Amy Frew, Ph.D., LMFT
Nurture House
232 Third Avenue North
Franklin, TN 37064
615.417.6009

NEW CLIENT INFORMATION PACKET
MINOR CHILD CLIENT

Included in this Packet

(1) Client Information Form
(2) Counseling Practices and Policies
(3) Notice of Privacy Practices
(4) Receipt of Privacy Practices
(5) Authorization to Release Confidential Information
(6) Permission to Treat Minor Child Form
(7) Directions

Instructions

Before your Appointment:
(1) Complete the Client Information Form
(2) Read Counseling Practices and Policies and Notice of Privacy Practices
(3) Initial and Sign Counseling Practices and Policies
(4) Sign Receipt of Privacy Practices
(5) Sign Authorization to Release Confidential Information for applicable parties (physician, psychiatrist, family)
(6) Sign Permission to Treat Minor Child Form
(7) Sign Contract for Parents Who Are Separated or Divorced if applicable

Bring all completed and signed forms to your first appointment
If you have questions about these forms, please contact me before our session.

CLIENT INFORMATION FORM

Child's Name: _____ Age: _____ DOB:_____

Child's Primary Address:_____
City: _____State: ___ Zip: _____

Parent/Legal Guardian:_____
Home: _____ Cell: _____
Email: _____

Parent/Legal Guardian Name: _____
Home: _____ Cell: _____
Email: _____

Emergency contact: Name:_____ Phone: _____

Sibling's Names: Ages:
_____
_____
_____

CURRENT CONCERNS

Please describe why you have chosen to seek counseling for this child at this time:
_____
How long has this been a problem / concern? _____
Have you sought counseling for this in the past?_____
Who referred you to this office? _____

MEDICAL HISTORY

Primary care physician: _____Phone:_____
Current medications:_____

Has the child ever experienced abuse (emotional, verbal, physical, sexual) YES / NO
If yes, please explain: _____
_____
Family member alcohol use YES / NO Family member drug use YES / NO
If yes, please explain: _____
_____

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COUNSELING PRACTICES AND POLICIES

Please initial each section and sign at the bottom of the second page

TREATMENT CONSENT, CLIENT INFORMATION, AND CLIENT RIGHTS

____You have the right to: be informed of your Therapist's qualifications, ask questions about your Therapist's style, procedures and risks of treatments, be informed of your Therapist's limitations; request of second opinion; participate in treatment planning/review/revision as well as terminate treatment at any time with a request for a referral if desired. You are responsible for terminating your counseling relationship prior to entering into therapy with another therapist, unless special circumstances, agreed upon by the client and the new therapist warrant otherwise.

____You have the right to treatment confidentiality. Information may not be revealed to anyone without written permission from you except when disclosure if required by law, as in the following circumstances: suspicion of child abuse, neglect, sexual abuse or abuse of a senior citizen; suspicion that the client presents a danger by a having a plan to hurt himself/herself or someone else; when disclosure may be required pursuant to a legal proceeding; where your insurance company requires information such as diagnosis, treatment plan, etc. to process claims, and professional consultation with anonymity.

____Said Minor (under 18) in therapy, _____, is seen only with permission from his or her parents or guardian. A child will be seen only with written permission and/or acknowledgement of both parents. Children of divorce must have signed permission from BOTH parents to attend counseling. Participation from both parents, regardless of the custodial arrangement, is the preferred practice of this office. A copy of the parenting plan must be included in the client file indicating the custodial arrangement prior to the first session with the minor child. In any custodial arrangement, both parents have the right to contact the therapist and inquire regarding their child's treatment progress (unless otherwise indicated by the courts).

EMERGENCY PROCEDURES

Amy Frew can be contacted at 615.417.6009. This Therapist strives to return calls and emails of current clients within 24 hours of receipt. If you need to speak with someone immediately, The Crisis Line (615.244.7444) is staffed with mental health professionals trained to provide free phone counseling an support to anyone experiencing a crisis. For emergencies call 911 or go to the nearest Emergency Room.

