Christiane Creveling-Benefield, Ph.D., Clinical & School Psychologist
www.YourPsych360.com ♦ New Orleans ♦ Metairie ♦ Baton Rouge ♦ Thibodaux

NEW CLIENT REGISTRATION PACKET

Revised 6/2016

CLIENT's Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Email: _____ Race: _____

Driver's License State & #: _____ Soc Sec # _____

Date of Birth: _____ Age: _____ SEX: M F Marital Status: _____

CHILD: School & Grade: _____ ADULT, Employer & Position: _____

***If married,* SPOUSE**'s Name: _____ Primary Phone #: _____

Address (If different from client): _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Employer: _____ Position: _____

IF CLIENT IS A MINOR:

Marital status of biological parents: __Single __Married __Div/Sep __Widow

If not married, status of custody: __Joint __Sole Who is domiciliary? _____

*** Please provide the most recent Custody Consent Judgement signed by your Judge. ***

MOTHER's Name: _____ Age/DOB: _____

Address (If different from client): _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Email: _____ Driver's License State & #: _____

Employer: _____ Position: _____

FATHER's Name: _____ Age/DOB: _____

Address (If different from client): _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Email: _____ Driver's License State & #: _____

Employer: _____ Position: _____

Nearest Relative (or stepparent if applicable): _____ Relationship to Client: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Email: _____

REFERRED BY: _____ Relationship to client (e.g., MD, teacher, other)? _____

May we contact this person to thank them for your referral? YES NO

May we forward a report of evaluation results to this person after testing? YES NO

Address: _____ Phone: _____

REASON FOR SEEKING ASSESSMENT/TREATMENT/CONSULTATION:

_____

_____

Please notify your interviewer/evaluator if the client has made **suicidal or homicidal verbalizations/attempts** within six (6) months of contacting this office.

CLIENT'S PHYSICIAN: _____

Last Physical Exam: _____ Height: _____ Weight: _____

Prescription medication being taken & dose? _____

_____

Last vision exam (when, by whom, results): _____

Last hearing exam (when, by whom, results): _____

FEES ARE DUE AT THE TIME OF SERVICE. If you would like us to consider insurance for in-network policy reimbursement, PLEASE PROVIDE A COPY OF YOUR *DRIVER'S LICENSE & INSURANCE CARD (front & back)* no later than your first appointment. For out-of-network reimbursement, we are able to provide appropriate documentation upon request for you to file charges with your insurance company. Consultation services are not covered by insurance. **It is the client's responsibility to check what is or is not covered by their particular insurance company and policy.**

PERSON RESPONSIBLE FOR PAYMENT: _____

Address (If not listed above): _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Date of Birth: _____ SS#: _____

INSURANCE COMPANY:_____POLICY ID#:_____

NAME OF INSURED:_____ GROUP ID#:_____

PLEASE NOTE

- **PAYMENT IS DUE AT THE TIME OF SERVICE**
- **FAILURE TO CANCEL AN APPOINTMENT WITHIN 48 HOURS OF THE SCHEDULED TIME WILL RESULT IN A FULL CHARGE TO ACCOUNT.**
- **$30.00 NSF CHARGE ON ALL RETURNED CHECKS**
- **ACCOUNTS ARE CONSIDERED PAST DUE AFTER 30 DAYS AND ARE SUBJECT TO BEING TURNED OVER TO AN OUTSIDE COLLECTION AGENCY. A PROCESSING FEE OF 50% WILL BE ADDED TO ALL SUCH ACCOUNTS**
- **Payment may be made by check, credit card, or cash. We will gladly furnish you with a receipt for any purpose (e.g., non-network insurance, tax purposes) upon request.**

I HAVE READ AND AGREE WITH THE ABOVE STATED TERMS.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY Date

_____

Please print name

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INFORMED CONSENT FOR TREATMENT & ASSESSMENT

We are pleased that you have selected Dr. Christiane Creveling-Benefield, Ph.D., as your psychologist. This document is designed to inform you of her practices and to ensure that you understand the nature of our professional relationship and its limits.

Dr. Christiane Creveling-Benefield has been conducting assessment, therapeutic, and/or consultation services since 1993. She earned a doctorate from Tulane University and is license to practice in the State of Louisiana with dual specialties in both clinical and school psychology. Her practice has focused on meeting the psychological and educational/vocational needs of school-aged youth, families, and adults.

All services will be rendered in a professional manner consistent with ethical guidelines promulgated by the **American Psychological Association**. Your personal records will be kept in accordance with these guidelines, as well as regulations pertaining to **Health Insurance Client Privacy Act (HIPPA)**. The details of this federal legislation are attached.

_____Confidentiality will be kept with the following exceptions: 1) You direct us to disclose information to someone else, 2) we determine that you are a danger to yourself or others, 3) we must report child abuse as mandated by law, 4) you are currently involved or **MAY AT SOME FUTURE POINT** be involved in a child custody case in which you are seeking custody or visitation, 5) you were ordered by the court for mandated treatment and we must provide proof of compliance, 6) we are ordered by a court to disclose information, or 7) your account is turned over to collections for nonpayment at which time the dates, times and nature of services only will be disclosed in order to collect payment for those services.

_____Our evaluation process utilizes a team approach, which allows us to obtain the most thorough information possible about you and/or your child. As such, your child may be tested by a clinical associate specially trained in psychological and educational assessment. Dr. Creveling oversees and guides the direction of all evaluations, and supervises all unlicensed staff. If tested, your child may be videotaped for staffing purposes. We collaboratively discuss all test results prior to your feedback session, which facilitates the interpretation of test data and subsequent diagnoses. In the event that we cannot complete testing in one day, we will schedule additional sessions as necessary.

The test measures, procedures, and reports issued are College Board compliant. Although our reports can be utilized to expedite the assessment process within a public school context, be advised that additional components will be needed for compliance with Louisiana Bulletin 1508, Pupil Appraisal Handbook. Please consult with your clinician ***at your first session***, if you are interested in the additional services required for 1508 compliance.

We will make every attempt to return all phone calls as soon as possible. In case of an emergency during normal business hours, please inform the receptionist that your call is urgent. After regular hours (Monday-Thursday 9AM-5PM), please follow the instructions on the voice mail message.

_____FEES are $175 for an initial consultation and $150 for individual and family sessions. Therapy sessions are 45-50 minutes in duration with the remaining 10 minutes devoted to maintaining your personal file.

_____We require **48-HOUR NOTICE FOR CANCELLATION** of appointments to enable us to fill that appointment from a client waiting list. Missed appointment fee of $150/hour is due out-of-pocket from Client/Responsible Party the day of the missed appointment. **Insurance does NOT pay for appointments miss or canceled with less than 48-hours notice.**

_____ FEES for evaluation vary with your assessment needs. When you schedule a date for you or your child's evaluation, a retainer of $500 is payable at that time. We require **48-hour notice** for cancellation of a *testing appointment*, as that time has been set aside solely for your child. Once the appointment is kept, the $500 retainer is applied to the cost of the evaluation.

_____Remote consultation services (text, email, phone, etc.) are prorated at a rate of $150/hour. Our fees are $25 for a one-page letter (e.g., with diagnoses only) and $150/hour to write more detailed letters (e.g., summarizing test results and/or recommendations).

_____In the event that we are asked to copy records, copies will be made according to the following fee schedule: $1.00 per page for pages 1-25, $.50 per page for pages 25-100, and $.25 per page for pages over 100.

_____**All fees are due at the time of service. Cash, personal checks, or Visa/MasterCard/Discover are accepted. We will provide you with a receipt upon request.**

_____**Clients must check their specific policy to determine which services are/are not covered by their insurance company and specific policy**. PREAUTHORIZATION OF SERVICES FROM YOUR INSURANCE COMPANY DOES NOT GUARUNTEE PAYMENT.

