Eva Benmeleh, PhD
Licensed Clinical Psychologist

Practice Policies

Credit Card Authorization Form

I ________________________________, hereby authorize Eva Benmeleh, PhD (My Treetop Center) to charge the following credit card account for any billing that includes psychotherapy and testing session fees, missed appointment without 24 hour notice, school observations, meetings, and any other services related to care and consultation for the client.

Credit Card Information:

Type: ☐ Visa ☐ Mastercard ☐ American Express

Name on card: ____

Credit Card Number: ______________________________________

CVV code: __________ Expiration Date: ____________

Billing address zip code: ____________________

____

Signature of Client (Guardian) Print Name Date

221 W. Hallandale Bch Blvd #202
Hallandale Beach, FL 33009
(786) 383-4942
info@mytreetopcenter.com
www.mytreetopcenter.com

Eva Benmeleh, PhD
Licensed Clinical Psychologist

Consent to Treatment and Use of Protected Health Information for treatment, payment, and healthcare operations

Acknowledgment of Receipt of HIPAA Privacy Notice

Client's Name: ____

I, the undersigned client and/or guardian, consent and authorize Dr. Eva Benmeleh (My Treetop Center) to administer treatment to the client. Treatment may include any of the following: individual, family, and/or group therapy, psychological assessment, and any other treatment appropriate to the diagnosis. I understand that Dr. Eva Benmeleh originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I consent to the use and disclosure of protected health information about the client for treatment, payment, and healthcare operations. This means that information about client's health will be used by Dr. Eva Benmeleh or disclosed to other people or organizations whenever needed to:

• Provide treatment to client or arrange for treatment by another health care provider
• Arrange for payment for services to client
• Enable other healthcare organizations that provide treatment to client or pay for services to review the quality and appropriateness of care received, conduct other healthcare operations

I authorize the release of medical information necessary to process any of my insurance claims, and I authorize payment of medical benefits directly to Dr. Eva Benmeleh, My Treetop Center for services rendered. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay for any missed appointments that are not rescheduled or canceled within 24 hours of the scheduled appointment time. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client he/she hereby individual obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I fully understand and accept the terms of this Consent and acknowledge the receipt of the Notice of Privacy Policies detailing how my information can be used and disclosed under Federal and State law. I understand the contents of the Notice. I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of the information. I understand that there is no time limit on this consent. I also understand that I may revoke this consent at any time. I am the client/ guardian of the client who is subject of the health records that will be used or disclosed. I consent to treatment and agree to the use and disclosure of my health information as described in this consent.

____

Signature of Client (Guardian)   Print Name   Date

Eva Benmeleh, PhD
Licensed Clinical Psychologist

Consent for Psychological / Psychoeducational Evaluation

Session Length: Testing sessions last between 60-180 minutes, depending on schedule and given age/development of your child.

Cancellation Policy and Fee: If you cancel a session with less than 24 hrs notice, I will charge a full fee for service. Your insurance does not cover this charge. If you need to cancel, please contact me directly. Exceptions can be made, and the fee waived at my discretion for emergency or unusual circumstances. If I may need to cancel my appointment, I will make every effort to reschedule within an appropriate time frame.

No Court Involvement: If you ever become involved in a divorce custody dispute, or any other legal matter, I will not provide evaluation or expert testimony in court. Your signature indicates your agreement with this provision.

Phone Contact: In cases when I am not immediately available by phone, please leave a message on my voicemail and I will attempt to return your call within 24 hrs except for holidays / weekends. If this is a medical emergency, please go to the nearest emergency room or call 9-1-1.

Means of Contact: Please be aware that text messages are unencrypted forms of communication and could result in an unintended breach of confidentiality. Any texts you send may also become a part of your legal medical record and will need to be documented and archived. Email communication is limited to scheduling appointments, insurance verification, receipt of forms and receipt of payment. Though I do my best to maintain confidentiality via email, be aware that emailing is not a secure means of communication.

Please initial if you prefer to be contacted via: Text message Y _____ N _____

Email Y _____ N _____

Payment: Cost for psychological testing varies depending on the referral question, tests administered, and need to review collateral records. Both private pay and/or insurance are often used to cover the fees including an initial diagnostic interview, testing and report writing hours, and the final session when the test results are reviewed. It is important to be aware that insurance will not approve all of the hours that are necessary to complete the assessment process. For this reason, the evaluation may need to be adapted or you may pay out of pocket for the remaining costs. While an estimate for the number of hours and the overall payment will be calculated prior to testing, this is only an estimate. As such, additional hours/payment may be required for testing. In addition, most insurance companies specifically exclude psychoeducational and ADHD testing from their policies.

Testing Process includes the following:

• *Clinical Interview*: A structured clinical interview with the client contains background information, mental health concerns, educational history, social functioning, and a mental status exam.
• *Review of relevant records*: In order to provide a comprehensive picture of your child, background information, including prior records and prior evaluations, is reviewed as a part of the evaluation process.
• *Mental Health Assessment Inventories*: These inventories include surveys or performance exercises that assess varied mental health symptoms.
• *Cognitive/Neuropsychological Assessment Tools*: These may include tests of cognitive ability, academic achievement, visual-motor skills, attention span, neurological functioning, memory, and processing speed.

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Please initial the following:

____ I understand that I will need to provide copies of previous evaluations and other records as a part of the evaluation.

____ I understand the evaluation process may include an initial interview, testing, review of records, consultations with, scoring of tests, interpreting the results, and report writing, and all information disclosed may be part of the final written report.

____ I understand that if I choose to use my health insurance, they may not cover all the necessary hours, and as such I will be required to pay for all hours that exceed what is covered. I will also be charged a missed appointment fee for each hour set aside for my testing if I cancel or reschedule with less than 72 business hours' notice.

____ I understand that the number of hours for the evaluation is an estimate and that, depending on the length of the testing, the tests used in the evaluation and/or the thoroughness of the report or the number of hours billed may need to be adjusted. Furthermore, I am responsible for the final amount billed regardless of the estimate.

____ I understand the need to for me/my child to put forth good effort and complete items in a truthful manner in order to have the results of the evaluation be as accurate as possible.

____ I understand that any inventories not completed by myself or collateral contacts must be completed and returned within 7 days of testing in order to be included in the evaluation.

____

Client Name Date

____

Guardian Signature Print Name Date

Eva Benmeleh, PhD
Licensed Clinical Psychologist

Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Eva Benmeleh, PhD
Licensed Clinical Psychologist

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6. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
7. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
8. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
9. If a client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
10. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties, continued

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- *For Treatment*: If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. An authorization is required for most uses and disclosures of psychotherapy notes.
- *For Payment*: I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- *For Operations:* I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Client's Rights:

- *Right to Treatment*: You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- *Right to Confidentiality*: You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am 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.
- *Right to Choose* – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.

Eva Benmeleh, PhD
Licensed Clinical Psychologist

Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties, continued

- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- *Right to Amend* – If you believe the information in your records is incorrect and/or missing important information, you can ask me to make certain changes, also known as amending, to your health information. You must make this request in writing. You must tell me the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- *Right to a Copy of This Notice* – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details.
- *Right to Choose Someone to Act for You* – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- *Right to Release Information with Written Consent* – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss the effects of releasing the information in question to that person or agency.
- *Right to Terminate* – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services. Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form.

____

Client/Legal Guardian Signature Print Name Date

____

Eva Benmeleh, PhD Licensed Clinical Psychologist #8656 Date

Eva Benmeleh, PhD
Licensed Clinical Psychologist

Authorization for Release of Confidential Psychological Records and Protected Health Information

In order to protect your right to confidentiality, your written authorization is required if you request information to be shared with another person or agency.

I ____________________________________ authorize Dr. Eva Benmeleh (My Treetop Center) to:
□ release information □ to obtain information from □ exchange information with

The following (name, address, phone, fax):
____

All information pertaining to treatment of myself (or my dependent__________________):

The following information pertaining to myself (or my dependent___________________):
□ assessment □ testing/treatment summary □ recommendations □ treatment progress
□ psychological records

for the purpose(s) of: □ evaluation/assessment □ other (specify) ________________________

This consent will automatically expire:
□ One (1) year after the date of my signature below □ At the end of evaluation/treatment

You have the right to revoke this authorization in writing at any time by sending such written notification to one of our offices. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

By signing below, you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. You are indicating that you understand that Dr. Eva Benmeleh generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information, viewed by persons unknown to you, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

____
Signature Print Name Date

____

Witness Print Name Date

ATTENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED: If you have received this information in error please contact my office as soon as possible to arrange for the return of the received material. This information may be protected from redisclosure without informed signed consent from the individual or agency to which it pertains. Do not redisclose this confidential information without signed informed consent or as otherwise allowed.

