

GEORGE GLASER, LCSW

Clinical Social Work

Jefferson Bldg • 1600 West 38th Street • Suite 306 • Austin, Texas 78731 • (512) 371-9418 • (512) 828-7042 (fax)

Thank you for setting this appointment with me, and I look forward to meeting you and your child. You have my commitment to provide you and your family the best and most efficient services.

This packet is the correct set of intake documents for any child or adolescent clients being seen individually or in a family interview.

There are several documents in this packet:

- **Office Information and Policies** is a 1-page document describing my office policies.
- **Client Information – Child and Adolescent Services** is a 4-page form containing identifying data, insurance information (if applicable), health history, and details about the problem and what you and your child want help with.
- **Fee Information and Contract** lists my professional fees and contains an agreement about payment of those fees. Two copies are included, one for you and the other for me. Please bring my copy when you come for your first appointment.
- **Problem List** is a 1-page form about the kinds of problems your child has been experiencing during the past month.
- **HIPPA Notice of Privacy** is a 1-page form explaining the current HIPPA privacy regulations, and asking for your signature as a statement of understanding.

Please complete all the forms and bring them with you to the first appointment. Call me if you have any questions.

Sincerely,

George Glaser

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OFFICE INFORMATION AND POLICIES – CHILD AND ADOLESCENT SERVICES

I appreciate the trust you have shown in making this appointment. It is my intention to provide you and your child with effective, personalized and constructive mental health services. Below is information about my office policies.

- 1) I hope my office is a place where your child, family and you can comfortably and safely work on resolving problems. Please let me know if there is anything in the office, which interferes with that process.
- 2) Our office is not equipped to handle unsupervised children under twelve in the waiting room.
- 3) Notify me as soon as possible, and no later than 24 hours in advance, when canceling or rescheduling an appointment. The reason for this is simple: you have contracted for a portion of my time, and if you don't show up that time is empty. Missed appointments and late cancellations (i.e. less than 24 hours notice) incur a \$50 charge.
- 4) I understand that unusual circumstances occur that might keep you from an appointment. Let me know if such a situation occurs.
- 5) Payment is preferred at the time of service. If necessary, I will be happy to talk with you about other payment arrangements. I accept cash, checks, Visa, and MasterCard.
- 6) You are responsible for payment of all fees. Your services and fees may exceed the benefits provided in your insurance or managed care benefits package. Managed care/insurance plans are often complicated, and I will do what I can to help guide you, interpret the contracts and track your services and costs. Ultimately, though, it is your responsibility to know and manage your benefits.
- 7) I check my voice mail messages frequently throughout the day, and will usually be able to return calls within three hours. If you have an emergency outside of normal office hours, call me at (512) 791-7075 on my mobile phone. For calls regarding appointments or urgent matters during office hours, leave a message at (512) 371-9418. In a life threatening situation, go to the nearest emergency room
- 8) If your child sees a psychiatrist or other physician for medication, you will need to speak with that doctor or their representative for any questions about the medication. If a problem develops, contact your physician(s) or pharmacist immediately.
- 9) