KATHERINE A. ROBISON, PH.D.

LICENSED PSYCHOLOGIST

Dear Parent,

I look forward to meeting you at our first appointment. If the treatment is for your child, the first visit is PARENT(S) ONLY. **If you are coming for an evaluation, please bring copies of any prior evaluations, report cards, standardized testing, and any other school documents you feel are important. Please fill out all forms in advance, and bring them with you to the first appointment.** This will allow us to spend more time discussing your concerns.

I am not an "In-Network" provider for any insurance companies, but will provide you with a receipt with procedure codes, diagnosis, etc. which you can use to file for "out-of-network" benefits. The services I provide ARE typically covered by FSA or HSA plans. Payment is due by cash, check, or credit card at the time of service.

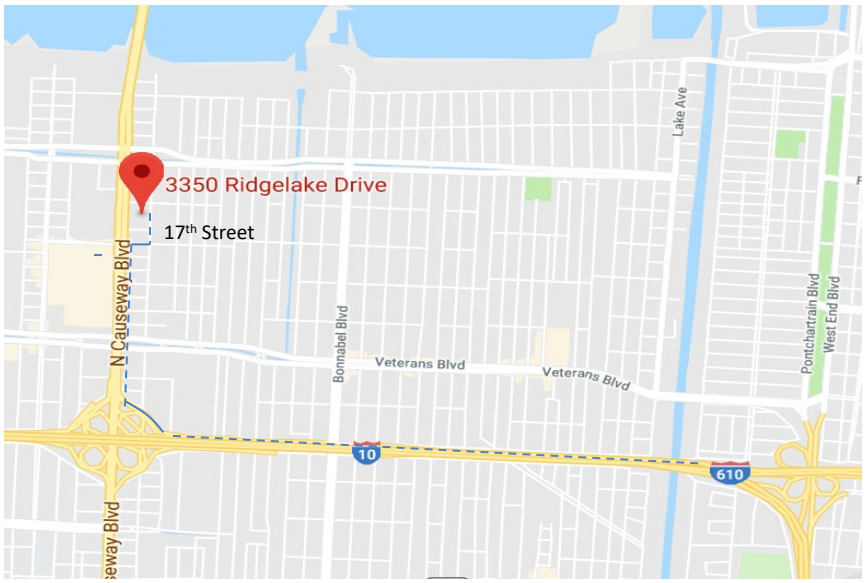
My office is in Ridgelake Office Suites, 3350 Ridgelake, Metairie, LA 70002. Park in the lot on the LAKE SIDE of the building, and enter the main entrance. Check in with the receptionist in room 200 on the SECOND FLOOR. She will contact me when you arrive and she or I will escort you to my office.

Thank you for the privilege of working with your family. Please do not hesitate to contact me with any questions or concerns by phone or text (504-913-2688) or email: krobisonphd@gmail.com I look forward to meeting you!

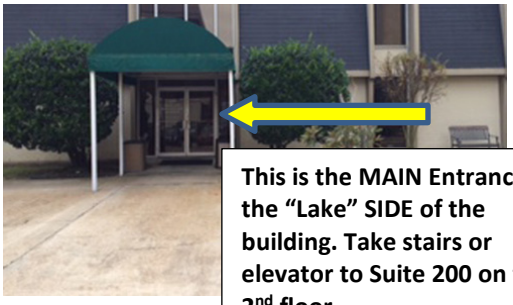
Sincerely,

Dr. Kathy

Katherine Robison, Ph.D.
Licensed Psychologist



Enter here, PARK on the LAKE side of the building.



This is the MAIN Entrance, on the "Lake" SIDE of the building. Take stairs or elevator to Suite 200 on the 2nd floor.

