



***WELCOME TO  
THE TARNOW CENTER FOR  
SELF-MANAGEMENT<sup>SM</sup>***

Jay Tarnow, M.D. and Associates welcome you to our practice. Our goal is to serve you as professionally and efficiently as possible, while focusing on your individual needs. Our staff is composed of various professionals, who work together as an interdisciplinary team to bring you the highest quality treatment in a warm and caring setting. We appreciate the opportunity to provide you with the quality service that you deserve.

We hope that you will take a few minutes to become acquainted with our office policies so that, with your help and cooperation, we are able to provide you with the best possible service. However, if you have any questions, please ask us.

Once again, welcome to our practice and please let us know how we can better serve you.

***ABOUT OUR OFFICE***

We are extremely proud of our office and have designed it to meet the needs of both our clients and staff. Included in our office is a comfortable waiting area, a separate children's playroom, a testing lab, a biofeedback lab, and an observation playroom used for therapy.

For your convenience, we have provided a telephone in the waiting area. We ask that all calls be limited to five minutes so that others may use the phone as well. There is a soda and snack machine located in the kitchen area of our office.

For everyone's safety, we ask that you please follow the following guidelines for the children's playroom. Children must be supervised at all times. We ask that children not engage in any unsafe activities (climbing over the backs of the chairs, throwing objects, etc.) Please encourage the children to treat the materials in this area as they would treat their own valuables.

We hope that you enjoy our office as much as we do, and we would appreciate your assistance in treating the waiting area as you treat your home.

# ***HOW DOES THE OFFICE WORK?***

## SCHEDULING THE INITIAL VISIT

When you first called, you spoke to an intake coordinator. She should have explained the process of scheduling an initial visit. At that time she took down some information from you to help us in the decision making process. Some forms may have already been sent to you, along with this introduction. These forms are very important in providing us developmental and past history. Please remember that the assistants are not clinically trained and will not be able to answer clinical questions, but all of our clinicians are able to speak with you over the phone if you have specific questions. You can always leave a detailed message on your clinician's voice mail. Please remember, unless it is an emergency, the clinicians cannot be interrupted during a session, but will return your call at their earliest possible opportunity.

## FEES

Fees for initial evaluations and follow-up appointments vary for each clinician. Please remember that medicine evaluations, medicine follow-ups, psychological, educational, and personality testing, school visits, lengthy telephone consultations, consultations and conversations with other professionals, and report writing all have separate fees that vary among the clinicians. If you have any questions about fees, please check with an assistant or your clinician.

## APPOINTMENTS

Appointments are typically 45-50 minutes long. Medicine follow-ups usually take 30 minutes. Scheduling an appointment usually requires speaking with the appropriate assistant. The assistant will work with you in trying to find the most convenient time for you to come see us. Please remember that afternoons are often filled with regular appointments, but we will work with you as best we can.

## CANCELLATION POLICY

Our office policy is that we require **48 hours** notice for all cancellations, with the exception of a serious emergency or sudden illness. The death of a family member, natural disaster, or even severe illness of a family member living at home, all qualify as an emergency. A business meeting, final exams, another doctor's appointment or minor illness, such as a cold or respiratory infection, would not qualify as an excused session. The session will be billed at the full rate unless the office received proper notification. You are always welcome to leave a message with our answering service if you must cancel an appointment after the office is closed. Please note that many insurance companies and PPO's will not reimburse you for a missed session.

Our policy for group therapy sessions is necessarily different since we cannot fill an empty space in a group, even with sufficient notice. Typically, group spaces are reserved for a specific period of time and you must pay for that space (like school tuition) whether you, or your child can attend or not. Often, we allow a "free" missed session over a given period of time, but please check with the particular clinician for that particular group's policy.

## TELEPHONE CALLS

Your telephone calls are always welcome. Our clinical assistants can answer most general questions you may have. Unless your question is clinical, it is best if you speak with the assistant first, and they will try to answer your questions. If they feel they cannot answer your questions, they will either take a message or forward you to the appropriate voice mail. Please remember that our clinicians schedule hourly appointments and are often in session much of the day. We ask that you keep this in mind when requesting a clinician call you back. Patient care is top priority and you will hear from them as soon as possible.

If you are having an emergency, please call the main number, 621-9515. This number is answered 24 hours a day by either our office or our answering service. Please let whoever answers the phone know that it is an emergency and that you would like the clinician paged. In the event of a medical emergency, please to go to the nearest Emergency Room. In the case of a psychiatric emergency, proceed to the Emergency Room at West Oaks Hospital (713-995-0909).

