McConnell Assessment and Psychological Services
drsarahmcconnell@mcconnellpsychologicalservices.com
620-481-6731

AGREEMENT/INFORMED CONSENT

I consent to enter treatment or a psychological evaluation, for either myself or my child, with Dr. Sarah McConnell. I understand therapy or an evaluation is a joint effort between the clinician and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. I agree that I will be responsible for the payment of all professional fees regardless of the outcome of therapy or the evaluation. I know I can end my relationship with my clinician at any time I wish and I can refuse any requests or suggestions made by my clinician.

By signing below, I am indicating that I have read, understand, and agree to the information contained in the Office Policies or Group Participation Agreement document, and I have received and reviewed a copy of this office's "Notice of Policies and Practices to Protect the Privacy of Your Health Information." These forms are all available on the website. A printed version is available upon request.

My clinician has verbally reviewed the following with me:

- Limits to confidentiality (harm to self or others, mandated reporting, legal situations, and public safety)
- Policies regarding unpaid balances, late cancellations, and no show fees

*I acknowledge that I have received the information listed above from my Dr. McConnell. I also understand that it is very important that I read this information carefully before our next session. I understand that I can discuss any questions I have about the procedures at that time.*

Client or Parent Signature Client or Parent Printed Name Date

Therapist Signature Date

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# Late Cancellation and No Show Policy

**Intake Appointments: $175** fee for cancellations less than **72 hours or 3 business days** before the appointment.

**Therapy Appointments: $150** fee for cancellations with less than **24 hours or 1 business day** before the appointment. Appointments on Saturday and Monday must be canceled by **8 am the Friday before the appointment**.

In case of adverse weather, every attempt will be made to offer the service remotely as appropriate. You will not be charged for late cancellation or not attending a session due to adverse weather. If a client is late **by 15 minutes** or more, it will be considered a late cancellation and rescheduled. If a client arrives for a session in an intoxicated state that is deemed unconducive to constructive therapy by their clinician, I reserve the right to refuse services and will charge a full session fee.

**Evaluation Appointments: $500** fee for cancellations less than **72 hours or three business days** before testing day appointments.

**No Shows:** If a client misses an appointment without any notification prior to the appointment start time, a no-show fee is **automatically** applied. The no-show fee is equal to the clinician's full session rate ($150). There are **no** routine fee waivers for missed appointments.

**Repeated cancellations/No Shows:** In the event that a client frequently cancels or misses appointments (i.e., 3 late cancels or no-shows in a row), developing a plan to avoid future recurrences will be handled by each clinician on a case-by-case basis. Actions may include no longer holding a designated appointment time for the client until a commitment to attendance is demonstrated or consideration of treatment termination until a future time when the client is more committed to treatment.

**How to Cancel an Appointment:** Clients are offered two different options for canceling appointments. You may email or call Dr. McConnell (drsarahmcconnell@mcconnellpsychologicalservices.com; 620-481-6731).

*I hereby certify that I have read and agree to the McConnell Assessment and Psychological Services Late cancellation & No Show Fee Policy:*

_____ _____

Client or Parent of Client Signature Date

_____ _____

Clinician Signature Date

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# PAYMENT AUTHORIZATION FORM

Client Name: Date of Birth: / /

McConnell Assessment and Psychological Services requires a credit or debit card on file for all services. We will NOT charge this card without your permission, EXCEPT in the following cases (please initial below to indicate an understanding of these circumstances):

- Late cancellations or appointment no-shows: **Initial Here**
- Your bill is more than 90 days past due, without alternative arrangements in place: **Initial Here**

**Payment Processing for Appointments and Ongoing Sessions**
For your convenience, our practice will save this card in our secure payment portal and process a payment automatically for any copayments, co-insurances, or other session balances owed on an ongoing basis. Please let us know if you want to pay with cash or with a check for sessions. **Initial Here**_____

**Late Cancelation Policy** (the full policy is listed in our Office Policies Document found on our website: www.mcconnellpsychologicalservices.com) Our practice applies fees for late cancelations and no shows that are not able to be rescheduled within a business week as follows:

- Intake Appointment: Applied for cancelations/no shows within 72 hours or 3 business days. ($175 fee)
- Therapy/Follow Up Sessions: Applied for cancelations/no shows within 24 hours or 1 business day. ($150 fee)
- Testing Day Appointment: Applied for cancelations/no shows within 72 hours or 3 business days. ($500 fee)

If a client is late **by 15 minutes** or more to an appointment, it will be considered a late cancelation and rescheduled. Emergency situations will be handled on a case-by-case basis and may require additional documentation. **Initial Here**

**For Office Staff to Complete at Your Intake Appointment Check In:**

Card Type: ❑ Visa ❑ MasterCard ❑ Discover ❑ AMEX Last 4 digits of card:
Date scanned or manually entered into the secure payment portal: / /
Staff Member Initials:

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*By signing, I authorize McConnell Assessment and Psychological Services to use and store my credit/debit card information to charge my credit/debit card. I understand that this card will be charged for either late cancellations, no-shows, and past due balances, as outlined in the Office Policies Document. My signature also indicates that I will inform my clinician and/or office staff of any changes to my billing information over the course of our work together.*

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Client or Parent Signature Client or Parent Printed Name Date

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SUPPLEMENTAL BILLING AGREEMENT REGARDING INSURANCE REIMBURSEMENT

I will provide you with a "superbill" that you can submit to your insurance company for reimbursement.