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INTAKE INFORMATION

CHILD'S NAME: _____ TODAY'S DATE: _____

GENDER (circle): Male Female Date of Birth: _____ AGE:_____ GRADE: _____

PARENT(S)/GUARDIAN(s): _____

ADDRESS: _____ Marital Status: _____

CUSTODY ARRANGEMENT, IF APPLICABLE: _____

PARENT CELL PHONE NUMBER: _____

PERSON FILLING OUT THIS FORM (circle): Mother Father Stepmother Stepfather Grandparent Other:

REASON FOR VISIT

Describe the reason for this consultation: _____

_____

_____

_____

How long has this been of concern to you? _____ When was this first noticed? _____

Has your child received evaluation or treatment for the current concern or similar concerns? Yes No

If yes, please describe previous treatment below:

PRIOR EVALUATIONS? (Please bring to intake or List date, Examiner, Results):_____

_____

What INTERVENTIONS/TUTORING, etc. has your child received? _____

SCHOOL RESOURCE ROOM or OTHER PROGRAM? _____

OTHER? (Speech Therapy, Occupational Therapy, Counseling etc.) PLEASE DESCRIBE: _____

_____

_____

Describe any major life events that might be related to your concern (e.g. death in family, trauma, move, family conflict, natural disaster): _____

_____

_____

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FAMILY INFORMATION

Mother's name: _____ Age:_____ Education: _____

Home phone: _____ Cell phone: _____Occupation: _____

Address (if different from child's address): _____

Father's name: _____ Age:_____ Education: _____

Home phone: _____ Cell phone: _____Occupation: _____

Address (if different from child's address): _____

Stepmother's name: _____ Age:_____ Education: _____

Home phone: _____ Cell phone: _____Occupation: _____

Address (if different from child's address): _____

Stepfather's name: _____ Age:_____ Education: _____

Home phone: _____ Cell phone: _____Occupation: _____

Address (if different from child's address): _____

List siblings and others living in the home:

NAME	RELATIONSHIP TO CHILD	AGE

List any siblings living outside of the home: _____

DEVELOPMENTAL HISTORY

Was your child adopted? _____ If so, child's age at adoption: _____

PREGNANCY:

Duration of pregnancy (weeks or months): _____

During the pregnancy, did the mother:

_____ Suffer from illness or disease
_____ Suffer from an accident
_____ Undergo surgery
_____ Take medication
_____ Undergo x-ray studies
_____ Smoke tobacco
_____ Consume alcohol

Pregnancy complications experienced:

_____ Excessive staining or blood loss
_____ Threatened miscarriage
_____ Infection
_____ Toxemia
_____ Diabetes
_____ High blood pressure
_____ Poor nutrition

_____ Use illegal drugs _____ Other: _____

DELIVERY:

Duration of Labor: _____ hours Birth Weight: _____ lbs. _____ ozs.

Type of Labor: Spontaneous Induced Type of Delivery: Vaginal Caesarean

Delivery Complications:

_____ None
_____ Cord around neck
_____ Hemorrhage
_____ Placental problems
_____ Delay in breathing
_____ Injury to infant
_____ Fetal distress
_____ Meconium aspiration
_____ Other: _____

NEWBORN AND POST-DELIVERY PERIOD:

Total days baby was in hospital after delivery: _____ Was your baby in the NICU? Yes No

Birth complications:

___ None
___ Addiction
___ Anemia
___ Birth defects _____
___ Cyanosis (turned blue)
___ Jaundice
___ Infection
___ Seizures
___ Trouble breathing
___ Intraventricular hemorrhage
___ Respirator required
___ Resuscitation required
___ Other: _____

INFANCY-TODDLER PERIOD:

Briefly describe your child's temperament during infancy: _____

_____

_____

Were any of the following present during the first few years of life?

___ Colic
___ Reflux
___ Feeding problems
___ Sleeping problems
___ Frequent headbanging
___ Excessive restlessness
___ Did not enjoy cuddling
___ Constantly into everything
___ Slow or unable to adapt to changes in routine
___ Excessively high or low activity level (circle one)
___ Was not calmed by being held and / or stroked
___ Excessive number of accidents compared to other children
___ Withdrawal or other problems adjusting to new people and situations
___ Variable or irregular body functions (sleep, hunger, bowel, etc.)