Eva Benmeleh, PhD
Licensed Clinical Psychologist

Social Media Policy

This document outlines Dr. Eva Benmeleh (My Treetop Center) policies related to use of Social Media. If you have any questions about the information within this document, I encourage you to bring them up when we meet. As new technology changes, this policy may be updated. You will be notified in writing of any policy changes and offered a copy of the updated policy.

As in any other public context, you have control over your own description of the nature of our acquaintance, if you choose to disclose a professional relationship. I will not confirm nor deny any professional relationship between myself and clients on any social network sites. I reserve the right to discontinue any social network connection without prior notification. I discourage the use of social network sites for any communication about our therapeutic relationship, including scheduling issues, due to the lack of privacy protections.

SOCIAL MEDIA IS CONSIDERED PUBLIC COMMUNICATION:
Messaging on Social Networking sites such as Twitter or Facebook is not secure. It could compromise your confidentiality to use Wall postings, @replies, or other means of engaging with me online if we have an already established client/therapist relationship. I may not read social media messages in a timely fashion. If you need to contact me between sessions, the best way to do so is by phone or email.

FOLLOWING/LIKING MY PROFESSIONAL PAGE MAY IMPLY ENDORSEMENT:
I keep a Facebook Page for my professional practice to allow people to share my blog posts and practice updates. You are welcome to view my Facebook Page and read or share articles posted there, and comment on them. However, referrals from other clients are one of my best sources of business. My website and Facebook Fan page are intended to let others know who I am as a professional and to make it easy to refer those you feel would benefit from my services. I will not confirm nor deny any professional relationship between clients on any social network site. I will not ask you to "like" my page or endorse me on other business pages during the time you are in my treatment.

Acknowledgement of Review of Social Media Policy
By signing below, I am indicating that I have read this document, understand my rights as a client, and accept the responsibility as stated. I have been offered a printed copy of the Social Media Policy and all questions regarding these policies have been answered to my satisfaction.

____

Client Name Date

____

Guardian Signature Print Name Date

____

Eva Benmeleh, PhD, Licensed Clinical Psychologist Date

Eva Benmeleh, PhD
Licensed Clinical Psychologist

Intake Form

Please complete this form to the best of your abilities. There may be areas that do not apply to you or your child. Please leave those areas blank or write "N/A". This form will be reviewed with Eva Benmeleh, PhD, Licensed Clinical Psychologist.

Date: _________

Client Name: _______________________ DOB: _________________ Age: _____________
Legal Guardian: ____________________ Relationship: ____________ Phone: ___________
Address: ___________________________ _______________________ _________________

INSURANCE INFORMATION

Insurance Company:________________________ Name of Insured: ________________
Insured's Member ID #:______________________ Insured's Group #:_________________

PRESENTING PROBLEM:

What has happened that has caused the client/ family to seek help now?

What actions has the client/family taken to address this issue prior to coming here?

When did these issues begin?

What are your goals for this evaluation/ treatment?

Please list strengths of the client: ____

____

____

____

DEVELOPMENTAL HISTORY

Did mother receive prenatal care? ☐ No ☐ Yes
Was this a planned pregnancy? ☐ No ☐ Yes
Problems with the pregnancy/delivery? ____
Use of cigarettes, alcohol, illicit drugs, prescription medication during pregnancy?
____

BIRTH

Place of birth: ____________________ Health at birth: ________________________
Type of delivery: _______________ Weight: __________ ________ Weeks
Milestones met on time? ____

EARLY CHILDHOOD ISSUES

Colic	☐ No	☐ Yes
Excessive crying	☐ No	☐ Yes
Delayed language development	☐ No	☐ Yes
Unclear speech	☐ No	☐ Yes
Eating difficulties	☐ No	☐ Yes
Delayed motor skills	☐ No	☐ Yes
Chronic ear infections	☐ No	☐ Yes

TOILET TRAINING (Please complete for young/elementary school age children)

Age began: _______ Age when fully trained: _________

Does the client wet/ soil now? If yes, was doctor consulted? ______________________
How often does this occur? ____

