2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee Psychological Testing

Demographic Information—Child

Please complete this form with all needed information. If you have any questions about this form, please ask us to explain.

Child's Name: _____ Today's Date: _____

Child's Date of Birth: _____

Parent/Guardian Name:_____

Relation to Child: _____

Phone Number: _____ Alternate Phone Number:_____

Address: _____

City: _____ State: _____ Zip: _____

Name of Insurance Carrier: _____

Name of Insured Person (If different than above): _____

Insurance Subscriber ID: _____

Group Number: _____ Date of Birth of Card Holder:_____

Address of Insurance Carrier:_____

City: _____ State: _____ Zip:_____

Provider Service Number (on back of card): _____

2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee Psychological Testing

Parental/Guardian Consent to Treatment

I do hereby seek and consent to take part in the assessment and/or treatment provided by East Tennessee Psychology Testing (ETPT) for my child _____ _____.
(Name of child) (Date of birth)

Parents/Guardians: I am aware that the age of consent for mental health treatment in the State of Tennessee is **16 years old**. This means that if your child is 16 years and older they can either accept or refuse treatment if they choose. In addition, you understand that the rules of confidentiality apply to your child. There may be things your child tells me they do not want me to tell you. I have a legal and ethical responsibility to keep this confidential, even from you. However, there are three exceptions to this confidentiality; (1) if your child expresses an intent or desire to harm themselves, (2) if your child expresses an intent or desire to harm someone else, or (3) if they tell me that they have been abused or they know of another individual who is, or has been, a victim of abuse. Under the circumstances I am required to tell you and possibly other authorities. In the case of, or suspected, abuse of any type, I am required to notify the State of Tennessee Department of Children's Services immediately.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided to me or my child by ETPT.

I am aware that I may stop the treatment or the assessment at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that there may be consequences to terminating the assessment or treatment before it is completed.

I know that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel and do not show up, I may be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of person acting for client Date

_____ _____
Printed name Relationship to client

I, the psychologist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Philip Axtell _____
Signature of Psycholigist Date

2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee Psychological Testing

Agreement to Pay for Professional Services
Child

I request that East Tennessee Psychological Testing (ETPT) provide professional services to my child,

_____, and I agree to pay all fees for these services.
Print child's name

I agree that this financial relationship with ETPT will continue as long as services are provided, and my account has a zero balance. I agree to inform ETPT if I wish to end the assessment with my child. I agree to pay for services provided to my child until the time my account has a zero balance after the assessment is over or I terminate the assessment.

I agree that I am responsible for the charges for services provided by ETPT, although other persons or insurance companies may make payments on my child's account. I am also informed that my insurance may not cover the entire cost of the services provided to me by the ETPT. I understand that I will be billed for the remainder of the cost that is not paid by my insurance company. I also agree to pay any amount that is not paid by the insurance company. A written report will be provided following the completion of the evaluation, but only **after all financial obligations have been met and your account has a zero balance.** If you have an outstanding balance, the final report will be sent when your balance is paid in full. Due to insurance policy, we cannot bill the testing until after the feedback session is completed. It could take weeks after the feedback session for your insurance company to reimburse me for the testing services I provided to your child. After we determine what you owe, after your insurance has paid, we will send you a final invoice. Once that final invoice is paid, I will send you the report of the results.

You understand that if your account is past due it may become necessary for our office to employ a collection agency. **Any accounts placed with a collection agency will be charged an additional fee of 35% of the account balance.** You agree to pay all costs including attorney's fees and court costs. All materials in your child's medical record remain the property of the psychologist. You realize that such action could require a release to the collection agency, attorneys, and/or the court, information which identifies the parties involved, give patient diagnoses, and describes the dates and nature of the charges as well as all other information contained on any claim filed.

I have read this information and agree to act according to everything stated here, as shown by my signature below.

_____ _____
Parent Signature Relation to client

_____ _____
Printed name Date

I have discussed this agreement with the parent or the person acting for the child.

Philip L Axtell _____ _____
Signature of psychologist Date

2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee Psychological Testing

Agreement for Parents

Psychological services can be a very important resource for children and adolescents. An essential aspect of an assessment is establishing a therapeutic alliance outside of the home. This can:

•Facilitate open and appropriate expression of the strong feelings which routinely accompany difficult times in and out of the family, including guilt, grief, sadness and anger.

