PAY ATTENTION TO ATTENTION GROUP
(INTENSIVE WEEKEND FORMAT)

INFORMATION AND REGISTRATION PACKET

Jeff Sosne, Ph.D.

This group is designed for elementary aged children with primary weaknesses in "effortful/executive/everyday" attention. Please note: Children with self-control/attention problems are better served in the Beginner's AD/HD Group. Students will learn the importance of giving teachers and tasks their undivided attention. Attention training games will help students improve their ability to sustain attention, sift focus and monitor task activity. Parents will learn how to light up their children's attention center and work within their child's attention span. The weekend begins with a Friday night class for parents-only. Students and parents will then meet on both Saturday and Sunday for group activities. **The Cost of the group is $320 and must be included with the registration forms.**

There is also an opportunity for parents whose children are too young/old to attend the group. These parents may attend the evening informational meetings and observe the group sessions for a reduced **cost of $150.**

Class Registration Form

☐ **Spring** ☐ **Summer** ☐ **Fall** ☐ **Winter**

Child's Name: _____ DOB:_____

Address: _____

_____

Parent / Guardian Name: _____

Phone Numbers: Day _____ Cell_____ Evening: _____

E-mail _____

Has your child been seen at this clinic before? ☐ Yes ☐ No

If yes, for: ☐ evaluation ☐ therapy

Desired Class Name: **Pay Attention to Attention Intensive Weekend Format**

Dates/Times: **1 Parent meeting, Thursday, May 3, 6:00 – 8:00 p.m.**
2 parent/student meetings: Saturday and Sunday, May 5 and 6, 2018, 1:00 – 4:00 p.m.

THIS CLASS REQUIRES PAYMENT IN FULL UPON REGISTRATION. If you must cancel, please notify us within **4** business days prior to the start of the class so we can refund your registration fee. Cancellations received after that time will receive a refund, less a $35 administrative fee. We reserve the right to refund your registration by check. Your refund will be mailed to you within approximately four weeks.

☐ **Check (please mail)** ☐ **Mastercard** ☐ **Visa** ☐ **Discover** ☐ **AMX** ☐ **PayPal**

(Provide credit card information below)

Cardholder's Name: _____

Card Number: _____ **Exp. Date:** _____

Security Code: _____

Return this packet with your payment by mail, fax or email to the Children's Program

6443 SW Beaverton Hillsdale Hwy, Suite #300, Portland, OR 97221
(503) 452-0084 (fax) **info@childrensprogram.com**

C O N F I D E N T I A L I T Y

1. Only parents/legal guardians will be allowed to observe without prior authorization. Everything that goes on in group is strictly confidential. We ask that families not discuss the details of other children in the group.

2. Occasionally, we have students and clinicians observe group. This helps to educate the community regarding the needs of children with attention problems. Visitors would never be given information about your children and we would ask that they tell us if they know any of the youngsters in the group. If there is a problem with observers, please let us know.

3. Observing behind a two-way mirror is a unique experience. It is tempting to chat about the kids and the group; we encourage it. Be careful not to interfere with parents who are trying to hear what is being said in group and please remember that what is being discussed behind the mirror is as confidential as what goes on with the kids.

_____
Jeffrey Sosne, Ph.D.
Clinical Psychologist

_____
Parent

_____
Date

Photo and Video Release Form for Minor Children

I hereby authorize Children's Program to publish the photographs and videos taken of me and/or the undersigned minor children, and our names, for use in Children's Program's printed publications, website and training purposes.

I release Children's Program from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed below and that I have the authority to authorize Children's Program to use their photographs, videos and names.

I acknowledge that since participation in publications and the websites produced by Children's Program is voluntary, neither the minor children nor I will receive financial compensation.

I further agree that participation in a publication and website produced by Children's Program confers no rights of ownership whatsoever. I release Children's Program, its contractors and its employees from liability for any claims by me or any third party in connection with my participation or the participation of the undersigned minor children.

Signature: _____ Date: _____

Street Address_____

City, State, Zip: _____

Names and Ages of Minor Children:

Name:_____ Age: _____

Name:_____ Age: _____

Name:_____ Age: _____

TREATMENT CONSENT

WELCOME TO THE CHILDREN'S PROGRAM! We look forward to assisting you with your goals. Here is some important information you should know BEFORE we begin to work with you/your child(ren)/family.