## TELEPHONE CONSULTATIONS

The fee for telephone consultations and telephone conference calls with other therapists, patient, patient's family, school personnel, etc. is set at the rate of \$3.00 per minute plus any charges assessed by the telephone company for the cost of long distance calls or conference calls.

## PAYMENT AND BILLING

We ask that you make payment in full at the time of the session. Usually we will ask that you make payment as you come in the door before the start of your session. This is not because we are afraid that you will leave without paying. Due to the office layout and staff work plan, there is limited space in the exit area and it is usually crowded with people scheduling appointments. The entry area and the computer and printer in that area are set up to check you in and receive your payment. If you can plan to arrive for your session five minutes early to check in and handle payment, it will ensure that you will get your full session. For your convenience, we accept Visa, Master Card, Discover, Cash, and Personal Checks. However, returned checks will result in an additional \$25 fee to cover our own bank charge and processing costs. For all services rendered to minor patients, we ask the adult accompanying the patient, whether parent or guardian, to make payment.

## STAFFING

At the Tarnow Center, an interdisciplinary team model is used to treat our patients. We believe that employing this team approach affords our patients excellent quality of care. Our philosophy is to recognize each patient as a whole person who operates from a biological, psychological and social perspective. In order to achieve this comprehensive approach to caring for our patients, certain cases are discussed in staffing with our team of clinicians. This is a confidential setting where only our mental health professionals participate in providing their valuable insight.

## INSURANCE

If you would like to use your insurance, please let us know in advance so that we can attempt to determine what services in our office will be covered by insurance and assist you to get your maximum benefit to the best of our ability. As a general policy, we only file insurance if we are a provider for a specific managed care plan. However, we will provide you with the documents

that you will need to file your own claim. If this is a problem for you, please let us know as soon as possible and we will try to make other arrangements.

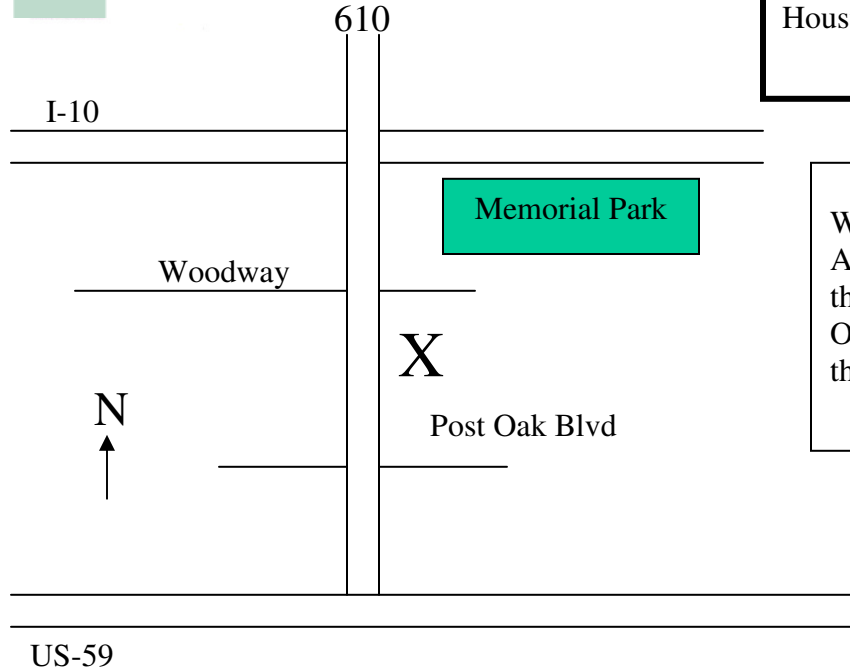
If you have questions on how to file a claim or interpret an EOB (Explanation of Insurance Benefits), please contact your insurance company or employee benefit department.

Please understand that insurance companies vary in their policies about reimbursement. Many times you may owe more than your listed co-payment due to the amount the insurance company pays. We cannot guarantee that you will obtain full reimbursement, even if we do pre-certify your insurance. In certain cases your insurance company may request a pre-certification before a treatment is rendered. Tarnow and Associates will make every effort to obtain this approval before your visit, but it is the patient's ultimate responsibility to pay for services rendered. If you have specific financial questions or concerns, please contact Financial Services at **(713) 621-9353 option 2**.

