Margaret M. Tripp, Ph.D.

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MINOR CONSENT FOR EVALUTION/TREATMENT

Patient Name (CHILD): _____ Date of Birth: ____-____-_____

I hereby give full consent for my child to receive services of Margaret M. Tripp, Ph.D. I certify that I have the legal authority to authorize and consent to this evaluation or treatment as parent, managing conservator, or guardian of this child. If there has been a divorce, I am aware that Texas law requires Dr. Tripp to obtain consent from both birth parents or divorce decree demonstrating sole authority before providing mental health services to my child.

CONFIDENTIALITY

Any information my child or I provide to Margaret M. Tripp, Ph.D. is confidential and when possible will not be released to others without my written consent. Professional ethical obligations, state and/or federal law require Dr. Tripp to disclose confidential information without my consent in the following situations:

1. If the therapy session reveals any information concerning the abuse of a child, elder or disabled person, Margaret M. Tripp, Ph.D. is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this law.
2. If the course of therapy reveals my child may have intent to harm either self or others, I acknowledge Margaret M. Tripp, Ph.D.'s legal and moral duty to prevent my child from bringing this harm about. If my child reveals an intent to harm self, Dr. Tripp has my irrevocable permission to prevent my child from accomplishing harm, including permission to warn law enforcement authorities about parties that may be harmed.
3. If I plan to request Margaret M. Tripp, Ph.D. provide detailed session receipts to file for reimbursement, I am aware information about my child's health status and treatment will be disclosed. As a billing submission requirement of the managed care or insurance company, I understand Dr. Tripp will be required to provide a mental health diagnosis for my child, and may be required to provide the company with detailed treatment needs or copies of the treatment records generated in therapy. Once these records are in the possession of the managed care or insurance company, Dr. Tripp cannot guaranty their continued confidentiality.
4. Additionally, if a law suit is filed by me or my child against Margaret M. Tripp, Ph.D. for breach of duty; or if a court order, legal proceeding, statute, or regulation requires disclosure of records, I understand legal obligations may require the release of my child's therapy records.

TREATMENT RECORDS

State law requires psychologists maintain a record of treatment given to my child. This record contains the information Margaret M. Tripp, Ph.D. will use to chart the course of therapy and it is Dr. Tripp's intent that the file remain private.

1. I may get a copy of the file by providing her with a signed release of information request and once my child becomes of age, child will have to provide Margaret M. Tripp, Ph.D. with written request. Dr. Tripp may provide me or my child with a synopsis of the course of treatment and outcome in lieu of the actual record.
2. I may be required to pay in advance for either the copying cost or the time required for the preparation of the treatment summary. This payment may also be required when requesting copies or reports be provided to any court or legal representative or designate.
3. If the therapy sessions contain more than one person, only the patient or authorizer(s) of patient treatment may obtain the complete treatment file.
4. In the event that Margaret M. Tripp, Ph.D. becomes in capacitated or dies, it will be necessary for another therapist to take possession of each patient's files and records. In this case another licensed mental health professional, selected by Dr. Tripp, will take possession of my records and if necessary provide me with copies upon request.

COMMUNICATION POLICY

Continuous effort is made to provide secure communication between patient and staff by phone, email, and fax. These forms of communication are subject to use and monitoring by trained office staff only, however, cannot be guaranteed secure. In accepting services from Dr. Tripp and authorizing communication with her office, patient agrees to knowledge of limitations/ restrictions of online communication and agrees to hold harmless Margaret M. Tripp, Ph.D. and staff for information loss due to technical failure or cyber occurrence. Telehealth services are offered by Dr. Tripp when deemed appropriate. In order to engage in phone or video-conferencing services, I agree to the following: 1) risks to patient confidentiality are higher over phone/video-conference, 2) session will occur over a secure internet connection rather than public Wi-Fi, 3) alternate phone

number/email and emergency contact will be provided for use in the event of a crisis, 4) insurance company may not reimburse for telehealth services, 5) Dr. Tripp may determine that telehealth services are no longer appropriate and require in-person therapy resume.

