Transformation Counseling & Assessment Center, LLC

663 N. Main Road, Vineland, NJ 08360
Office: 215.500.4924
Dr. Tiffany Leone-Vespa, Psy.D., LPC
info@tcactherapy.com
www.tcactherapy.com
NJ License #37PC00365600

Dear Parent/Guardian

Welcome to Transformation Counseling and Assessment Center, LLC. Please take the time to read and complete the following forms:

- *Information and Consent for Counseling Form: Please read and sign*
- *Child/Teen Privacy of Information/Rights and Responsibilities: Please read and sign*
- *Personal History Intake Form: Please fill out as completely as possible*
- *Child/Teen Checklist of Concern: Please fill out to the best of your knowledge*
- *HIPAA Signature Form: Please read and sign*
  The HIPAA Policy can be found on the website under "General Forms"
- *Authorization to Release Information Form: This form allows me to communicate with whomever you choose to add to this form, including doctors. This form can be completed and/or changed at any time. One form is required per person.*
- *Notice of Insurance Change Form: Please read and sign*
- *Credit/Debit Card Authorization Form: Please complete and sign*

If you will not be able to keep your appointment, you must notify your therapist 24 hours in advance. If your therapist does not receive such advance notice, you will be responsible for paying a late cancellation or no-show fee of $180 (not covered by insurance).

Payment is due prior to the therapy session.
For in-office sessions, checks are accepted and should be made payable to Transformation Counseling and Assessment Center, LLC (TCAC). For tele-therapy sessions, I only accept credit/debit card payments via IVY PAY, which is HIPAA compliant. The Credit Card/IVY PAY authorization form is required to be completed for tele-therapy sessions.

I look forward to working with you! - Dr. Tiffany

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Information and Informed Consent for Treatment

Thank you for choosing Transformation Counseling and Assessment Center, LLC. This document is designed to ensure that you understand our professional relationship.

I. Patient Agreement/Contract

Some patients need only a few counseling sessions to achieve their goals, while others may require months or years of counseling. As a patient, you have the right to end our counseling relationship at any point. If counseling is successful, you should feel that you are able to face your immediate challenges.

Although your sessions may be intimate psychologically, it is important for you to realize that it is a professional relationship rather than a social one. Please do not invite your therapist to social gatherings, offer gifts, or ask your therapist to relate to you in any way other than in the professional context of your counseling sessions. ***Your therapist will keep confidential anything that you say during session with the following mandatory exceptions: (1) your therapist determines that you are a danger to yourself or others, (2) your therapist is ordered by a court/judge to disclose information, or (3) your therapist suspects child or elder abuse.***

Sessions are approximately 45 minutes in duration. This is includes collecting copays/ fees, as well as scheduling. *Please note that it is impossible to guarantee any specific results regarding your counseling goals. Your therapist will help identify your issues, but it is up to you to do the work. You and your therapist will work together to achieve the best possible results for you.*

Please note that if you are not seen for a period of 90 days, your file will be closed and you will need to go through an initial intake as a new patient if you choose to return.

_____ ***Parent/Guardian Initial*** _____ ***Patient Initial (if age 14 and over)***

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II. Legal Issues

If you are in the midst of any type of legal issue, such as litigation, a dispute with your employer, separation, or divorce, etc. please inform your therapist immediately.

_____ ***Parent/Guardian Initial*** _____ ***Patient Initial (if age 14 and over)***

III. Payment Policy

Your therapist agrees to provide therapy services to you in return for a fee. ***The fee for each session will be due at the time of service. Cash and personal checks are acceptable forms of payment. Credit card payments are not accepted at this time.*** *There is a* ***$25.00 service charge for all returned checks.*** *You will be provided with a receipt for all fees paid if you request a receipt. Please note that many insurance companies require audits that request information about symptoms, diagnosis, and treatment. By using insurance, you are granting permission for us to communicate confidential information to your insurance company.*

Please remember that Transformation Counseling and Assessment Center, LLC has no control of, or responsibility for how information is handled once it is released to third parties. If you are using your insurance, and that insurance provider changes, or your co-pay changes, please let the front office know as soon as possible. ***Your initials below document that you understand you will be billed for unpaid sessions not covered by your insurance*** *and it is possible an outside billing service will be used. You give permission for the least amount of information necessary to be given to collect the balance.*

_____ ***Parent/Guardian Initial*** _____ ***Patient Initial (if age 14 and over)***

IV. Cancellation/Office Hours

In the event that you will not be able to keep an appointment you must notify your therapist 24 hours in advance. If your therapist does not receive such advance notice, you will be responsible for paying a late cancel/no show fee of $180 (not covered by insurance). You can provide this advance notice via a phone call or text message at (215) 500-4924. This fee must be paid before you are seen. As stated above, an outside billing agency may be used to collect this fee if necessary.