#### PRESCRIPTIONS AND RENEWALS

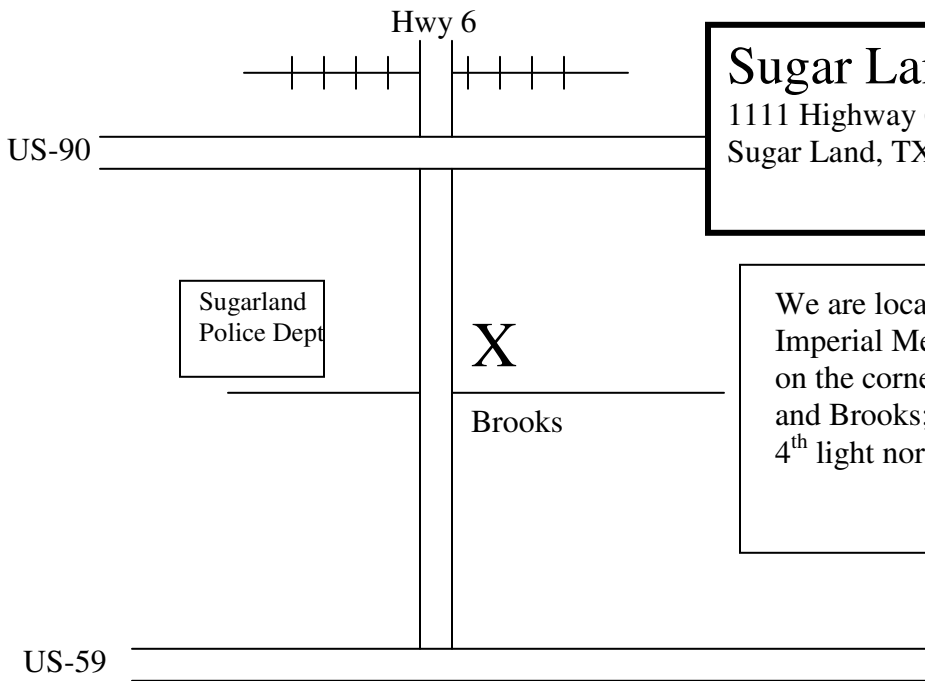
The phone number for our Prescription Phone Line is **(713) 621-9107 option 4**. The Center needs a 48-hour notice to have any prescription written or refilled. All prescription refills other than Dexedrine, Ritalin, and Adderall may be called into your pharmacy. When you call the Center to refill Dexedrine, Ritalin, or Adderall, please have the following information available: 1) the name of the medication, 2) the dosage and frequency, and 3) the quantity of the refill. Please note, these prescriptions must be filled within 7 days of the date on the written prescription. If your prescription should expire, there is a \$15 charge to rewrite the prescription. These medications are carefully monitored by the Drug Enforcement Agency and the Texas Department of Public Safety. They have specific guidelines that we must follow. In addition, all these prescriptions can be picked up at the Galleria office, they cannot be called into a pharmacy, nor put in the mail. We apologize if this causes any inconvenience, but to provide the best service, we must comply with the government requests.

***AGAIN, WELCOME TO OUR PRACTICE.***



**Galleria Office**  
 1001 West Loop South, Ste 215  
 Houston, TX 77027

We are located in the AT&T business building on the 610 feeder between Post Oak & Woodway, inside the loop.



**Sugar Land Office**  
 1111 Highway 6, Ste 210  
 Sugar Land, TX 77478

We are located in the Imperial Medical building on the corner of Hwy 6 and Brooks; which is the 4<sup>th</sup> light north of US-59.

# Tarnow Center for Self-Management

## Client Information Form (Child & Adolescent)

Intake Date: _____		Clinician: <u>Yael R. Ebenstein , Ph.D.</u>	
Patient's Name: _____		S.S.#: _____	
First	Middle	Last	
Address: _____		City _____ State _____	
Street _____		Zip _____	
Birth Date: _____		Age: _____ Sex: _____	
Home Phone: ( ) _____			
Employer Name: _____			
Address: _____			
Street		City	State
Zip			
Mother's Name: _____		Home Phone: ( ) _____	
Father's Name: _____		Work Phone: ( ) _____	
Home Phone: ( ) _____		Work Phone: ( ) _____	
Current Marital Status: _____			
Mother's Employer Name: _____			
Address: _____			
Street		City	State
Zip			
Father's Employer Name: _____			
Address: _____			
Street		City	State
Zip			
Other family members living at home (children, stepchildren, and other relatives):			
<u>Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Relationship to Patient</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
Person responsible for payment: _____			
First		Middle	Last
Address: _____		City _____ State _____	
Street _____		Zip _____	
Telephone: ( ) _____			
School: _____		Telephone: _____	
Address: _____		City _____ State _____	
Street		City	State
Zip			
Referred by: _____		Relationship: _____	
Address: _____		Telephone: ( ) _____	
Patient's medical doctor: _____			
Doctor's phone: ( ) _____			
Address: _____			
Street		City	State
Zip			

1. Why is the patient coming for consultation at this time?

---

---

---

---

---

2. What is the most important goal to be achieved during the visits?

---

---

---

---

---

3. Has any family member had psychotherapy, psychological testing, or counseling with a mental health professional? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please list the family member, the therapist/counselor's name, the year in which the service was provided, and the reason for seeking the service.