FAMILY HISTORY

Please provide the names and ages of persons living in the home:
Name, Age, and Relationship:

____
____
____
____

If emigrated to the USA, when and under what circumstances? ____________________
Education and occupation of parents: ____
Mental health concerns in family members? If so, please describe: ________________

Please describe relationship with siblings:

☐ No siblings	☐ Good Communication	☐ Argue Sometimes
☐ Supportive/helpful	☐ Angry/resentful	☐ Argue Frequently
☐ Respectful	☐ Loving	☐ Distant
☐ Physical Fights	☐ Domestic Violence	☐ No contact

Please describe relationship with parents:

☐ No contact	☐ Good Communication	☐ Argue Sometimes
☐ Supportive/helpful	☐ Angry/ resentful	☐ Argue Frequently
☐ Respectful	☐ Loving	☐ Distant
☐ Physical Fights	☐ Domestic Violence	☐ Defies Authority

Parental marital status:

☐ Married ☐ Never Married ☐ Divorced
☐ If divorced, type of parenting plan? ____________________________________
☐ How often does the noncustodial parent see the child? _____________________
☐ Have parents remarried or dating? ______________________________________
☐ Who cares for the child while caregivers are at work or gone? _______________

DISCIPLINE/ PARENTING STYLE

Who generally disciplines the client: ______________________________________
____

What method (s) of discipline do you use?

☐ Ignore	☐ Time –out	☐ Warning	☐ Loss of Privileges
☐ Argue	☐ Sent to Room	☐ Earn Privileges	☐ Praise good behavior
☐ Yell	☐ Compromise	☐ Spanking	☐ Consistent Limit Setting

Does discipline work? ____

Do all caregivers agree on discipline method(s)? ________________________________

Any current issues affecting the family? (i.e., divorce/separation, medical concerns, financial problems, recent moves) ____

Family history of a mental, psychological, or academic problem? Please explain: ______

DAILY ACTIVITIES

Sleep patterns/ bedtime routine: ____

Eating habits: ____

Routine of activities/ Homework: ____

MEDICAL HISTORY

Are medical exams up to date? ____

Does your child take medications currently or in the past? If yes, please state: Reason, prescribing physician, Dosage, and any side effects:

____

____

Allergies? ☐ No ☐ Yes ☐ Specify: ________________________

Has your child ever experienced head injuries, seizures, hospitalizations, surgery, or loss of consciousness? If yes, please explain: ____

____

PREVIOUS EVALUATIONS/ THERAPIES

Type	Name of Provider	Reason	Date

EDUCATIONAL HISTORY

Current school: ☐ Public ☐ Private ☐ Charter ☐ Home School

Name: ________________________________ Phone number: ____________________

Grade: ____________________ Teacher's name: ____________________

Please list all schools your child has attended (include nursery/daycare if applicable):

Name, City	Grade	Reason for Leaving

Does your child receive special education services? ______________________________

What grades does your child earn in class (FCAT. SAT)? ____________________________

Has your child ever repeated a grade? If yes, which? ______________________________

Has your child ever received tutoring? If yes, for what and how long? ______________

Does your child state if she/he likes/dislikes going to school? ________________________

What is your child's favorite/ least favorite subjects? ______________________________

What are your child's study habits? ____

Is there any family member who has/had learning difficulties/ attentional difficulties, or was in special classes? If yes, who and what kind/type? __________________

Has your child experienced any of the following at school?

Problem	Preschool	Elementary
Separation difficulties		
Peer relationship problems		
Failed classes		
Struggle academically		
Problems with authority		
Behavior problems		
Truancy		
Learning disabilities		
Bullying		
Other		

SOCIAL HISTORY

Does your child participate in any special interests, hobbies, sports? ______________
How does your child relate to other children? ___________________________________
How many friends does your child have? _______________________________________

SEXUAL DEVELOPMENT

Puberty: _______________ Girls: Age at first menstruation: ______

Problems associated with menstrual cycle? ☐ No ☐ Yes
Sexually active? ☐ No ☐ Yes

ABUSE HISTORY

History of neglect, sexual or physical abuse: ☐ No ☐ Yes
If yes, was the neglect or abuse reported? ☐ No ☐ Yes
Approx. date of incident: __________ Approx. date report was filed: _____
Relationship of abuser to client: ____
Outcome of report: ____