LIMITATIONS OF GUARANTEED CONFIDENTIAL COMMUNICATION VIA E-MAIL AND CELL PHONE

____Individuals may choose to contact Amy Frew via **e-mail or cell phone**. In doing so, they agree to the understanding that these forms of communications **are not guaranteed confidential methods of communication** and when they call, e-mail or text, they acknowledge their understanding that these communications are not secure. Please note that any communication outside of billing and scheduling that is sent via electronic transmission will be included in your permanent medical record. Clinical question via electronic transmission **will not** be responded to. Please initial the areas below that indicate the permissible forms of communication with you. Any communication via text message will be deleted off the Therapist's phone at the end of each month.

____voicemail on cell phone
____voicemail on home phone
____text messages
____email

PROFESSIONAL RELATIONSHIP

____For the purposes of professionalism and relational clarify, it is policy of this Therapist to not accept gifts of any kind from the client. The client is solely responsible for all public interaction with their counselor in a public setting. This Therapist does not engage in social communication with clients (Facebook Twitter, Instagram, or other).

NOTIVE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

____I acknowledge that I have reviewed a copy of the Privacy Practices of this office and understand its content.

PERMISSION TO LEAVE THE PREMISES

____I understand that I have the right to give or deny permission for my child to go outside with his/her Therapist. By initialing, I choose to give permission for the following, understanding that confidentiality cannot be guaranteed in these instances:

____outside play in the back yard of Nurture House

____outside play in the front yard of Nurture House

____walks in the community/entrance to restaurants/coffee houses

RECORDS

____I understand that records are destroyed after ten years of inactivity. Should I have a request for records I need to contact: Amy Frew at 232 Third Avenue North, Franklin, TN 37064. Copy and mailing costs will apply and are dictated by current state statutes. Records will be mailed within fifteen business days, not including legal state holidays.

FEES

____The fee of $140 will be paid at the beginning of each 45 minute session, for the treatment provided during that session. Cash and check (payable to Amy Frew) are accepted forms of payment. Credit card payment will include a 2.75% processing fee.

Phone conversations exceeding five minutes will be billable at the prorated session fee. Inpatient, school or home visits are based on the same fee as an in-office visit in addition to transportation expenses (as applicable).

____The client/guardian will give notice 24 hours in advance to cancel appointments and will be charged the normal session amount for any sessions missed without 24 hour notice. I have read and agree to the aforementioned cancellation policy.

____Amy Frew will not testify in court, unless mandated by law. In the event that a subpoena for records or to appear in person is served to this Therapist, I understand that I will be responsible for reimbursement of all legal costs incurred by Amy Frew. All fees incurred in the preparation of court documents, travel to and from court, review of records, wait time and testimony while under oath are all billable at the rate of $280 per hour. The retainer fee of $500 will be required prior to any of the court related work being done.

____Amy Frew does not accept health insurance. It is my responsibility to understand what services are covered by my insurance company/plan and I affirm that Amy Frew is not responsible for rejected claims. It is my responsibility to submit claims on my own behalf and that Amy Frew will only be responsible for generating itemized receipts every 4-6 sessions as requested by client.

AGE OF MAJORITY

Once a client turns 18, they are no longer considered a minor for purposed of medical and mental health treatment. At that time, they will be required to sign all new consent to treatment forms and will be solely responsible for their treatment.

TOUCH

Amy Frew strives to provide healing to children and families by utilizing healthy attachment behavior, which includes touch. Touch is a normal, healthy part of all parent-child interactions and this Therapist will strive to model the healthy uses of touch in building safe relationships with children while providing both structure and nurture along developmentally appropriate continuums. Several of the intervention models used include play-based therapy, Theraplay, and TBRI place a high value on the importance of healthy touch experiences for children in fostering connections with others, building empathy, enhancing playfulness and even in releasing neurochemicals that help to calm the child. The sharing of healthy touch between parents and children is valued. While Amy Frew is careful in how touch based treatments are implemented with children who have survived abuse or trauma, it is believed that these children are in great need of safe, healthy touch experiences. Additional resources regarding this philosophy are available.