Family Member

Therapist

Year

Reason

---

---

---

---

---

4. Please note any history of serious physical or mental illness of any family member:

---

---

---

---

---

5. Please note any major stresses that have occurred to any family member within the last five (5) years:

---

---

---

---

---

Please include your picture below:



Name: \_\_\_\_\_

Nickname (if any): \_\_\_\_\_

Age: \_\_\_\_\_

## Contract for Delivery of Professional Services Tarnow Center for Self-Management

I have read the "Welcome to the Practice Packet" and understand and agree to the contents that explain the office's policies and procedures.

I understand and agree to pay the fees that are listed below. I also understand that the fees pertain only to Yael Ebenstein, Ph.D.. If I am referred to another professional within the Center, the fees may be different than those listed below.

- The fee for the first one hour initial evaluation is \$ 200.00 per session.
- The fee for therapy is \$ 160.00 per session.
- The fee for psychological testing is \$185.00 per session

Please initial as indicated:

x\_\_\_\_\_ Unless other written arrangements have been made in advance by me, my health coverage carrier, a co-responsible party or a third party who has agreed to pay fees for services rendered to me and has signed this contract, full payment is due at the time services are rendered.

x\_\_\_\_\_ If the Center determines to be in-network providers for my health coverage carrier, I understand that the Center will attempt to verify my mental health benefits, but that this is not a guarantee of payment and that it is my personal responsibility to pay for services rendered.

x\_\_\_\_\_ I understand that if Tarnow and Associates does not have an arrangement with my health coverage carrier, then it is my responsibility to pay in full at the time services are rendered and to file and collect my own insurance claims. Tarnow and Associates will provide all reasonable information customarily needed to file a claim.

x \_\_\_\_\_ I understand that every effort will be made to obtain insurance pre-certification for my appointments when needed before a service is rendered, but that it is ultimately my responsibility to pay for services rendered.

x\_\_\_\_\_ I understand the Center's **48-hour cancellation policy** and agree to pay for appointments for which I am charged due to failure to cancel or because of late cancellations. I also understand that my health coverage carrier does not cover non-cancellation fees; therefore, the full non-insurance fee will be my responsibility.

x\_\_\_\_\_ I understand that all services rendered at the Center are charged for differently and agree to pay the fees set forth by the Center. These services include telephone calls, medicine evaluation appointments, medicine follow-up appointments, group therapy, telephone consultations, conference calls, educational, personality, and psychological testing, co-therapy/feedback sessions, lab work, and school visits.

x\_\_\_\_\_ I understand and agree that in the case of divorced parents, the parent bringing the child to the office is responsible for payment at the time of the services.

x\_\_\_\_\_ I understand and agree that from time to time my case may be discussed in a confidential staffing among the professional clinical team.

x\_\_\_\_\_ I understand and agree that the adult accompanying a minor or the legal guardian will be responsible for payment at the time of the service.

**Confidentiality:** All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law.

Disclosure may be required in the following circumstances. Where there is a reasonable suspicion of child abuse or elder adult physical abuse; where there is a reasonable suspicion that the patient presents a danger of violence to others, or where the patient is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

I consent to services performed by the Tarnow Center. My signature below indicates that I have read the above contract and agree to be bound to its terms.

\_\_\_\_\_  
Signature of Patient or Responsible  
Party if a Minor

\_\_\_\_\_  
Signature of Co-Responsible Party

\_\_\_\_\_  
Signature of Third Party Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of the Patient

\_\_\_\_\_  
Signature of Clinician

\_\_\_\_\_  
Date

---

### Optional Addendum

If you have signed the foregoing contract as a co-responsible party or a third party guarantor, your signature indicates that you have unconditionally promised to pay for all services determined by the Tarnow Center to be medically necessary, in the best interests of and provided by the Tarnow Center to \_\_\_\_\_.

All payments are due by the co-responsible party or the third party guarantor and shall be due and payable in the amount and at each time set forth in this contract to which this acknowledgement and guarantee is attached.

