MARGARET E. (PEG) McCARTHY, PH.D., LP DATE:

CLIENT INFORMATION (MINOR)

Legal name _____

Preferred name: _____

Birth date: _____

Referred by: _____

School: _____ Grade: _____

Mother's name: _____ Mother's birthdate: _____

Mother's address: _____

Mother's phone no.: _____ Mother's education: _____

Mother's occupation and employer: _____

Father's name: _____ Father's birthdate: _____

Father's address: _____

Father's phone no.: _____ Father's education: _____

Father's occupation and employer: _____

Siblings, names and ages: _____

Medical History

Primary care physician: _____

Psychiatric prescriber (if any): _____

Health problems for which this minor is currently being treated: _____

_____

Medications this minor is currently taking: _____

_____

Prior psychological treatment, including dates, focus of treatment, and providers:

_____

_____

_____

_____

Underline any of the following symptoms/behaviors that apply to this minor:

Headaches; dizziness; bed-wetting; soiling; stomach trouble; chronic fatigue; insomnia; nightmares; temper tantrums; lying; stealing; truancy; school problems; poor peer relations; difficulty with authority; legal problems; alcohol use; other drug use; chronic tension; panic; specific fears; depression; hopelessness; self-harm; suicidal ideas; withdrawn; lonely; conflict with family members; hyperactivity; sexual problems; gender questioning; running away; inferiority feelings; high anxiety; unusual visual or auditory experiences; confusion; absence of feelings; lack of motivation; loss of control; fear of "going crazy"; anger control problems; aggression; difficulty concentrating; memory loss; racing thoughts; thoughts of harming others.

Past illnesses or injuries:

_____

_____

_____

_____

Please briefly state the nature of your child's needs: _____

_____

_____

_____

_____

_____

What are your child's strengths and challenges?

_____

_____

_____

_____

_____

_____

Margaret (Peg) McCarthy, Ph.D., LP

3649 SW Burlingame Road, Suite 100, Topeka, Kan., 66611 (785) 266-6751

TREATMENT AUTHORIZATION AND AGREEMENT

I hereby authorize Margaret E. McCarthy, Ph.D., LP, to administer such care as is necessary in her judgment, including but not limited to individual, couples, group, conjoint/family therapy and psychological testing to:

_____

I understand that Dr. McCarthy received her Ph.D. in Clinical Psychology from the University of Kansas in December 1998, and that she is a Licensed Psychologist in the state of Kansas (LP 1140). I understand that she works with an association of independent mental health professionals, under the name Shadow Wood Clinical Associates, who share certain expenses and administrative functions. I understand she operates independently in providing clinical service and is alone fully responsible for those services. I understand my professional records are separately maintained, and no member of the association can have access to them without my specific, written permission.

I understand that under Kansas law and professional guidelines, a therapy relationship is considered privileged. This means that anything discussed in therapy will be kept in strictest confidence within the confines of the law. (Please refer to paragraphs 2 and 3 below regarding exceptions to "confidentiality.") I authorize and understand that Dr. McCarthy may consult with other health-care professionals for the sole purpose of providing best possible care. No guarantee or assurance has been given by anyone as to the results that may be obtained by the therapeutic process.

IN CONSIDERATION of Margaret E. McCarthy, Ph.D., agreeing to undertake this case, I agree to the following:

1. To keep all scheduled appointments and to give at least twenty-four (24) hours' notice of intention to cancel any appointment. I agree to assume full responsibility for payment of all charges for professional services rendered. I understand I may be billed for cancellations of less than 24-hours' notice or for no-shows, at the discretion of Dr. McCarthy. An individual payment plan will be arranged and kept current. I understand that a persistent unpaid bill may result in use of a collection agency to ensure payment.

2. I understand that the law requires that in the case of any reported or suspected child or elder abuse, these facts must be reported to the local Child or Adult Protective Services. In most cases, the reporting of these matters will be done

with my full knowledge and understanding. In fact, whenever possible, Dr. McCarthy will assist me in making the report myself.

3. I understand that in the event of threatened physical harm toward myself or any other person(s), Dr. McCarthy will notify the potential victim(s) and the authorities of such a threat. Dr. McCarthy will take any action necessary to prevent such threats from being carried out.

4. I understand that during marital or family therapy, communication is not allowed with family members that are not directly involved in therapy, unless I give written permission for such contact. In the case of child or adolescent therapy, for the purpose of maintaining the best possible therapeutic relationship(s), Dr. McCarthy reserves the sole right to determine what information will be passed on to the parent or guardian.

5. I understand that Dr. McCarthy cannot guarantee the confidentiality of my communications with her through electronic means or social media and that she will not accept Friend requests from clients, to protect clients' privacy and to maintain good therapeutic boundaries.

I hereby certify that I have read and understand this agreement and that any questions have been fully explained. Upon my request, a copy will be delivered to me. I accept the terms and conditions of this TREATMENT AUTHORIZATION AGREEMENT.

SIGNED: _____ DATE: _____
Client or Legal Guardian

SIGNED: _____ DATE: _____
Client or Legal Guardian

SIGNED: _____ DATE: _____
Witness