PAYMENT POLICY

Payment is due at the time of service. My consent to treatment includes an electronic payment permission, authorizing Dr. Tripp and her staff to deduct service fees from my designated account. It is my responsibility to file and collect my own insurance. I understand if I do not uphold my responsibility to pay for services, this may result in the termination of treatment with Dr. Tripp and referral for appropriate treatment services elsewhere. Payment after the date of service will include a late payment charge of $25.

FEE SCHEDULE

Initial Evaluation/New Patient	**$215 per 60 minute session**
Treatment/Psychotherapy Session	**$195 per 50 minute session**
No Show or Late Cancel Fee (<24 hours)	**FULL Session Fee**
Late Payment Fee-charged day after service	**$25**
Letter Writing or Treatment Summary	**$100 per 30 mins**
Forensic or Court Involvement	**$400/60 mins, $100/15 mins**
Consultation/Class Fee	**$215 initial 60 minutes, $195 each additional 60 mins**

12 months between visits = New Patient, New Consent Form

MISSED SESSION POLICY

If I need to cancel a session with Margaret M. Tripp, Ph.D., I agree to provide at least 24 hours notice.

1. **24 hours notice of cancellation is required**, and 48 hours is preferred. I understand that my appointment time is reserved for me. Dr. Tripp does not double book patients and therefore, if I fail to show up and/or provide appropriate notice of cancellation she is unable to fill my appointment time with someone who can use that time instead.
2. **Cancellation with less than 24 hours notice or no show will result in a charge of FULL session fee**. This policy applies to all reasons for cancellations, including illness or work/school conflicts. I understand and agree that the credit card on file with the office will be charged the cancellation fee whether I choose to return for follow up services.

I understand I am responsible for coming to my session on time, and if I am late, the appointment will still conclude at the scheduled end time.

PRIVACY POLICY & CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

As described in detail in the Notice of Privacy Practices, Dr. Tripp requests my consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. By signing consent for my child, I: (1) Acknowledge that a copy of the Notice of Privacy Practices (Eff. 02/2005, Rev. 09/2021) is available to me; and (2) Consent to provider use and disclosure of my child's health information for treatment, payment, or health care operations. I have the right to revoke consent to use or disclosure in writing any time, except where practice has already used or disclosed your health information in reliance upon this consent.

TERMINATION OF TREATMENT

I understand the length of time and frequency of sessions required for therapy will be determined by my child's personal situation. I understand Margaret M. Tripp, Ph.D. will do her best to fulfill identified therapeutic needs and to provide my child with her best professional care. There is no guarantee of a cure. Any break in treatment longer than 12 months will require reinitiating treatment with Dr. Tripp as a new patient, with no guarantee of Dr. Tripp's availability at that time.

My signature on this consent form verifies that I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction, and that I give consent for evaluation/treatment of my child. I understand that I have the right to withdraw my consent for treatment at any time.

_____	_____	_____
Parent's Signature	**Printed Name of Parent**	**Date**
_____	_____	_____
***Additional Parent's Signature**	**Printed Name Additional Parent**	**Date**

* Texas law requires that a psychologist obtain consent from both birth parents or a divorce decree granting sole permission before providing mental health services to a minor.

CHILD / ADOLESCENT HISTORY QUESTIONNAIRE

CONTACT INFORMATION

Child Name :		**Today's Date:**
Child Date of Birth:	**Child** Age:	**Child** Grade:
Child School:		
Parent 1 (Mother/ Father/ Step Parent):		
Parent 2 (Mother/ Father/ Step Parent):		
Other Caregiver(s):		
Child's Primary Address:		
	City:	Zip:
Primary Parent Address (if different):		
	City:	Zip:
Alternate Parent Address:		
	City:	Zip:

Phone Contact Numbers		Can I leave a message on this line?	
Primary Parent Cell		YES ☐	NO ☐
Alternate Parent Cell		YES ☐	NO ☐
Primary Parent Work		YES ☐	NO ☐
Alternate Parent Work		YES ☐	NO ☐
Home Phone	YES ☐ NO ☐	Child's Cell	YES ☐ NO ☐

Dr. Tripp provides the option of communicating or sending appointment reminders by email. Please be aware that email is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for treatment or intervention. By listing email addresses below, you are acknowledging your understanding of these statements.