_____ ***Parent/Guardian Initial*** _____ ***Patient Initial (if age 14 and over)***

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V. Emergencies

Transformation Counseling and Assessment Center, LLC is an outpatient facility. Your therapist cannot assume responsibility for day to day functioning, as some more intensive treatments are designed to do. In the case of an emergency, when a client fears harm to him/her self or another, please dial 911 or go to your nearest emergency room, as Transformation Counseling and Assessment Center, LLC is not an emergency facility.

_____ ***Parent/Guardian Initial*** _____ ***Patient Initial (if age 14 and over)***

VI. Social Networking

It is the policy of Transformation Counseling and Assessment Center, LLC that employees/ therapists do not accept requests for friendship, follows or connections from clients or solicit themselves to clients as friends on social networking sites such as Facebook, Twitter, etc. This applies to active as well as non-active clients.

_____ ***Parent/Guardian Initial*** _____ ***Patient Initial (if age 14 and over)***

My signature below indicates that I understand these policies and I grant consent for Transformation Counseling and Assessment Center, LLC to provide psychological services and counseling to myself. I also understand that in order for information to be released I must sign a Release of Information Form, with stated exceptions above.

Parent/Guardian Signature: _____ *Date:* _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ *Date:* _____

Parent/Guardian Name: _____

Doctor Signature: _____ *Date:* _____

Doctor Name: _____

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Child/Teen Privacy of Information and Consent
Your Rights & Responsibilities

What to expect

The purpose of meeting with a therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk with a therapist about these problems, or you may be here because your parent, guardian, doctor, or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you, and suggest a plan for improving these problems. It is important that you participate in therapy and feel comfortable talking with me about the issues that are bothering you. Sometimes these issues will include things you do not want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- *You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.*
- *You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to hurt.*
- *You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In this situation, I will need to use my professional judgment to decide whether a parent or guardian should be informed.*

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- *You tell me you are being abused physically, sexually, and/or emotionally or you have been abused in the past. In this situation, I am required by law to report the abuse to the correct authorities.*
- *You are involved in a court case and a request is made for information about your therapy. If this happens, I will not disclose information without written consent unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you this is happening.*

Communicating with your parent(s) or guardian(s)

- *Except for situations such as those mentioned above, I will <u>not</u> tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of - or would be upset by - but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.*
- *Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or I believe based on things you've told me, that you are addicted to alcohol, I would not keep this confidential.*
- *Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people that you do not know or in unsafe situations, I would not keep this information confidential. You can always ask me questions about the types of information that I would disclose. You can ask me in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"*
- *If I have agreed to keep information confidential - to not tell your parents or guardian - I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, to help them know how to be more helpful to you.*

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Communicating with other adults

- *School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission, but both your parent or guardian and I believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.*
- *Doctors: Sometimes your doctor and I may need to work together. For example, if you need to take medication in addition to seeing a therapist, I will get written permission from your parent or guardian in advance to share information with your doctor.*

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask me at any time.

Child/Teen Signature: _____ *Date:* _____

Child/Teen Name: _____

Parent/Guardian Signature: _____ *Date:*_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ *Date:* _____

Parent/Guardian Name: _____

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Parent/Guardian Only

Please initial below indicating your agreement to respect your child's/teen's privacy:

_____ *I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/ or may be asked to participate in therapy sessions as needed.*

_____ *I understand that I will be informed about situations that could endanger my child/teen. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment.*

_____ *I understand I have brought my child/teen to Dr. Tiffany Leone-Vespa, Psy.D., LPC, for evaluation and/or treatment. I understand that Dr. Leone-Vespa's patient is my child/teem - not me, any other sibling, or my spouse/partner. This is true no matter who is financially responsible for the evaluation/treatment of my child/teen.*

_____ *I understand that Dr. Leone-Vespa's primary responsibility is my child's best interest and that Dr. Leone-Vespa may decide to involve me in my child's/teen's evaluation/treatment at her sole discretion.*

I have read the above and understand. By signing below, I agree to the above.