It is your responsibility to verify coverage prior to consenting to services. While we make every effort to verify benefits and coverage prior to beginning services, you are ultimately responsible for knowing your coverage and for all charges. Most insurance companies require that you be informed of the reason testing hours or services were denied or deemed not medically necessary.

Your signature below indicates that you have read this document and agree to pay for all psychological testing and evaluation services, even those not reimbursed by your insurance carrier. Payment is expected at the time of service.

*By signing below, I am indicating that I understand and agree to the information above. My signature indicates that I understand I am completely responsible for payment to Dr. McConnell. I understand Dr. McConnell will provide me with documentation I can submit to my insurance company for reimbursement. I also understand it is my responsibility to understand and know my insurance coverage and that assessment often requires pre-approval.*

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Client or Parent Signature  Client or Parent Printed Name  Date

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Therapist Signature  Date

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AUTHORIZATION TO RELEASE INFORMATION

Client Name: Date of Birth:

I understand that the purpose of this release is to increase communication between McConnell Assessment and Psychological Services providers and other care providers or significant individuals relevant to myself/my child/my family. By signing this release, I authorize the McConnell Assessment and Psychological Services to release the following information:

- □ Acknowledgement of treatment only
- □ Relevant diagnostic and treatment information
- □ Progress notes or other treatment/evaluation records

I authorize McConnell Assessment and Psychological Services staff to release this information to the following individuals/agencies: (Please provide any contact information including phone numbers and email addresses of the specific persons involved)

1)
2)
3)
4)

In addition, I authorize the above individuals/agencies to release the following information to the McConnell Assessment and Psychological Services :

- □ Acknowledgement of treatment only
- □ Relevant diagnostic and treatment information
- □ Progress notes
- □ Educational records/information

I understand that I can revoke this authorization at any time except to the extent that it has already been acted upon. Otherwise, this authorization will expire exactly one year from the undersigned date.

Client/child Signature Printed Name Date

Parent/guardian name Relationship Date

Witness Name Printed Name Date

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# DEMOGRAPHIC FORM-ADULT EVALUATION

## General Information

Full Name: Today's Date: ____/____/____ Date of Birth:_____/____/
Street Address (include ZIP code):
Phone Numbers:
Home: Is it okay to leave a detailed message at this number? Yes___ No
Cell: Is it okay to leave a detailed message at this number? Yes___ No

E-Mail Address:
Do I have your consent to email an appointment reminder prior to sessions? Yes No
Do I have your consent to email digital copies of:
1) Records: Yes No
2) Billing statements: Yes No

Emergency Contact: Phone #:

**Please tell us a little more about yourself:**
Gender (pronouns): _ Sexual orientation:
Ethnicity/Cultural identity: _ Spiritual beliefs:
Disabilities (any):
Occupation and/or School & Major:
Handedness (right/left/ambidextrous):

Please list the reason(s) you are seeking this evaluation:

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How long have these problems occurred? (number of weeks, months, years):

Who referred you to our practice? Please provide contact information:

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Is this referral a result of or related to any legal or court proceedings? If so, please provide name of attorney.

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Have you had previous neuropsychological testing? Yes No
If Yes, where? When?

Have you had any additional testing (e.g., psychoeducational, speech/language?) Yes No
If Yes, where? When?

**If you answered Yes to either of the above questions, please attach or otherwise provide report(s).*

Please list any other healthcare providers involved in your care (e.g., neurologists, other physicians, occupational therapists, etc.):

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**Developmental/Medical History**

Pregnancy and Birth (your own, not your children's – leave blank if unknown)

Pregnancy/Birth/Delivery Complications? Please Describe:

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Medications used during pregnancy?

Did your mother engage in any of the following during pregnancy?

**Yes No** Smoking?How much?
**Yes No** Drug intake? Type? How much?
**Yes No** Alcohol consumption? How much?

Length of pregnancy?
(weeks):
Age of mother at birth:
Birth weight: lbs. oz. Birth length:
APGAR scores? /

Type of delivery (check please): spontaneous induced cesarean with instruments breech Any complications for mother or infant (yourself) after birth?
Please explain:
_____

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Developmental Milestones

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**Yes No** Did you enjoy cuddling?
**Yes No** Were you fussy or irritable?
**Yes No** Were you more active than other babies?
**Yes No** Was your development significantly different than your siblings? If yes, please explain:

---

At what age did you first do the following (indicate with year and month of age).

| | | | |
|---|---|---|---|
| Turn Over | Crawl | Stand Alone | Walk Alone |
| Walk Upstairs | First Words | First Phrases | |

Toilet Trained during the day by age 5? Yes No
Did bed wetting or soiling occur after training? Wetting Soiling If yes, until what age?