The undersigned confirms that he/she is the sole managing conservator and joint managing conservator, guardian, guardian ad litem, next friend, or other person with the court ordered right and duty to authorize the medical treatment of \_\_\_\_\_. In connection with and simultaneously with the execution of this letter of authorization, I deliver the Tarnow Center copies of the following court orders:

- a) Divorce Decree;
- b) Order of Modification and an order SAPER (where applicable);
- c) Temporary Order and a SAPER (where applicable);
- d) Temporary Order (where applicable); and
- e) Emergency Order (where applicable).

**AUTHORIZATION  
TO RELEASE MEDICAL RECORDS  
TO MY INSURANCE COMPANY**

Due to the influx of managed care, many insurance companies will request medical records before processing claims for you. To make the process faster, we ask that you check a box of your choice and sign below.

I authorize the release of my medical records to my insurance company.

I do not authorize the release of my medical records to my insurance company.

In signing this authorization, it is my understanding that this information shall be held CONFIDENTIAL, that I do not waive the physician-patient privilege, and that the information will be utilized for professional use only. I do not authorize the person/company to whom these records are being forwarded to release them to any other person, company, or entity whatsoever.

At the time of request, your account will be charged for this request and your insurance company will be billed at the time records are sent.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Guarantor

\_\_\_\_\_  
Date

## Contract for Delivery of Professional Services Tarnow Center for Self-Management

I have read the “Welcome to the Practice Packet” and understand and agree to the contents that explain the office’s policies and procedures.

I understand and agree to pay the fees that are listed below. I also understand that the fees pertain only to Yael R. Ebenstein, Ph.D.. If I am referred to another professional within the Center, the fees may be different than those listed below.

- The fee for the first one hour initial evaluation is \$ 200.00 per session.
- The fee for therapy is \$ 160.00 per session.
- The fee for testing is \$185.00 per unit.

Please initial as indicated:

x\_\_\_\_\_ Unless other written arrangements have been made in advance by me, my health coverage carrier, a co-responsible party or a third party who has agreed to pay fees for services rendered to me and has signed this contract, full payment is due at the time services are rendered.

x\_\_\_\_\_ If the Center determines to be in-network providers for my health coverage carrier, I understand that the Center will attempt to verify my mental health benefits, but that this is not a guarantee of payment and that it is my personal responsibility to pay for services rendered.

x\_\_\_\_\_ I understand that if Tarnow and Associates does not have an arrangement with my health coverage carrier, then it is my responsibility to pay in full at the time services are rendered and to file and collect my own insurance claims. Tarnow and Associates will provide all reasonable information customarily needed to file a claim.

x \_\_\_\_\_ I understand that every effort will be made to obtain insurance pre-certification for my appointments when needed before a service is rendered, but that it is ultimately my responsibility to pay for services rendered.

x\_\_\_\_\_ I understand the Center’s **48-hour cancellation policy** and agree to pay for appointments for which I am charged due to failure to cancel or because of late cancellations. I also understand that my health coverage carrier does not cover non-cancellation fees; therefore, the full non-insurance fee will be my responsibility.

x\_\_\_\_\_ I understand that all services rendered at the Center are charged for differently and agree to pay the fees set forth by the Center. These services include telephone calls, medicine evaluation appointments, medicine follow-up appointments, group therapy, telephone consultations, conference calls, educational, personality, and psychological testing, co-therapy/feedback sessions, lab work, and school visits.

x\_\_\_\_\_ I understand and agree that in the case of divorced parents, the parent bringing the child to the office is responsible for payment at the time of the services.

x\_\_\_\_\_ I understand and agree that from time to time my case may be discussed in a confidential staffing among the professional clinical team.

x\_\_\_\_\_ I understand and agree that the adult accompanying a minor or the legal guardian will be responsible for payment at the time of the service.

**Confidentiality:** All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law.

Disclosure may be required in the following circumstances. Where there is a reasonable suspicion of child abuse or elder adult physical abuse; where there is a reasonable suspicion that the patient presents a danger of violence to others, or where the patient is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

I consent to services performed by the Tarnow Center. My signature below indicates that I have read the above contract and agree to be bound to its terms.

\_\_\_\_\_  
Signature of Patient or Responsible Party if a Minor

\_\_\_\_\_  
Signature of Co-Responsible Party

\_\_\_\_\_  
Signature of Third Party Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of the Patient

\_\_\_\_\_  
Signature of Clinician

\_\_\_\_\_  
Date

---

### Optional Addendum

If you have signed the foregoing contract as a co-responsible party or a third party guarantor, your signature indicates that you have unconditionally promised to pay for all services determined by the Tarnow Center to be medically necessary, in the best interests of and provided by the Tarnow Center to \_\_\_\_\_.

All payments are due by the co-responsible party or the third party guarantor and shall be due and payable in the amount and at each time set forth in this contract to which this acknowledgement and guarantee is attached.