Parent/Guardian Signature: _____ *Date:* _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ *Date:* _____

Parent/Guardian Name: _____

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Personal History Intake Form Ages 2-17

Patient's Name: _____ *Date:* _____

Gender: ☐*F* ☐*M* *Date of birth:* _____ *Age:* _____ *Grade Level:* _____

School: _____ *Address:* _____

Form completed by: _____

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Best contact number: _____ ☐*Cell* ☐*Landline* *Leave msg:* ☐*Y* ☐*N*

Current Medications: _____

Medical Problems: _____

Pre-existing psychological diagnoses: _____

Parents are: ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Never Married*

Child lives with: _____ *Adopted:* ☐*Y* ☐*N*

Primary reason(s) for seeking services: _____

_____

Family Information

Relationship	*Name*	*Age*	*Living*		*Living with you*	
			Yes	*No*	*Yes*	*No*
Mother	_____	_____	☐	☐	☐	☐
Father	_____	_____	☐	☐	☐	☐
Siblings	_____	_____	☐	☐	☐	☐
_____	_____	_____	☐	☐	☐	☐
_____	_____	_____	☐	☐	☐	☐

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*Mother's Address:*_____

Phone Number: _____ *Ok to leave msg:* □ *Y* □ *N*

Occupation: _____ □ *FT* □ *PT* *Education Level:* _____

*Father's Address:*_____

Phone Number: _____ *Ok to leave msg:* □ *Y* □ *N*

Occupation: _____ □ *FT* □ *PT* *Education Level:* _____

Others Living in Household with patient: _____

Stepfamily Information (if applicable)

Stepmother Name: _____ *Age:* _____

Occupation: _____ *Relationship with child:* _____

Stepfather Name: _____ *Age:* _____

Occupation: _____ *Relationship with child:* _____

Step siblings:

Name	_____	*Age*	_____	*Live in home*	□ *Yes*	□ *No*
Name	_____	*Age*	_____	*Live in home*	□ *Yes*	□ *No*
Name	_____	*Age*	_____	*Live in home*	□ *Yes*	□ *No*
Name	_____	*Age*	_____	*Live in home*	□ *Yes*	□ *No*

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Child/Teen Checklist of Concerns

Child Name: _____ Age: _____

Person Completing this Form: _____ Date: _____

Please mark all items that apply to your child

- ☐ *Affectionate*
- ☐ *Anxious, Nervous, Worried*
- ☐ *Appetite Changes*
  - ☐ *Eating more than usual*
  - ☐ *Eating less than usual*
- ☐ *Argues, talks back, defiant*
- ☐ *Bed wetting*
- ☐ *Breath holding*
- ☐ *Bullies or intimidates*
- ☐ *Cruel to animals*
- ☐ *Conflicts with parents over persistent rule-breaking, chores, homework, grades*
- ☐ *Complains*
- ☐ *Concentration problems, poor focus, difficulty making decision*
- ☐ *Cries easily, feelings are easily hurt*
- ☐ *Procrastinates, wastes time*
- ☐ *Difficulties with parents/new marriage/new family*
- ☐ *Dependent, immature*
- ☐ *Developmental delays*
- ☐ *Disrupts family activities*
- ☐ *Disobedient, uncooperative, noncompliant, doesn't follow rules*
- ☐ *Distractible, inattentive, poor concentration, daydreams, slow to respond*
- ☐ *Drug or alcohol use*
- ☐ *Eating - poor manners, refuses to eat, hoards food*
- ☐ *Failing- grades in school*
- ☐ *Fatigue, low energy*
- ☐ *Fearful*
- ☐ *Fighting, hitting, violent, aggressive, destructive*
- ☐ *Fire-setting*
- ☐ *Friendly, outgoing, social*
- ☐ *Friendship changes, few friends, withdrawing from friends*