Were there any special problems in the growth and development of your child during the first year? Yes No
If yes, please describe:

_____

_____

DEVELOPMENTAL MILESTONES:

The following is a list of infant developmental milestones. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Walked alone	____	Stayed dry at night	____
Spoke first single words	____	Fed self	____
Put words together	____	Rode tricycle	____
Became toilet trained	____		

Compared to other children, the child's early development was: Normal Delayed Advanced

CHILD'S MEDICAL HISTORY

Pediatrician's name: _____Phone number: _____

If the child has ever been treated with medication other than for colds and minor infections, please list medications below. Place a check under "current" for those medications the child is currently taking.

MEDICATION	AGE	REASON PRESCRIBED	CURRENT ?

Has your child ever suffered from a head injury that caused confusion or loss of consciousness? Yes No

If yes, describe: _____

Place a check next to any illness or condition that your child has now or previously. When you check an item, also note the child's approximate age at the time of the illness.

ILLNESS OR CONDITION	AGE	CURRENT?	ILLNESS OR CONDITION	AGE	CURRENT?
__ AIDS or HIV positive			__ Fainting spells		
__ Allergies			__ Fetal Alcohol Syndrome		
__ Anemia			__ Fever (if high or prolonged)		
__ Aneurysm			__ Guillain-Barre Syndrome		
__ Anoxia			__ Head injury		
__ Arteriovenous-Malformation			__ Headaches		
__ Arthritis			__ Heart disease or problems		
__ Asthma			__ Lead poisoning		
__ Ataxia			__ Hepatitis		
__ Automobile accident			__ Herpes		
__ Back pains or problems			__ High blood pressure		
__ Bleeding problems			__ Jaundice		
__ Blood disorders			__ Leukemia		

ILLNESS OR CONDITION	AGE	CURRENT?	ILLNESS OR CONDITION	AGE	CURRENT?
__ Bone or joint disease			__ Malnutrition		
__ Broken bones			__ Meningitis		
__ Cancer			__ Muscular disease		
__ Chorea			__ Pain problems		
__ Coma			__ Paralysis		
__ Cystic Fibrosis			__ Pituitary Disorder		
__ Dazed or unconscious			__ Pneumonia		
__ Dementia			__ Poisoning		
__ Diabetes			__ Poliomyelitis		
__ Dysarthria			__ Rheumatic Fever		
__ Dyspraxia (or Apraxia)			__ Scarlet Fever		
__ Ear infections (PE tubes)			__ Sensory losses		
__ Other ear problems			__ Sexual molestation		
__ Eczema or hives			__ Sexually Transmitted Disease		
__ Electric or chemical shock			__ Speech and Language problems		
__ Encephalitis			__ Spells (_____)30		
__ Epilepsy, Seizures, fits			__ Stroke		
			__ Suicide attempts or thoughts		
Indicate if the child has undergone any of these medical tests (place check and give age)			__ Sunstroke or heat exhaustion		
			__ Thyroid Disorder or problem		
__ Electroencephalogram (EEG)			__ Trauma (_____)		
__ Skull X-rays			__ Tuberculosis		
__ CT Scan			__ Tumor		
__ MRI Scan			__ Visual problems		
__ BEAM Study			__ Whooping Cough		
__ Evoked Potentials					
__ Ophthalmology (vision) evaluation					
__ Audiology evaluation					
__ Chromosome study					

FAMILY MEDICAL HISTORY

Place a check next to any illness, condition, or problem experienced by any **blood relative**. When you check an item, please note the relative's relationship to the child. If any problems run in the family, please write them at the end of the list.

√	CONDITION	RELATIONSHIP TO CHILD
	Alcoholism.....	
	Antisocial (criminal) behavior	
	Autism Spectrum Disorder.....	
	Asperger's Disorder.....	
	Bipolar (Manic-depressive) Disorder	
	Depression.....	
	Drug addiction or drug problems.....	
	Headaches (e.g. migraine).....	
	ADHD (Hyperactivity / Attention problems).....	
	Language disorder or delay.....	
	Learning problems	

	Developmental Delay / Mental Retardation.....	
	Tic or Movement Disorders	
	Nervous or mental problems	
	Schizophrenia	
	Seizures, Epilepsy, or convulsions.....	
	Sexual / physical abuse	
	Suicide or suicide attempt	
	Other (specify _____).....	
	Alcoholism.....	