STAFF AND OUR SERVICES: The Children's Program is a private, multidisciplinary clinic. Our clinical staff consists of developmental/behavioral pediatricians, consulting psychiatrists, licensed psychologists, licensed professional counselors, speech/language pathologists, and a certified educational specialist. We help adults, families and children with social, emotional, developmental, and learning concerns. When you call for an initial appointment we encourage you to formulate questions for us to answer or specific goals you want to accomplish. With that information, we will schedule appointments for consultation, evaluation and/or treatment with appropriate staff. Your clinician will suggest the frequency of appointments. Patients may call or schedule return visits while in the office. Treatment is considered concluded if a period of 120 days or greater has passed since the last appointment, unless otherwise specified by you and your clinician. We will attempt to remind you of your appointment via email, text and telephone.

During the first appointment, your clinician will introduce him/herself to you and, at your request, share specifics regarding his/her education and training. You can then further clarify goals and agree how they will be reached. If you have difficulty describing clear goals for treatment, it is important to discuss this with your clinician. We will work with you to meet your/your family's specific needs. It is a collaborative process that is provided without a guarantee of satisfaction or results. You retain the right to request changes in treatment or to end treatment at any time. When medication is recommended, your doctor will discuss the risks, benefits, and alternatives. When accepting a prescription for medication, you agree to follow the prescribing physician's recommendations regarding ALL aspects of treatment. If we recommend referral inside the clinic, information will be shared between clinicians. If we recommend referral outside our clinic, we will attempt to provide you with alternatives.

IF YOU ARE RECEIVING SERVICES UNDER A MANAGED CARE HEALTH INSURANCE CONTRACT, your policy may limit behavioral health coverage to **"medically necessary" procedures (for acute symptom relief)**. It is the responsibility of the patient/ family to ensure all necessary preauthorization is current. Your provider has an agreement with your insurance company to provide services within the limitations of these conditions. The managed care company may require a release of information about your treatment to the primary care physician. Your managed care health insurance company hires reviewers to assess the record keeping and functioning of provider offices. As part of this process, they may either send a reviewer to our office to inspect your record or request a copy of your record be sent to their office for review. If this is the case, we will follow all procedures to protect the confidentiality of your record. Your managed care insurance may request that information regarding treatment and/or treatment authorization be transmitted via facsimile or e-mail. If you do not want us to send or receive information in this manner on your behalf please inform your clinician and specify this request in writing. Some concerns you want to address in therapy may not meet the conditions of your insurance coverage. Should you want to receive treatment for a non-covered condition, your therapist will discuss options with you.

The Children's Program will not be a party to any legal proceedings/lawsuits. Our goal is to support clients to achieve therapy goals, not to address legal issues. Clients entering treatment agree not to involve the Children's Program and their treating clinician in legal/court proceedings or attempts to obtain records of treatment/evaluation for use in legal/court proceedings.

CONFIDENTIALITY: The privacy of your evaluation/treatment is important to us. Information shared with clinicians is confidential. The Children's Program maintains a single chart to record the services that are provided. We will maintain your chart for 7 years from the last date of treatment. Information from that record can be shared with other professionals/agencies/individuals **ONLY** with your **WRITTEN** consent by signing a release to disclose confidential information. Please be conservative and circumspect when requesting release of information. This is to protect your child/family's privacy now and into the future as your child ages. Please be aware that the record we release may be released by other providers/agencies. The Release to Disclose Confidential Information form requires specifying **WHAT** information is to be shared, **WHO** shall receive it, for **WHAT** purpose and the **DATES** of the confidential information. In Oregon, the age of consent for treatment and release of mental health records is 14 years of age. The signature of patients 14 years or older is required to release the information in the treatment record. With written permission, we can communicate with other professionals on your behalf via phone or email and provide evaluation reports and/or a summary of treatment. We do not generally release patient chart notes or test protocols. If under a special circumstance, release of additional information is requested, this will be reviewed after conferring with the patient/family members and the requesting clinician/physician. There may be charges for photocopying and mailing records. In the case of divorce, both parents have equal access to the information in the chart of a child under the age of 14. If consultation with other professionals on your behalf is necessary, your anonymity will be preserved.

We may, but do not guarantee calls to remind you of upcoming appointments. Please let us know **EACH** time you schedule an appointment if you **DO NOT** want a reminder call.