The undersigned confirms that he/she is the sole managing conservator and joint managing conservator, guardian, guardian ad litem, next friend, or other person with the court ordered right and duty to authorize the medical treatment of \_\_\_\_\_. In connection with and simultaneously with the execution of this letter of authorization, I deliver the Tarnow Center copies of the following court orders:

- a) Divorce Decree;
- b) Order of Modification and an order SAPER (where applicable);
- c) Temporary Order and a SAPER (where applicable);
- d) Temporary Order (where applicable); and
- e) Emergency Order (where applicable).

# **NOTICE CONCERNING COMPLAINTS**

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners  
Attention: Investigations  
1812 Centre Creek Drive, #300  
P.O. Box 149134  
Austin, Texas 78714-9134

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

*Tarnow Center for  
Self-Management<sup>SM</sup>  
Parent Questionnaire*

*A Developmental And Historical  
Perspective On Your Child*

*Tarnow Center for Self-Management  
1001 West Loop South, Suite 215, Houston, Texas 77027  
1111 Highway 6 South, Suite 210, Sugar Land, Texas 77478  
Tel: 713-621-9515 Fax: 713-621-7015  
[www.tarnowcenter.com](http://www.tarnowcenter.com)*

*Copyright 1998*

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Your Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
School: \_\_\_\_\_ Grade Placement: \_\_\_\_\_  
Child lives with: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Tel: \_\_\_\_\_  
\_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Tel: \_\_\_\_\_

Stepmother's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Tel: \_\_\_\_\_  
\_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Tel: \_\_\_\_\_

Father's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Tel: \_\_\_\_\_  
\_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Tel: \_\_\_\_\_

Stepfather's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Tel: \_\_\_\_\_  
\_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Tel: \_\_\_\_\_

Other family members (Indicate whether at home or away)

Name	Date of Birth	Where Living
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please state why you are seeking evaluation at this time: \_\_\_\_\_

---

---

---

At what age was this problem first noted? \_\_\_\_\_

In what areas does the problem interfere with your child's current functioning? (Family, School/Academic, Peer Relationships) \_\_\_\_\_

---

---

What specific assistance would you like to get out of this evaluation? \_\_\_\_\_

---

---

Has your child been evaluated or tested before? If so, please list dates and by whom. (Please sign release of information with addresses and include copies of any evaluations.)

Evaluator

Dates

Reason

---

---

---

What is the primary language spoken at home? Indicate other language used: \_\_\_\_\_

---

Does this child have difficulty making friends? Yes \_\_\_\_\_ No \_\_\_\_\_

Does this child have difficulty keeping friends? Yes \_\_\_\_\_ No \_\_\_\_\_

Does this child prefer having younger friends? Yes \_\_\_\_\_ No \_\_\_\_\_

Does this child prefer having older friends? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe relationship with father: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe relationship with mother: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe relationship with stepfather: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe relationship with stepmother: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe relationship with siblings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe relationship with stepsiblings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe relationship with peers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Birth History

Is your child adopted? If yes, please give age adopted: \_\_\_\_\_

Was this a planned pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_

Were any miscarriages suffered? Yes \_\_\_\_\_ No \_\_\_\_\_

How many miscarriages? \_\_\_\_\_

Length of this pregnancy? \_\_\_\_\_

Any difficulties during delivery? If so, please describe in detail: \_\_\_\_\_

---

---

---

Were any medications given? \_\_\_\_\_

Length of labor? \_\_\_\_\_

Type of delivery (e.g., cesarean, breech, vaginal) \_\_\_\_\_

Birth weight: \_\_\_\_\_ Apgar Score: \_\_\_\_\_

### Baby's Condition at Birth (Circle all that apply)

Cord around neck                      No                      Yes

Injured during birth                      No                      Yes

Breathing difficulty                      No                      Yes

Required oxygen                      No                      Yes

Turned blue                      No                      Yes

Had an infection                      No                      Yes

Was placed in an incubator                      No                      Yes

Had difficulty sucking                      No                      Yes

Was jaundiced                      No                      Yes

Please list any other problems: \_\_\_\_\_

---

---

---

## Early Development

Sat up without help \_\_\_\_\_ Months \_\_\_\_\_ Years

Crawled \_\_\_\_\_ Months \_\_\_\_\_ Years

Walked alone (10-15 steps) \_\_\_\_\_ Months \_\_\_\_\_ Years

Walked up stairs \_\_\_\_\_ Months \_\_\_\_\_ Years

Rode a tricycle \_\_\_\_\_ Months \_\_\_\_\_ Years

Caught a ball \_\_\_\_\_ Months \_\_\_\_\_ Years

Spoke first words (mama, dada, etc.) \_\_\_\_\_ Months \_\_\_\_\_ Years

Put words together (Daddy bye-bye,  
Mama home, etc.) \_\_\_\_\_ Months \_\_\_\_\_ Years