•Provide an emotionally neutral setting in which children can explore their feelings.

•Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

However, the usefulness of such services is extremely limited when the assessment becomes simply another matter of dispute between parents. With this in mind, and in order to best help your child, I strongly recommend that each of the child's caregivers (e.g., parents, stepparents, daycare workers, guardian ad litem [GAL], etc.) mutually accept the following as prerequisites for the child's participation with the requested services.

1. As your child's Psychologist, it is my primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers, other psychologists, social workers, etc.). In some cases, this may include a recommendation that you consult with your Pediatrician, Primary Care Provider (PCP), or a therapist; if you/your child does not already have one.

2. I ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite each of you to initiate frequent and open exchange with me as your child's therapist.

3. The following are the important limits of confidentiality as it applies our assessment with your child:

    - I keep records relevant to your child. There is a chance that these records could be released to a Court of Law with the proper Court Order.

    - If you tell me, or it is brought to my attention, any information that I would suspect indicates a child is a victim of abuse, by Tennessee State law I must report it to the State immediately.

    - For a child whose parents are no longer married, or in their previous relationship, and both parents have legal custody any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to my attention that are irrelevant to the child's welfare may be kept in confidence. **You understand that it is my decision, as the Psychologist, what information is relevant and what is not.**

    - In the state of Tennessee, a child who is 16 years and older has the same privacy rights as an adult. Your child must to also consent to the assessment as their choice. Your child also has the right to refuse treatment, even over the objections of his or her parents/caregivers. Thus, it is important to

have open communication with your older child with whom you are seeking services.

*** As a Psychologist, I am legally obligated to bring any concern regarding the child's health and safety to the attention of relevant authorities. When possible, should this necessity arise, I will advise all parties regarding my concerns and actions that will be taken.**

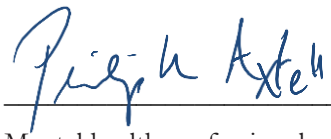
Your understanding of these points and agreement in advance of starting the services requested may resolve difficulties that would otherwise arise and will help make this assessment successful. If you have any questions about the agreement please ask, I'll be happy to explain any of this in detail with you before we get started. Your signature below signifies that you have read and accept this agreement.

_____ _____ _____

Caregiver's Signature Printed name Date

_____ _____ _____

Child's name Date of birth Age



_____ _____

Mental health professional Date

2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee Psychological Testing

Consent to Treatment

Child 16 to 17:11 years old

I do hereby seek and consent to take part in the assessment provided by the East Tennessee Psychological Testing (ETPT). I agree to play an active role in this process. I also agree to release a copy of the results of the assessment to my parents/legal guardian.

I understand that as a child over 16 years old, I have the option of agreeing, or not, to the assessment that my parent /guardian is requesting. I understand that the things I discuss with the Psychologist are confidential, which means it is private and will not be discussed with my parents/guardian. However, there are limitations to this privacy. If, or when, the Psychologist must tell another person what we talked about, we will discuss it together before anyone else is told. I understand that what we talk about in our sessions may not be private in the following instances:

- I understand that if the Psychologist believes I am a danger to myself or someone else, the Psychologist will discuss this with my parent(s) or legal guardian.
- If I tell that I have been abused or another child has been abused, my Psychologist is required to tell my parents/guardian, the State of Tennessee Department of Children's Services, other authorities as needed.
- I understand that no promises have been made to me as to the results of the assessment provided to me by East Tennessee Psychological Testing.

I am aware that I may stop the assessment at any time. If the assessment process is stopped before completion I, or my parents/guardian, are still be responsible for paying for the services I have already received. I understand that there may be consequences if I stop the assessment before completion.

I understand that I, or my parent/guardian, must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I, or my parent/guardian, do not cancel and do not show up for the scheduled appointment, my account may be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the Psychologist may stop my assessment and refuse to schedule any further appointments until my account has a balance of zero dollars.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client Date

_____
Printed name

I have discussed the issues above with the client and his or her parent, guardian, or other representative.

Philip A Axtell _____ _____
Signature of Psychologist Date

2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee Psychological Testing

Communication Agreement

In this agreement, you are giving us permission and indicating methods to contact you. Below you can specify the method(s) in which we can communicate information with you if we cannot talk with you directly. If you are bringing your child to us, we will not contact your child directly for any reason. However, if your child is 16 years or older he/she does have the right to have communication sent directly to them. Please check the following statements allowing us way(s) to communicate with you.