Primary Parent email:	
Child's email:	

How did you find out about Dr. Tripp?

What has you seeking therapy at this time?

At what age was the issue/concern first noticed?

What are you hoping to achieve with therapy?

ACADEMIC INFORMATION

Is your child in any special programs at school, such as GT, Special Ed, Speech or Occupational Therapy, Content Mastery, Alternative Schooling, Home Bound Schooling, etc.? If so, please describe:

Does your child receive any formal or informal modifications at school? Please describe:

Has your child had any previous educational, psycho-educational, neuropsychological, or psychological testing? If so, please BRING A COPY OF THE TESTING RESULTS. Please also describe your understanding of the results of this testing.

If not already described, do you have any concerns about your child's behavior or functioning at school?

FAMILY INFORMATION

Please list all family members who live in the home:

Name	Relationship	Age

Are there any family members who live elsewhere? If so, list their names, ages, and reasons for moving out:

Primary parent highest level of education completed:

Primary parent employment status:

Alternate parent highest level of education completed:

Alternate parent employment status:

Has there been a divorce in the family? YES ☐ NO ☐

If divorced, what are the custody arrangements?

If divorced, is either parent remarried? If step-parent(s) was not named in contact information, please list name(s) here:

Are there any parents or step-parents who travel frequently? If so, who and how often?

Are there any significant caregivers in your child's life (grandparent(s), nanny, etc.)?

RECREATIONAL / SOCIAL INVOLVEMENT

How does your family spend free or unscheduled time?

What are your child's favorite hobbies and interests?

Does your child have difficulty making or keeping friends? If yes, please describe:

Please check the following activities in which your child participated in the last month:

- ☐ Exercised or played a sport, how frequently?
- ☐ Played with friends outside of school, how frequently?
- ☐ Engaged in group activities outside of school, what activities?
- ☐ Read or was read to, how frequently?
- ☐ Watched T.V., how much?
- ☐ Played videogame or computer games, how many hours per day?

Which social media applications are you aware of your child utilizing to track or communicate with peers?

Do you know/suspect that your child uses tobacco, alcohol, and/or any recreational drugs? If so, please describe your knowledge or suspicions:

Has your child experienced any of the following:

- ☐ Being teased or bullied
- ☐ Teasing or bullying another peer
- ☐ Loss of friendships
- ☐ Change in school setting, teacher, or childcare setting?
- ☐ Other?

Please describe several strengths that your child has in their interactions with others:

STRESSORS

Has your family experienced any stressful events in the last year? Please check the following.

- ☐ Death in the family
- ☐ Death of a close friend
- ☐ Serious illness or injury, your child
- ☐ Serious illness or injury, a loved one
- ☐ Family fighting
- ☐ Marital problems
- ☐ Divorce or separation
- ☐ Marital reconciliation
- ☐ Problems with child rearing
- ☐ Move to a new home
- ☐ Son or daughter leaves home
- ☐ Conflict with in-laws
- ☐ Change in job- new position, new company, laid-off, retired, quit
- ☐ Change in financial status- more or less money
- ☐ Change in daily responsibilities
- ☐ Change in social network
- ☐ New marriage in the family
- ☐ Outstanding personal achievements
- ☐ Other stressors (significant or traumatic events):

MEDICAL HEALTH

Does your child have any of the following medical problems?

Current	Past		Current	Past	
☐	☐	Heart Problems	☐	☐	Head Injury
☐	☐	Digestive Problems	☐	☐	Surgeries
☐	☐	Hypothyroidism	☐	☐	Tics
☐	☐	Hyperthyroidism	☐	☐	High Blood Pressure
☐	☐	Diabetes, Type I	☐	☐	Unexplained Pains
☐	☐	Diabetes, Type II	☐	☐	PMS Symptoms
☐	☐	Overweight	☐	☐	Muscle Tension
☐	☐	Underweight	☐	☐	Headaches
☐	☐	Back or Neck Pain	☐	☐	Cancer
☐	☐	Alcohol use/abuse	☐	☐	Drug use/abuse

If you checked any of the boxes above, please describe the health problem:

Are there any other medical problems not listed above that your child experiences?