Spoke clearly so strangers understood \_\_\_\_\_ Months \_\_\_\_\_ Years

Used fingers to feed self \_\_\_\_\_ Months \_\_\_\_\_ Years

Used a spoon \_\_\_\_\_ Months \_\_\_\_\_ Years

Fully bowel trained \_\_\_\_\_ Months \_\_\_\_\_ Years

Fully bladder trained \_\_\_\_\_ Months \_\_\_\_\_ Years

Able to dress self \_\_\_\_\_ Months \_\_\_\_\_ Years

Able to tie shoelaces \_\_\_\_\_ Months \_\_\_\_\_ Years

Able to separate easily from mother  
(for school, play, etc.) \_\_\_\_\_ Months \_\_\_\_\_ Years

Did child attend preschool? \_\_\_\_\_

Were problems with behavior noted? \_\_\_\_\_

Were problems with learning noted? If so, at what age? \_\_\_\_\_

Was this child ever retained or recommended to be retained? If so, which grade? \_\_\_\_\_

Social history (Divorce, Losses, Moves, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medical History

Family medical history (Diabetes, Seizures, Neurological Problems, Cardiac problems, Metabolic Problems, ADHD, LD, Depression, Anxiety, Manic-Depression, Schizophrenia, Motor Tics, Obsessive-Compulsive Disorder, Suicide, Alcoholism, Substance Abuse, Glaucoma, Renal, Endocrine)\_\_\_\_\_

---

---

Head Injury	No	Yes	Age_____
Loss of Consciousness	No	Yes	Age_____
Motor Tics or Vocalizations	No	Yes	Age_____
Ear Infections	No	Yes	Age_____
P.E. Tubes	No	Yes	Age_____
Meningitis	No	Yes	Age_____
Seizures	No	Yes	Age_____
Injuries	No	Yes	Age_____
Bowel Problems	No	Yes	Age_____
Chicken Pox	No	Yes	Age_____
Measles	No	Yes	Age_____
Asthma or Allergies	No	Yes	Age_____
Hospitalizations	No	Yes	Age_____
Food Allergies	No	Yes	Age_____
Other Allergies	No	Yes	Age_____
Slow Weight Gain	No	Yes	Age_____
Heart Problems	No	Yes	Age_____
Other	No	Yes	Age_____

Medications taken over a long period of time. Please specify.\_\_\_\_\_

---

---

Overactivity	No	Yes	Age_____
Head banging	No	Yes	Age_____
Rocking in bed	No	Yes	Age_____
Temper tantrums	No	Yes	Age_____
Self-destructive behavior	No	Yes	Age_____
Difficulty in being comforted or consoled	No	Yes	Age_____
Stiffness or rigidity	No	Yes	Age_____
Looseness or floppiness	No	Yes	Age_____
Crying often and easily	No	Yes	Age_____
Shyness with strangers	No	Yes	Age_____
Bashfulness with new children	No	Yes	Age_____
Irritability	No	Yes	Age_____
Extreme reaction to noise of sudden movement	No	Yes	Age_____
Difficulty in keeping to a schedule	No	Yes	Age_____
Trouble getting satisfied	No	Yes	Age_____
Desire to be held too often	No	Yes	Age_____
Failure to be affectionate toward parents	No	Yes	Age_____
Unwillingness to go along with change in daily routine	No	Yes	Age_____
Tendency to make off sounds, grunts, or snorts	No	Yes	Age_____
Tendency to twitch or jerk arm(s) or head often	No	Yes	Age_____

## Review of Systems

Does your child have any history of:

1. Neurological

Seizures	No	Yes
Staring episodes	No	Yes
Motor/vocal tics	No	Yes
Previous requirement for head imaging (MRI/CT Scan)	No	Yes

2. Eyes

Parental concerns about vision	No	Yes
Previous vision screen/ophthalmologic assessment	No	Yes