I_____, hereby give my consent to allow
(Please print your name)

Family Psychology Group to contact me in the following ways by checking the following:

- ○ I give my permission to have messages left on my landline answering machine or voice mail
- ○ I give my permission to have messages left on my cellular phone voicemail
- ○ I give my permission to have messages sent to me at my email address: (please print clearly)

  _____

- ○ I give permission to have text messages sent to the following number:_____
- ○ I give my permission to leave messages about me or my child with the following person(s) in the event you cannot contact me directly

_____ _____
Name of person Relationship

_____ _____
Name of person Relationship

If you have any special requests about our office contacting you please indicate that request below

_____

_____

_____ _____
Name of client or child Client/Child's date of birth

_____ _____
Signature of client, parent or guardian Relationship

2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee Psychological Testing

Health History Form

Your Child's Name: _____ Date: _____

Does your child currently have, or a history of, any of the following health conditions:

	During early Childhood	Currently
Serious head injury		
Loss of consciousness		
Epilepsy or seizures		
Broken bones		
Thyroid condition		
Migraine headaches		
Diabetes		
Allergies		
Asthma		
Heart problems		
Lead poisoning		
Problems with hearing		
Problems with vision		

Any other serious medical conditions not addressed above either currently or in the past:

_____

Please list all of the medications you are currently taking

Name	Dose	Reason for taking medication

Continue on next page if needed

Medications (continued)

Name	Dose	Reason for taking medication

2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee Psychological Testing

Policy Regarding Electronic Media

The following policy gives you information about our policies and procedures of our use of electronic media. Included in this policy is the use of cell phones, smart phones, email, and social media (Facebook, Linked In, Four Square, Twitter, and other forms of social internet sites). Our use of, and participation in, these forms of media is very limited as outlined below and serves to protect you and your confidentiality and that of your children. If you have any questions about this policy feel free to talk with me at any time. As technology develops and changes over time these policies will be reviewed, amended, and changed. When we make changes to this policy we will notify you in writing.

1. Contacting you: In providing you with services we will have the need to contact you. Typically, this is accomplished with a phone call. At the time of your initial appointment, we will get contact information, your permission and modes of contact, and how our office will be able to leave information for you in the event we do not talk with you directly. You will have the opportunity to grant, or restrict, the administrative information we send to your selected device(s); cell phone, voicemail, text message, or email. Our office will only send administrative information including such things as appointment reminders, changes in appointment, or other information regarding your appointment. To protect your privacy, we will not use text or email for treatment related conversations. You can change, grant, or deny our office the use of your selected means of contact at any time by completing and signing our Communication Agreement.

2. Social Media: Our practice does not have a presence in the social media realm. We do not have a Facebook page, My Space account, Twitter account or other social media accounts or pages. However, many of our staff members have social media accounts and pages. To protect your privacy we do not accept, or invite, friend or contact requests of current and former clients and their parents. This allows us to have a professional therapeutic relationship that protects the privacy of both you and us.

3. Email: If you give us permission we may contact you via email to give you information about your appointment. However, it is important to understand that this form of communication is not secure and the privacy of our clients is our upmost concern. Any emails that we exchange will become part of your mental health record. Additionally, emails are logged with internet service providers (both mine and yours) and are potentially available to be read by these providers. As such we will not include information related to you, or your child's assessment, therapy or therapeutic sessions. We do not use this as a therapeutic, treatment, or recommendation tool or send information related to you or your child regarding their services here.

4. Location and check-in services: Many social media sites and smart phones have check-in and location services. You should be aware that with the use of these services at our office others can know where you are while you are here. This potentially gives others information that may

compromise your privacy by alerting them that you are at a location that provides psychological services. Please be aware of this risk if you routinely use check-in services or have a passive location service app or enabled service on your device.

5. Internet Search Engines: Our office does not routinely search clients on Internet search engines. However, in rare cases if we feel you may be a danger to yourself, others, or your children we may make use of an internet search of you or your child's name. In the rare event that a provider here makes use of a search engine concerning you or your child we will document this in you or your child's record and discuss it fully the next time we meet.