We respect the rights of a child/parent/adult to have particular information remain private between themselves and the therapist. If you have concerns about this, let your therapist know and a comfortable arrangement can be reached which allows therapy to progress, yet respects the rights of individuals. Please advise us in writing if you wish to be contacted only in a particular way or only at particular phone numbers. There are several situations in which the law requires clinicians to make exceptions to the confidentiality of communications between client and clinician. These situations are:

- when there is suspected child, elder, or disabled abuse
- when there is threat of harm to self or others
- when medically relevant information is needed for emergency medical treatment
- when records are subpoenaed by order of a Judge, or if the client waives confidentiality
- when conducted at the request of an outside agency with the client's approval

Information may be required by your insurance company to process a claim. Typically, this involves disclosure of a diagnosis and the dates of services, though at times, more may be required. Your file may be reviewed for quality assurance by the Children's Program or your insurance company. We will maintain your confidentiality during this process.

ELECTRONIC COMMUNICATION, I.E., E-MAIL/FAX, PRESENTS A POTENTIAL RISK TO PATIENT CONFIDENTIALITY. Email is not a replacement for office visits. While families and patients may find this a convenient way to communicate they must be aware of the risks and discuss them with their clinician. If a patient/family still wishes to assume these risks and communicate with their clinician in this way, they may acknowledge this by signing below and exchanging information with their clinician within a session. Clinically relevant information exchanged by fax/email may become a part of the clinical record.

FEES/PAYMENT: Fees are billed on an hourly basis and vary for each discipline. When you call for an appointment, we provide an estimate of the fee(s). We will inform you if this changes. We request payment of the fee(s) at each appointment. In some cases, we will bill your primary insurance directly. HOWEVER, THIS DOES NOT GUARANTEE COVERAGE. Health insurance plans vary widely in their mental health coverage. A copy of our **FINANCIAL POLICY** is available on our website. **Please read our Financial Policy**. We require that you read/sign **INFORMATION** and **CONSENT FOR PAYMENT** forms prior to initiating evaluation/treatment**.** We require you provide a valid credit card number. Charges remaining after 90 days may be charged if you have not called us regarding arrangements for payment of a past due balance

There are circumstances that impose additional fees. To cancel a scheduled therapy appointment, please call during office hours and give at least 48 business hours' advance notice. To cancel an evaluation appointment, please notify us at least one week in advance. We may elect not to reschedule evaluations cancelled without sufficient notice. A mandatory fee of up to 100% of the charge may be assessed for missed appointments or appointments cancelled without sufficient notice. Cancellations left on voicemail after business hours will be considered received as of the next business day. Reminder phone calls are not guaranteed. You will be charged for telephone/email consultation outside a session or a cancellation without sufficient notice. This is billed at the clinician's hourly rate and is not reimbursable by a health insurance company. Same day requests for refills of prescriptions incur a $10 charge. If a clinician is required to testify on a client's behalf court preparation/travel/testimony will be billed at $200 per hour. In the unlikely event that your account is referred to a collection agency or small claims court, we will release your name, address, phone number, social security number, and amount owed. You will be notified in writing if this is to occur.

EMERGENCIES: Office phones are answered between 8:00 a.m. and Noon and 1:00-5:15 p.m. Monday through Thursdays and between 8:00 a.m. – Noon and 1:00-3:30 p.m. on Fridays. The office is closed on Fridays during July and August. Messages may be left on the voicemail at any time. Our clinicians will attempt to return your call within 24 hours. If you feel you have an **emergency** situation that cannot wait until the office re-opens, please call the Answering Service at (503) 294-1309. They will make every effort to contact your clinician; however, it is possible that your clinician may be unavailable or unreachable. Families needing immediate attention are advised to contact the Emergency Room of the nearest hospital.

GRIEVANCE PROCEDURE: If you have concerns regarding these policies, please discuss them with your clinician during your initial session. Should you feel dissatisfied with your treatment for any reason, please talk to your clinician. If you and your clinician are unable to resolve the problems, you may submit a written letter of concern to our Clinic Administrator. You will receive notice of action taken within 10 working days.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND I CONSENT TO TREATMENT. BY FURNISHING MY EMAIL ADDRESS, I CONSENT TO THE USE OF EMAIL TO COMMUNICATE.

Email Address: _____

_____ _____
(Name of Patient) (Date of Birth)

_____ _____
Signature (clients age 14 years and above) (Date)

_____ _____
Signature (Parent/Guardian/Legal Rep.) (Relationship to Client) (Date)
(If Guardian/Legal representative, please provide documentation of guardianship status.)

_____ _____
Clinician's Signature (Date)

Please sign and return this form.