EDUCATIONAL HISTORY

CURRENT SCHOOL: _____ CURRENT GRADE: _____

PREVIOUS SCHOOLS:

Grade Levels (e.g. K-5)	School Name	Accommodations?	Academic Performance

Grades repeated (if any): _____

Describe any current academic, behavioral, or social concerns at school:

_____

_____

List or estimate current report card grades: _____

_____

What are your child's favorite activities?

_____

_____

What are your child's assets or strengths?

_____

_____

Is there any other information that might help me to understand your child? _____

_____

_____

KATHERINE A. ROBISON, PH.D.

LICENSED PSYCHOLOGIST

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

(HIPAA Notice of Privacy Practices is included below.)

I have been provided a copy of Dr. Robison's "Notice of Privacy Practices." We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of my child receiving mental health services.

Parent: Printed Name: _____

Parent: Signature: _____

Date: _____

****

Consent for Treatment

Your signature below grants consent for evaluation and/or treatment of your child by Katherine A. Robison, Ph.D.

Child's Name: _____

Child's Date of Birth: _____

Parent's Signature: _____

Date: _____

****

Permission for individuals other than parent(s) to participate in treatment

The following adult individual(s) may take part in my medical care including, but not limited to attending or bringing my child to clinic appointments. ANYONE OTHER THAN PARENT WHO BRINGS CHILD TO APPOINTMENT SHOULD BE LISTED HERE.

No One: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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"Notice of Privacy Practices"

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS
AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED,
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Confidentiality:
Uses and Disclosures of Information Requiring Your Authorization or Consent

As a rule, I will disclose no information about your child, or the fact that your child is my patient, without your written consent. My formal Mental Health Record describes the services provided to your child and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. **However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship** (by signing the attached general consent form), **or through your written authorization at the time the need for disclosure arises.** You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality:"
Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, and some required by law. If your child is to receive mental health services from me, you must sign the attached form indicating that you understand and consent to accept my policies about confidentiality and its limits. Please feel free to ask any questions you have about these policies at the parent intake.

I may use or disclose records or other information about your child without your consent or authorization in the following circumstances, either by policy, or because legally required:

· **Emergency** If your child is involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to your child.
· **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Louisiana law to report the matter immediately to the Louisiana Department of Social Services**.**
· **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Louisiana law to immediately make a report and provide relevant information to the Louisiana Department of Welfare or Social Services.
· **Health Oversight:** Louisiana law requires that I report misconduct by a mental health care provider of my own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make a report to the licensing board. If you are yourself a health care provider, I am required by law to report to your licensing board if I believe your condition places the public at risk . Louisiana Licensing Boards have the power, when necessary, to subpoena relevant records for investigating a complaint of provider incompetence or misconduct.
· **Court Proceedings:** If you are involved in a court preceding and a request is made for information about your child's diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so that you (or your attorney, or I) can file a motion to quash (block) the subpoena and can give reasons why I think your records should be protected from disclosure. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. NOTE: In Louisiana civil court cases, therapy information or records are not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue (e.g., if you sue someone for mental/emotional damages), or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Louisiana has no

statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court- ordered. You will be informed in advance if this is the case.

· **Serious Threat to Health or Safety:** Under Louisiana law, if I am engaged in my professional duties and your child communicates to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe that your child has the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about your child when necessary to prevent an immediate, serious threat to your child's own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your child's records to the magistrate, your attorney or guardian *ad litem,* a CSB evaluator, or law enforcement officer, whether you are a minor.