_____**In the event that you are unable to keep an appointment, you must notify the office 48 hours prior to therapy/consultation/testing appointments. If such notice is not received, we will use the credit card on file to pay for that session.**

_____**In the event that your account is turned over to an outside collection agency for non-payment, there will be 50% surcharge added to the balance to cover all fees we may incur.**

_____It is YOUR responsibility to schedule and appear for appointments. As a *convenience*, we *may* contact you prior to your scheduled appointment in order to confirm that appointment. Please check below for appointment reminder preferences:

☐ Email: _____ ☐ Text: _____ ☐ Phone: _____

☐ I do not wish to receive appointment reminders.

Your signature below signifies that you agree to all terms stated above. If you have any questions or concerns about any of this information, please ask either my staff or myself.

_____ _____

Client or Parent/Guardian Signature Date

_____

Name – Please Print

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NOTICE OF INFORMATION PRIVACY PRACTICES

This notice describes how medical/mental health information about our clients may be used or disclosed, in accordance with state and federal law (e.g., HIPAA/Health Insurance Portability and Accountability Act), and how you can access that information. Please read it carefully.

Dr. Christiane Creveling-Benefield, Ph.D. and staff, herein referred to as Dr. Creveling and/or staff, are required by law to protect the privacy of your personal health information, provide this notice about its information practices, and follow the information practices that are described herein.

Uses & Disclosures of Health Information

Dr. Creveling and staff use your personal health information primarily for treatment, consultation, and assessment, obtaining payment, conducting internal administrative activities, and evaluating the quality of care that this office provides. For example, Dr. Creveling and/or staff may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you. Dr. Creveling and/or staff may also use or disclose your personal health information without prior authorizations for public health purposes, auditing purposes, and/or emergencies. Dr. Creveling and/or staff also provide information when required to do so by law. In other situations, the policy of Dr. Creveling and/or staff is to obtain your written or verbal authorization before disclosing your personal health information. If you provide Dr. Creveling and/or staff with authorization to release your information, you may later revoke that authorization for any reason to stop future disclosures. This office may change its policy at any time. You may request an updated copy of our Notice of Information Privacy Practices and/or additional HIPAA information at any time.

Client's Individual Rights

You have the right to review or obtain a copy of your personal health information. You have the right to request that Dr. Creveling and/or staff correct any inaccurate or incomplete information in its records. You have the right to request a list of instances where Dr. Creveling and/or staff has disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may also request, in writing, that Dr. Creveling and/or staff not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Dr. Creveling and/or staff will consider all such requests on a case-by-case basis, but Dr. Creveling and/or staff are not legally required to accept them.

Concerns and Complaints

If you are concerned that Dr. Creveling and/or staff may have violated your privacy rights or if you disagree with a decision Dr. Creveling and/or staff has made regarding access to or disclosure of your personal health information, please contact Dr. Creveling or inform this office of your concerns via Dr. Creveling's website. You also have the right to send a written complaint to the Louisiana State Board of Examiners of Psychologists.

Privacy Practices Acknowledgement

I have received the this office Notice of Privacy Practices and have been provided an opportunity to review it and, upon request, more comprehensive information about privacy practices outline in the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

Signature Date

_____

Printed Name

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

By my signature below, I am hereby authorizing Christiane Creveling-Benefield, Ph.D. and/or staff to release and obtain information regarding professional services via fax, telephone, mail or e-mail to the following person(s) and/or organizations:

Name	*Address*	*Phone #*	*Fax #*

I understand the following:

- The records/information to be disclosed are protected by State and Federal law, with limitations detailed under the Health Insurance Portability and Accountability Act.
- The information is intended for professional use only
- I have the right to refuse consent to release information to Dr. Christiane Creveling-Benefield or her staff

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

Information Requested: _____

I understand that I may revoke this consent at any time and that such revocation **MUST BE IN WRITING**. Consent will expire one year from the date below unless sooner revoked.

_____ _____
Signature of Client/Parent/Guardian Date

_____
Print Name & Relationship to Client

_____ _____
Witness Signature Date

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BACKGROUND INFORMATION & HISTORY

Client's Name: _____ DOB: _____ Age: _____
Person completing this form? _____

The following questionnaire gives you "prompts" to provide personal information about your medical, mental health, academic, work, and family history. Feel free to use the back of the page, if you need additional space to report your history.

