Anna McQuinn PH.D.
Licensed Psychologist, PSY#12098
P.O. Box 226
San Carlos, Ca 94070
650-508-1942
www.AnnaMcQuinnPhD.com

Date _____/_____/_____

Patient Information:

Child's Name_____

Address_____

City_____State_____Zip_____

Birth Date ____/_____/_____ Age_____

Child Social Security Number_____

Name of those living in household	Relation to patient	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/ Guardian Information:

Name of person completing form_____ Relationship_____

Check one: □Married □Divorced □Separated □Unmarried

If divorced, who has legal custody? _____

Mother's name_____ Address_____
Home Phone_____ Work Phone_____

Father's Name_____ Address_____
Home Phone_____ Work Phone_____

Guardian's name, if different_____

Medical History Questionnaire:

Current Health On a scale of 1 (very poor) to 10 (excellent) how would you rate your present health? (Circle one) 1 2 3 4 5 6 7 8 9 10

Who is the child/adolescent's pediatrician:

_____

What prescription medications are he/she currently taking and why?

_____ _____ _____

What non-prescription medications are he/she currently taking and why?

_____ _____ _____

Is there any suspected alcohol/drug consumption:

What kind_____How frequently_____

How much_____ Has it changed recently? _____

How were you referred?_____

Have you had previous counseling?____ With Whom?_____When_____

Briefly describe the difficulties for which you are seeking help:

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Client Agreement Form for a Minor

Fee Payment My fee is $_____ per session, per agreement, and appointments are 50 minutes in length. Payment is requested at the beginning or end of each session.

Cancellations I will make every effort to accommodate your scheduling needs. In return I ask that you help out by keeping your scheduled appointment, and by notifying me in advance if you are unable to do so. With advance notice, I am often able to accommodate other clients that are waiting to get an appointment.
ALL APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 72 HOURS ADVANCE NOTICE ARE SUBJECT TO A MISSED APPOINTMENT FEE. 72 hour cancellation policy is Monday – Friday during business hours. Please note that this is NOT covered by insurances. It is the client's responsibility.

If you fail to arrive for your appointment without 72 hour advance notification, you will be charged the full hourly rate which is $_____. This fee is due and payable at your next appointment.

Professional Fees. Billing and Payments
My services are provided for at the time of service. Individual psychotherapy, couples, family sessions are 50 minutes at a rate of $_____ per session. Payment is by cash/check at the beginning of your session. I do not take Insurance and I am not affiliated with any Insurance Company. Please note you are responsible for paying me directly, completing forms and obtaining reimbursement. You may wish to contact your insurance representative to ask about mental health coverage, out-of-network providers, and reimbursement rates. In addition to therapy sessions, I charge a fee (discussed as needed) for other-professional services you may require or request such as report writing, telephone conversations, attendance at meetings or consultations with other professionals which you have authorized, or the time required to perform other services you request. A 6% late fee will be added to your bill after 20 days of nonpayment. I may refer the overdue bill to a collection agency or small claim court.

Psychotherapy involving Legal issues
If you are seeking a therapist to support you with legal issues involved in therapy, e.g. divorce, child custody issues, disability claims, harassment claims, etc. Please note I do not have the training, education or experience to represent you. I will be glad to give you a referral to a competent therapist.

Please initial Here:

Assignment of benefits I hereby authorize Anna McQuinn, PhD to release any information required to process my mental health claims, and I also give authorization for direct payment of mental health claims reimbursement to Anna McQuinn, PhD.

Acknowledgement of receipt of Notice of Privacy Practices I hereby acknowledge that I have received a copy Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available upon request, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Confidentiality All communications between the therapist and client in the therapeutic sessions are privileged and confidential with the following exceptions mandated by law:

- If there is reasonable cause to believe there is a clear and imminent danger to another person or persons.
- If there is a reasonable cause to believe that the client is in danger to himself/herself.
- If there is reasonable cause to believe there is child, elder or dependent adult abuse.

Consent to Treatment Most people who participate in behavioral or mental health treatment benefit from it. Like most kinds of healthcare, this kind of treatment requires a very active effort on the individuals part. In addition, there may be certain kinds of risks involved. For example, the counseling process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks.
It is important that the individual participates in this treatment willingly. If you have any questions or concerns about this document, about the services being provided, or about the treatment options, please feel free to ask questions.

Termination of Therapy Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside the Therapist's scope of practice or competence, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in one or more termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals when appropriate.

By signing this agreement, I acknowledge that the patient is a minor, and I am the parent or legal guardian, and I have read this agreement, understood its terms, agree to be subject to its provisions, and voluntarily agree to the minor's participation in the treatment.

Signature of Parent or Legal Guardian Date

_____ _____

In circumstances where parents are divorced or separated, it is important that both parents are in agreement to the child's treatment. Therefore, the document entitled "Confidentiality and Consent to

Treatment of a Minor" requires the signature of the parent or legal guardian to ensure that he or she is aware that their child is in counseling.

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By signing this agreement, I acknowledge that the patient is a minor, and I am the parent or legal guardian, and I have read this agreement, understood its terms, agree to be subject to its provisions, and

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Signature of Parent or Legal Guardian Date

_____ _____

In circumstances where parents are divorced or separated, it is important that both parents are in agreement to the child's treatment. Therefore, this document requires the signature of the parent or legal guardian to ensure that he or she is aware that their child is in counseling.

Anna McQuinn PHD
PSY 12098, California
Telehealth Consent Form

I, _____ hereby consent to engage in Telehealth with Anna McQuinn, PhD.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in–person psychotherapy. The same mandatory and permissive expectations to confidentiality outlined in the informed consent form I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
6. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above and had discussed it with my therapist, and I understand that I have the right to have all my questions regarding this information answer to my satisfaction.

_____ _____

Patient Signature Date

_____
Patients Printed Name

Verbal Consent Obtained
Therapist reviewed Telehealth consent form with patient, patient understands and agrees to the above advisement, and patient has verbally consented to receiving psychotherapy services from therapist via Telehealth.

_____ _____
Therapist Signature Date