Primary Physician's Name:	**Phone Number:**
Is your child currently taking any medications?	
If so, please list here:	
Have multiple medication trials gone on before this current list of medicine(s)?	
Are there any medical problems for someone in the family that may be impacting your child?	

MENTAL HEALTH

How would you describe your child's overall mood?
Have you sought psychotherapy for your child or your parenting before? If so, what were the circumstances?
Did you find therapy helpful?
If your child is taking medication for emotional or behavioral struggles, who is the prescribing physician?
Is the medication helpful?
Please describe your child's sleep habits. How many hours per night of sleep are typical for your child? Do you have any concerns about your child's sleep?
Please describe your child's eating habits. Do you feel satisfied with the variety and quantity of food consumed by your child? Do you have any concerns about your child's eating?

SYMPTOM	**Child, current**	**Child, past**	**Primary Parent**	**Alternate Parent**	**Sibling: _____**	**Other: _____**
Please check all that apply:						
Depression, sadness						
Suicidal Thoughts/ Attempts						
Bipolar or Manic Episodes						
Anxiety/ Excessive Worry						
Obsessions and/ or Compulsions						
Panic Attacks						

(continued from last page)

SYMPTOM	Child, current	Child, past	Primary Parent	Alternate Parent	Sibling: _____	Other: _____
Post Traumatic Stress/ PTSD						
Attention Deficit/ Hyperactivity						
Autism/ PDD/ Asperger's						
Tourette's/ Tourette Syndrome						
Learning Disabilities						
Explosive Outbursts						
Oppositionality/ Defiance						
Problems with Anger						
Problems with Assertiveness						
Schizophrenia or Psychosis						
Heavy Alcohol Use						
Drug Use/ Abuse						
Eating Disorder						
Abused in Any Way						

Other Family History of Emotional or Behavioral Symptoms?

Do you have any additional comments that you think would be helpful?

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TO BE COMPLETED BY DIVORCED or DIVORCING PARENT(S) SEEKING TREATMENT FOR CHILD

Custody Dispute Contract

PATIENT NAME (CHILD): _____ PATIENT DOB: _____

The purpose of this contract is to obtain written agreement that the psychologist, Margaret M. Tripp, Ph.D. will not be asked to participate in any litigation regarding any custody or child access disputes. If Dr. Tripp is asked to participate in any litigation, Dr. Tripp's neutral role with the family can be compromised. Involvement of Dr. Tripp is likely to jeopardize any progress that may have been made in therapy, to hinder likelihood of future progress, and possibly to limit the patient's willingness to seek help from a psychologist at any later time in life. In order to prevent these potential problems, it is crucial that Dr. Tripp, the parents, and the patient have every reassurance that there will be absolutely no involvement on Dr. Tripp's part in any current or future litigation between parents. This is best accomplished by both parents signing this statement:

We wish to enlist the services of Margaret M. Tripp, Ph.D. in the treatment of our child. We understand such treatment will be compromised if information revealed therein is brought to the attention of the court in the course of a custody dispute. Accordingly, we mutually pledge that we will neither individually nor jointly involve Dr. Tripp in any litigation. Specifically, we will neither require nor require Dr. Tripp provide testimony in court or turn over her notes to the court, attorneys, or other personnel involved in any custody dispute process in order to maintain treatment sessions with Dr. Tripp as a secure place of disclosure for our child.

If the services of a mental health professional are desired for court purposes, the services of a person other than Dr. Tripp must be enlisted.

_____ _____
Signature of Parent **Date**

_____
Printed Name of Parent

_____ _____
Signature of Parent **Date**

_____
Printed Name of Parent