REASON FOR REFERRAL/PRIMARY CONCERN

Mental health/psychiatric condition/disability (anxiety, depression, etc.)? **Yes** **No**
If YES, who diagnosed and when/date of diagnosis? _____
Have these conditions/disabilities been treated (medical management, therapy, etc.) Yes No
If yes, please explain. _____
_____

Intellectual or cognitive disability (e.g., "slow learner")? Yes No
If YES, who diagnosed and when/date of diagnosis? _____
Have these conditions/disabilities been treated (medical management, therapy, etc.) Yes No
If yes, please explain. _____
_____

Learning disability (e.g., difficulty with reading, writing, or math? **Yes** **No**
If YES, who diagnosed and when/date of diagnosis? _____
Have these conditions/disabilities been treated (medical management, therapy, etc.) Yes No
If yes, please explain. _____
_____

Other diagnosis or condition? **Yes** **No**
If YES, who diagnosed and when/date of diagnosis? _____
Have these conditions/disabilities been treated (medical management, therapy, etc.) Yes No
If yes, please explain. _____
_____
_____
_____
_____
_____
_____
_____
_____

PRE-NATAL & EARLY CHILDHOOD

Describe client's mother's pregnancy & delivery with client (complications, premature, C-section?). _____

Did client come home with mother after normal hospital stay following birth? Yes No
If NO, please describe (how long in hospital, placement in neonatal intensive care unit [NICU], reason for prolonged hospital stay, etc.). _____

Developmental Milestones (When met, any delays, etc.)
Walking? _____
Talking? _____
Toilet Train? _____
Enuresis (daytime or nighttime urination/bedwetting)? _____
History of Ear Infections/Tubes? _____

Speech Therapy (when, where, how long, results)? _____

Occupational Therapy (when where, how long, results)? _____

Physical Therapy (when where, how long, results)? _____

MEDICAL HISTORY

Medical conditions (including substance abuse)? Yes No
If yes, please explain. _____

Diagnosis/condition?	Treatment?	Medication?	When (to/from)?	Physician?

Describe major accidents with injury. Any history of loss of consciousness? _____

Hospitalizations (When/Why)? _____

General Health (good, fair, poor, etc.)? Describe _____

Recurrent Ailments (e.g., headaches, stomachaches)? If yes, how often (e.g., 1x/day, 4x/week)? _____

_____

_____

_____

Current Medications or regular intake of vitamins?

Medication?	Dose?	What condition?	When (to/from)?	Prescribing MD?

Last Hearing Test (when, by whom, results): _____Passed _____Failed When? _____

Last Vision Test (when, by whom, results): _____Passed _____Failed When? _____

Hearing aids or glasses (nearsighted, farsighted, or other)? _____

Sleep Habits:
What time does client go to bed on school/work days? _____ On weekends? _____
What time does client wake on school/work days? _____ On weekends? _____
Is sleep disrupted? If yes, please described (e.g., grinds teeth, restless, talks in sleep, wakes often, etc.). _____

_____

Describe appetite. _____

_____

Substance Use & Experimentation:
Alcohol, age of first experimentation/use? _____
Current use: How often (e.g., 2 nights/week, 5 nights/week)? _____
What does client drink? _____ How much (e.g., 3 drinks/sitting)? _____
Illicit drugs, age of first experimentation/use? _____
Current use: How often (e.g., 2 nights/week, 1 nights/month, daily)? _____
What does client use? _____

Describe substance abuse treatment attempts (inpatient or outpatient, approximate dates, length of treatment, where/with whom). _____

_____

EMOTIONAL & MENTAL HEALTH/PSYCHIATRIC HISTORY

Describe infancy or childhood temperament (fussy, calm/easy, easy or difficult to soothe). _____

_____

Any nervous habits (bites nails, chews clothing, motor tics)? Yes No
If yes, please explain. _____

_____

Any emotional or behavioral/outbursts? If yes, please describe.
What causes tantrums/outbursts? _____

How often (e.g., 3x/day, 1x/month) and how long do outbursts last (e.g., 5 minutes, 2 hours)? _____

How did/does the client calm down? _____

How was/is he/she disciplined? By whom? What was/is the client's reaction to discipline? _____

List all childhood and adult mental health/psychiatric diagnoses. _____

List all mental health medications.