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- ☐ *Frequently complains about being sick*
- ☐ *Immature, has only younger playmates, clowns around*
- ☐ *Imaginary playmates pass appropriate stage, indulges in a lot of fantasy*
- ☐ *Insulting, name-calling*
- ☐ *Interrupts, yells, talks out of turn*
- ☐ *Lacks organization, unprepared, doesn't follow through*
- ☐ *Legal difficulties - truancy, loitering, vandalism, stealing, fighting, drug use, drinking*
- ☐ *Likes to be alone, isolates, withdrawals*
- ☐ *Loss of interest in hobbies, friends, normal activities*
- ☐ *Low frustration tolerance, irritability, angry outbursts*
- ☐ *Lying*
- ☐ *Mute, refuses to speak*
- ☐ *Nail biting*
- ☐ *Nightmares*
- ☐ *Need for high degree of supervision at home for play, chores*
- ☐ *Obesity*
- ☐ *Overactive, restless, hyperactive, fidgety, noisy*
- ☐ *Overly compliant*
- ☐ *Oppositional, resistant, overly negative*
- ☐ *Recent move, new school, loss of friends or change in friends*
- ☐ *Poor peer relations - competitive, fights, teases, provokes*
- ☐ *Recklessness, high-risk behavior, lack of concern for self*
- ☐ *Repetitive movements, rocking, hand-flapping*
- ☐ *Runs away*
- ☐ *Sad, unhappy, depressed*
- ☐ *School avoidance*
- ☐ *Self-esteem problems, self-critical, feels worthless, lacks confidence*
- ☐ *Self-harming behaviors - head banging, cutting, scratching self, biting or hitting self*
- ☐ *Sexually inappropriate - preoccupied with sex, publicly masturbates*
- ☐ *Shy, timid*
- ☐ *Sleep problems How many hours of sleep is averaged a night? _____*
- ☐ *Speech difficulties*
- ☐ *Suicide thoughts or attempt*
- ☐ *Temper tantrums, rages*
- ☐ *Thumb sucking, finger sucking, hair chewing*
- ☐ *Tics, muscle, verbal*
- ☐ *Teased, picked on, bullied*
- ☐ *Uncoordinated, accident prone*

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HIPAA ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);*
- *Obtaining payment from third party payers (e.g. my insurance company);*
- *The day-to-day healthcare operations of your practice.*

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices (found on the website under General Forms), which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may obtain the most current copy of this notice on the website

Parent/Guardian Signature: _____ *Date:* _____

Parent/Guardian Name: _____

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Notice of Insurance Change Form

Transformation Counseling and Assessment Center, LLC bills services under your insurance company. Typically, the coming new year results in changes of insurance coverage. In some cases, your insurance carrier may change altogether. In other cases, there may be changes in your insurance plan that will result in co-pay changes. Please remember:

- *Contact me immediately if your insurance changes for any reason.*
- *You are ultimately responsible for the bill. If your insurance changes and I do not accept that insurance, then you are responsible for the bills.*

My signature below indicates that I understand that I am responsible for notifying the billing department of any changes in my insurance at 215.500.4924. I am aware that I am fully responsible for any services provided to me or my family members in the event that my insurance is no longer valid.

Current Insurance Information:

Name of Insurance: _____

Name of Insurer: _____ *Birthdate:* _____

ID Number: _____

Group Number: _____

Patient Signature: _____ *Date:* _____

Patient Name: _____

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CREDIT CARD AUTHORIZATION FORM
IVY PAY AUTHORIZATION FORM

I authorize Transformation Counseling and Assessment Center, LLC to charge my credit card on file with "IVY PAY" (HIPAA compliant) for the following:

- *copay or coinsurance rate for all attended appointments*
- *$180 for any appointment missed or canceled with less than 24 hour notice*
- *any portion of billable services not covered by my insurance policy*

Name as shown on Credit Card: _____

Type of Credit Card: ☐ *Visa* ☐ *Mastercard* ☐ *Discover* ☐ *Amex*

Credit Card Number: _____

Expiration Date: _____ *CV 3- or 4-Digit code:* _____ *Billing address zip code:* _____

By signing below, I certify that my above information is true and accurate and that I am an authorized user on the credit/debit card account above.

I authorize Transformation Counseling and Assessment Center, LLC to keep my credit card information on file and charge the above fees.

I understand that I am responsible for notifying Transformation Counseling and Assessment Center, LLC if my credit/debit card information needs to be updated.

Transformation Counseling and Assessment Center, LLC agrees to ONLY charge for services rendered or for appointments not cancelled 24 hours in advance.

I understand that if I wish to cancel an appointment I will need to contact my therapist at (215) 500-4924 via text or phone call.

Parent/Guardian Signature: _____ *Date:* _____

ParentGuardian Name: _____