountable, and are payable in advance only.

CANCELLATIONS

Insights asks that you provide at least 24 hours notice prior to canceling an appointment. There is a $150.00 charge for no-shows and late cancellations that must be paid immediately and is not eligible for reimbursement by insurance, and will not be applied to rescheduled evaluations. Please contact Insights regarding cancellations.

EMERGENCIES

Insights does not provide formal emergency services. Please visit our website for current office hours. If you are unable to reach anyone during office hours, please leave a message and your call will be returned as quickly as possible. Nighttime and weekend calls will typically be returned during business hours. If you find yourself in an urgent situation, please dial 911 or go to the nearest emergency room.

I understand that I am fully responsible for all fees incurred through Insights. I agree to pay all fees in full, including those that are not covered by my insurance company (unless otherwise agreed upon). I understand that my account may be turned over to a collection agency for non-payment after 30 days.

Please sign below indicating that you have read, understand, and agree to the information and terms of this document.

_____
Patient's name

_____ _____
Signature of responsible person Date

_____ _____
Insights Staff Date