Medication?	Dose?	What condition?	When (to/from)?	Prescribing MD?

Therapy/Counseling Interventions:

____Individual, _Family or _____Group Therapy? Describe when, how long, why, with whom, etc.?

Diagnosis or reason for therapy?	Treatment?	When (to/from)?	Practitioner?

Past & present suicide attempts/ideation? Yes No
If yes, please explain. _____

Mental Health/Psychiatric hospitalizations? If yes, please describe.

Where?	Diagnosis(es)?	Medication?	When (to/from)?	Why (suicidal, etc.)?

History of emotional, physical, sexual abuse (specify)? Yes No
If yes, please explain. _____

Significant life events & dates (Include deaths, parental separation/divorce, trauma, change in financial status, recent moves, divorce, loss of friends/pets, etc.)?

Legal history (Specify ALL juvenile and adult arrests and charges with approximate dates/ages, convictions, and sentence/penalties, etc.)?

FAMILY INFORMATION

Describe marital history of parents (if client is a minor) or personal marital history (for adults).

Status? Married Single Divorced Cohabitating
Length of Current Relationship?
Previous marriages/divorces (who, when, how long, reason for separation)?
Children (biological/step, who, age, other parent, living arrangements)?

Please describe education, occupation, current relationship, etc. for each parent figure.

Mother

(Stepfather)

Father

(Stepmother)

List siblings (Birth order, names, ages, living situation/visitation, and current relationship).

Have any close family members had/have any of the following? If YES, please describe what & who:

Mental health/psychiatric?
Academic/learning/attention problems?
Medical/Attention/ADD/ADHD?
Legal?
Other?

DAILY SCHEDULES: Please describe day and nighttime routines for both weekdays and weekends.

Mother?
Father?

Child?

SOCIAL/INTERPERSONAL & EXTRACURRICULAR HISTORY

Describe relationships with others as a child. _____

_____

Describe relationships with significant others (family, friends, spouses, boss/coworkers, etc.). _____

_____

Describe involvement in extracurricular activities (baseball, dance, boy scouts, gymnastics, etc.). _____

_____

_____

Check activity use: __ TV __ Computer __ Video gaming console __ Tablet/IPad __ Other media
How many hours does your child engage in these activities (i.e., any/all "screen time" activities) daily?
School days? _____ Hour per day. Describe _____
Non-school days? _____ Hour per day. Describe _____
Are screen time devices stored in your child's bedroom? If yes, please described. _____

_____

SCHOOL HISTORY

For adult clients, highest degree completed (What degree, when, where, what major, grade point average (GPA) at graduation)? _____

_____

For child clients, highest grade completed? _____ Current school & grade? _____
Previous schools/grades (include dates)? _____

_____

Current grades/academic standing (if applicable): _____

_____

Cumulative GPA currently: _____ *Cumulative* GPA high school: _____ *Cumulative* GPA /college: _____
Best Subject:_____Worst Subject: _____

Any failed or repeated grades? If so, which grade(s)? _____
Any summer school? If so, following which grade(s)? _____

Relationship with teachers? _____
School-related behavior problems? If yes, describe. _____

_____

History of suspensions or expulsions (when, what grade, offense, how long, etc.)? _____

_____

Tutoring, Reading programs, IEPs, or any current/historic class accommodations? If yes, please describe. _____

_____

_____

For adult clients, would you like to return to school? If yes, when, what school, what program/major/field of study?

_____

WORK HISTORY (IF APPLICABLE)

Describe current position (with whom/company, when/how long, duties)? _____

Describe previous jobs/fields (with whom, when/how long, duties, reasons left)? _____

Ever fired? If so, which position and why (e.g., event leading to termination)? _____

Are you interested in changing jobs? If so, to what field or type of position? _____

If never employed, what type of job/work do you think you would enjoy? _____

OTHER INFORMATION THAT MAY BE HELPFUL IN THIS CLIENT'S EVALUATION?

What are the clients STRENGTHS? _____

What are the client's biggest CHALLENGES (weaknesses)? _____

Additional information? _____