3. Ears, Nose, Mouth, Throat

Previous hearing screen/audiologic assessment	No	Yes
--	----	-----

What medications are prescribed at this time? Please specify. \_\_\_\_\_

Surgery. Please specify. \_\_\_\_\_

Genetic or Congenital Conditions. Please specify. \_\_\_\_\_

### Early Life Difficulties

Feeding difficulty	No	Yes	Age_____
Poor appetite	No	Yes	Age_____
Unwillingness to try new foods	No	Yes	Age_____
Very unpredictable appetite	No	Yes	Age_____
Extreme hunger	No	Yes	Age_____
Colic	No	Yes	Age_____
Constipation	No	Yes	Age_____
Headaches	No	Yes	Age_____
Stomachaches	No	Yes	Age_____
Trouble falling asleep	No	Yes	Age_____
Trouble staying asleep	No	Yes	Age_____
Very unpredictable length of sleep	No	Yes	Age_____
Very heavy sleeping	No	Yes	Age_____

# **Tarnow & Associates, P.A.**

## **Notice of Office Policies and Practices to Protect the Privacy of Your Health Information**

IN ACCORDANCE WITH THE NEW HEALTH INSURANCE PRIVACY AND PORTABILITY ACT (HIPPA) AND TEXAS STATE LAW, THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
  - Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist or psychiatrist.
  - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for you health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of the center. Example of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within our [offices, clinics, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our [offices, clinics, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

### Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purpose outside of treatment, payment and health care operations, we will obtain an authorization for you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation during a private, group, joint, or family sessions, which are kept in your medical records. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

## Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **To Communicate with Individuals Involved in Your Care or Payment for Your Care:** We may disclose to a family member, other relative, close personal friend or any other person you identify, PHI directly relevant to that person's involvement in your care or payment related to your care.
- **Law Enforcement:** We may disclose your PHI for law enforcement purposes as required by law or in response to a subpoena or court order.
- **As required by Law:** We will disclose your PHI when required to do so by federal, state, or local law.
- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the State Board, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.
- **Coroners and Medical Examiners:** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

## Patient's Rights and Center's Duties

### Patient's Rights:

- Psychotherapy Notes - A licensed psychologist or a psychiatrist who is providing psychological or psychiatric services to an individual is not required to permit the individual to inspect or copy personal records containing PHI relating to the individual if the information contained in the records has not been disclosed to a person other than another psychologist or psychiatrist for the specific purpose of clinical supervision conducted in the regular course of treatment.
- Marketing – PHI may not be used, disclosed, or sold for marketing purposes without first obtaining consent or authorization from the individual. Written communications must explain the recipient's right to removal from the mailing list, and removal must be accomplished within five days after the receipt of the request.
- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- 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 you are seeing us. Upon your request, we will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to an Accounting – 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 request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy of Notice – You have the right to obtain a paper copy of the notice from us upon request.

### Center Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you a copy personally or mail it to you.

## Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer at Tarnow & Associates, P.A. Privacy Office, 1001 West Loop South, Ste 215, Houston, Texas 77027 or by telephone at (713) 621-9515.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the appropriate address upon request.

## Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 1, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in person or by mail should a change become effective.

.....

I have read and understand the policy and procedures regarding the privacy of health information.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

# Tarnow Center for Self-Management<sup>SM</sup>

## E-MAIL CONSENT FORM

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient/Parent's e-mail address \_\_\_\_\_

### 1. RISK OF USING E-MAIL

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

- a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- c. E-mail senders can easily misaddress an e-mail.
- d. E-mail is easier to falsify than handwritten or signed documents.
- e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- h. E-mail can be used to introduce viruses into computer systems.
- i. E-mail can be used as evidence in court.

### 2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

- a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
- b. Provider may forward e-mails internally to Provider's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's/parent's prior written consent, except as authorized or required by law.
- c. Although Provider will endeavor to read and respond promptly to an email from the patient/parent, the provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient/parent shall not use e-mail for medical emergencies or other time-sensitive matters.
- d. If the patient's/parent's e-mail requires or invites a response from the provider, and the patient/parent has not received a response within a reasonable time period, it is the patient's/parent's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- e. The patient/parent should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- f. The patient/parent is responsible for informing Provider of any types of information the patient/parent does not want to be sent by e-mail, in addition to those set out in 2(e) above.
- g. The patient/parent is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient/parent or any third party.
- h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- i. It is the patient's/parent's responsibility to follow up and/or schedule an appointment if warranted.

### 3. INSTRUCTIONS

To communicate by e-mail, the patient/parent shall:

- a. Limit or avoid use of his/her employer's computer.
- b. Inform the provider of changes in his/her e-mail address.
- c. Put the patient's name in the body of the e-mail.
- d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).

- e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to Provider.
- f. Inform the provider that the patient/parent received an e-mail from the provider.
- g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
- h. Withdraw consent only by e-mail or written communication to Provider.

4. PATIENT/PARENT ACKNOWLEDGEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein, as well as any other instructions that the provider may impose to communicate with patients/parents by e-mail. Any questions I may have had were answered.

Patient/Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_