Did you have any speech difficulties?
Motor difficulties (e.g. clumsiness)?
Medical History

Has your medical history been normal/unremarkable? Yes No
If no, please explain:

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Have you received any medical diagnoses? Yes No
Please explain:

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Circle All that Apply:

**Yes No** Have you completed genetic testing?
**Yes No** Have you had an MRI?
**Yes No** Have you had an EEG?
**Yes No** Frequent ear infections?
**Yes No** Were ear tubes ever placed?
**Yes No** Hearing problems? **Yes No** Vision problems? **Yes No** Headaches?

**Yes No** Meningitis?
**Yes No** Seizures?

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**Yes No** Asthma?
**Yes No** Slow/fast growth?
**Yes No** Head injury?
**Yes No** Allergies?
**Yes No** Hospitalizations?
**Yes No** Have you experienced anything you would call traumatic (physical, verbal, or emotional abuse; unwanted sexual experiences; accidents or other events)?

Have you ever been hospitalized, had surgeries, or major illnesses?

| *Age* | *How long* | *Reason* |
|---|---|---|
| | | |
| | | |
| | | |

What medications do you currently take? (Include over-the-counter supplements)

| *Name* | *Dose* | *Frequency* | *Reason* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Describe your sleep routine:

Typical bed time:
Typical wake time:
Trouble falling asleep? **Yes No**
Trouble staying asleep? **Yes No**
Trouble waking up early? **Yes No**

Any other sleep problems? Explain:

Describe your diet:

Describe your current level and type(s) of exercise:

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Mental Health History

List any previous or current mental health diagnoses:

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Have you received therapy services or counseling in the past? **Yes No**

Name of provider: Dates:
Name of provider: Dates:
Name of provider: Dates:

Are you seeing a psychiatric clinician (Psychiatrist, Nurse Practitioner, Physician Assistant) for medication? **Yes No**
Have you in the past? **Yes No**

Name of Clinician: Dates of treatment:
Medication(s) Prescribed:

Is there a history of self-harm or suicidal thoughts, threats, or attempts? Please explain:

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Have you ever been hospitalized for mental health concerns? Please explain:

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Do you have a history of angry outbursts? **Yes No**
If yes, please explain:

Have you ever physically assaulted another person, animal, or object? **Yes No**
If yes, please explain:

**Psychosocial Functioning**

Describe your personality:

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What are your non-academic strengths?

What are your non-academic weaknesses?

How do you spend your free time?

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What is your current level of alcohol and/or drug use?

Alcohol: Recreational drugs:

How is your social group? Do you have close friends? Any trouble initiating or maintaining relationships?

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**Please place a mark next to behaviors that you believe you experience to an *excessive or exaggerated degree* when compared to others your age.**

*Behavior*
- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with others
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Impulsive (does things without thinking)
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor
- ❑ History of vocal or motor tics
- ❑ Poor sense of danger/risk
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug use
- ❑ Alcohol use

*Sleeping and Eating*
- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Excessive snoring during sleep
- ❑ Decreased need for sleep without getting tired
- ❑ Eating excessively
- ❑ Eating Poorly

*Social*
- ❑ Prefer to be alone
- ❑ Excessively shy or timid view
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Not sought out for friendship by peers
- ❑ Excessive daydreaming and fantasy life
- ❑ Difficulty seeing another person's point of view
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor

*Motor Skills*
- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ "Clumsy" in general

**Academic History**

Did you ever have an IEP or 504 Plan, or other modified learning program or participation in special education services when younger? **Yes No**

If yes, please describe:

_____

_____

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What was your high school GPA: What was/is your college GPA: Grad school GPA:

How do you generally perform on standardized tests?

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What are your strongest and weakest points, academically?

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**Legal History**

Have you been involved with the court currently or in the past?
Date(s):
Describe:

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Currently on Probation? **Yes No** Probation Officer: Phone #:

**Family History**

Are you (choose one): **Married** **Living Together** **Separated** **Divorced** **Single**

If married, for how long?
If separated or divorced, when? _ Do you have children? Ages?
Who else lives in your home?

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Have any of the following diseases occurred among your blood relatives (parents, aunts, uncles, grandparents)? Check all that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD/ADD
- ❑ Bleeding tendency
- ❑ Depression
- ❑ Cancer
- ❑ Suicide
- ❑ Learning problems
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety
- ❑ Autism/Asperger's
- ❑ Intellectual disability/ cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Bi-polar Disorder
- ❑ Schizophrenia
- ❑ Other (specify):

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