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NOTICE OF PRIVACY PRACTICES

This notice went into effect on September 20, 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.
For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

If you have any questions about this notice, please contact myself or the PRIVACY OFFICER listed below.
If you believe I have violated your privacy rights, you may file a written complaint with the agency listed below. You will not be affected by filing a complaint.
TN Department of Health's Privacy Officer, Bureau of Health Informatics,
Sixth Flour, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-0460
877-280-0054 Fax: 615-532-1886

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Name of Patient: _____
Patient's Date of Birth: _____
Name of Parent / Legal Guardian: _____

I hereby authorize the release to AMY FREW of all information / medical records pertaining to my / my child's mental health treatment.

Organization: _____

Name: _____

Address: _____

Phone: _____

Email: _____

I further authorize the release of information from AMY FREW to the above named entity, in so far as the information pertains to continuity of care in treatment.

I understand that this authorization is valid until such time as I revoke the authorization in writing.

Signature _____ Date _____
(Client – if 18 years of age)

Signature _____ Date _____
(Parent / Legal Guardian)

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CONSENT FOR TREATMENT OF A MINOR CHILD

We, (Parent's Names) _____ and _____, are legal custodial parents with decision-making responsibility for (Minor's Name) _____, a minor.

We authorize AMY FREW to begin the mental health assessment and treatment of said minor on (Date) _____. Authorization will be in effect until such time as this psychotherapeutic relationship is terminated. As legal custodial parent(s), we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law. We give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rule, in deciding what information revealed by my child is to be shared with us. This is my written consent to the mental healthy assessment and treatment of said minor child under the terms stated above. It is clearly understood that AMY FREW is hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that such duties are performed with standard case and responsibility.

***Both parents must consent for treatment unless the treatment is court ordered or one parent is sole legal custodian. A copy of the current Parenting Plan or Court Order is required.

PARENT / LEGAL GUARDIAN SIGNATURE:_____ DATE:_____

PARENT / LEGAL GUARDIAN SIGNATURE:_____ DATE:_____

My signature also represents that I exercised my option to ask questions about any aspect of my/my child's treatment and that my questions were answered to my satisfaction. I understand this authorization can be revoked at any time through my written request. Unless otherwise indicated, it will remain in effect until I revoke it's authorization in writing.

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CONTRACT FOR PARENTS WHO ARE SEPARATED OR DIVORCED

If you are involved in a divorce or custody litigation, it is important for you to understand that my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this disclosure statement, you agree not to call me as a witness in any such litigation. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between a therapist and client. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

If required to testify, I am ethically bound not to give an opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but will not make any recommendation about the final decision. If I am required to appear as a witness, the parent responsible for my participation agrees to pay a retainer fee and all associated costs. If the parent who subpoenaed the therapist was not a party to this contract, then the parent who signed the contract is obligated to reimburse me the costs for involvement on behalf of your family.

In the event that a subpoena for records or to appear in person is served to this Therapist, I understand that I will be responsible for reimbursement of all legal costs incurred by Amy Frew. All fees incurred in the preparation of court documents, travel to and from court, review of records, wait time and testimony while under oath are all billable at the rate of $280 per hour, with no proration of fees. The retainer fee for court involvement is $500 will be required prior to any of the court related work being done.

A copy of the parenting plan is required (or a copy of the order of protection) when counseling services are given for children who are experiencing the separation / divorce of their parents.

____ / ____ I agree to provide Amy Frew a copy of the parenting plan / order of protection prior to the beginning of counseling services for my child(ren).

____ / ____ I agree to NOT involve Amy Frew in court proceedings related to divorce or custody arrangements.

____ / ____ I agree to pay the retainer fee plus additional hourly charges if Amy Frew is required by the court to be involved in litigation.

PARENT / GUARDIAN SIGNATURE:_____ DATE:_____

PARENT / GUARDIAN SIGNATURE:_____ DATE:_____

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DIRECTIONS

From I-65, take exit 65 onto TN-96 toward Franklin
At the roundabout, take the second exit (straight through) onto Third Avenue North
Nurture House is a white house located on the right
Parking is typically available on the street across from Nurture House
Please do not park in front of Nurture House or in the driveway
The entrance is located at the BACK of the building

Please make yourself comfortable in the waiting room
Your child is welcome to play with the toys
Remember to respect the counseling sessions
which are in progress by being quiet while waiting