· **Records of Minors:** Louisiana has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors. Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

· **Right to Request Restrictions-**You have the right to request restrictions on certain uses and disclosures of protected health information about your child. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations --** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that your child is seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· **Right to an Accounting of Disclosures -** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

. Right to Inspect and Copy - In most cases, you have the right to inspect and copy your child's medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· **Right to Amend** - If you feel that protected health information I have about your child is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· **Right to a copy of this notice -** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about your child as well as any information I receive in the future. The notice will contain the effective date . A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: June 1, 2010

KATHERINE A. ROBISON, PH.D.

LICENSED PSYCHOLOGIST

Authorization to Release Protected Health Information

I hereby authorize Dr. Robison to request / release information regarding services for:

_____ _____

Name Birth Date

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed:

Records are specified to include:

- Telephone consultations
- In-person conferences
- Written reports and/or progress notes
- Questionnaires
- Pscho-educational testing results and reports
- Medication information

The following person(s) or organization(s) are authorized by this form to receive and disclose the protected health information selected above:

_____ _____ _____

Name Address Phone

_____ _____ _____

Name Address Phone

This authorization shall expire on _____. After this date, Dr. Robison can no longer use or disclose your protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Signature **Date**

I have a right to revoke this authorization in writing except to the extent that action has been taken in reliance on this authorization, or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Dr. Robison must receive the revocation in writing. The revocation must include: My name and address, the effective date of this authorization, and the recipients of the protected health information according to this authorization, my stated desire to revoke this authorization, and the date of revocation and my signature

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FINANCIAL POLICY AGREEMENT

Please REVIEW this financial policy which you and Dr. Robison will sign at the intake appointment..

1. **PAYMENT FOR INITIAL AND ONGOING SESSIONS**: Payment is required at the time services are rendered unless other arrangements have been made in advance. I accept cash, checks, and credit cards. Health Spending Account cards can also be used as payment. There is a $35 service charge for returned checks.
2. **PHONE CONSULTATION, LENGTHY EMAILS, LETTERS**. Time spent on Phone Consultation (with yourself or your child's school), lengthy emails, and Letters written on behalf of you are your child will be billed at the rate of $135 per hour. Payment will be charged to your credit card at the time of service. If your credit card is not on file, you will be asked to provide this information at the time of service.
3. **INSURANCE**: I am not an "in-network" provider for any health insurance providers. However, I will provide you a receipt for each session that you can file with your insurance if you have "out-of-network" insurance coverage. **My services are covered by Health Spending Account (HSA) and Flexible Spending Account (FSA) plans.You are responsible for getting any pre-authorizations and/or forms needed for your benefits.**
4. **MISSED APPOINTMENT/LATE CANCELLATION POLICY**: Please contact me by telephone or e-mail 24 *business* hours before the appointment time to cancel; otherwise you will be billed $50.00 for a missed therapy appointment or $150 for a missed testing appointment. This fee must be paid prior to another appointment being scheduled. I have a limit of two late cancellations / no-shows allowed per client; any more than this may result in discharge.
5. **SCHOOL OBSERVATIONS/CONSULTATIONS**: Please pay in full at the time of the initial appointment or before the school visit is scheduled.
6. **PSYCHOLOGICAL EVALUATIONS / TESTING**: I will confirm the fee agreed upon for any testing at the intake appointment. The total fee includes the time required for the intake session, face-to-face testing, scoring, typing a comprehensive report, and a feedback session to review the report and evaluation findings. My current fee is $1480 paid as follows: $180 at the parent intake session; $600 due on the 1st day of testing; $600 due on the second day of testing; and $100 due at the parent feedback session.
7. **LEGAL FEES**: Subpoena's, depositions, court appearance, and any time spent in preparation for these are billed at the rate of $300 per hour. At the time a subpoena is received, a deposit of $500 will be due.
8. **QUESTIONS**: I encourage you to contact me if there are any questions about this information. If problems with this financial policy arise at any time during your course of treatment, please feel free to speak with me.

Fee per session: As stated avove **Total Evaluation Fee: $1480**

Patient's Name: _____ Date of Birth: _____

I have read and agree with these terms.

Name of person who is financially responsible for payment: _____

Relationship to Patient: _____ Phone Number: _____

Signature: _____ Date: _____

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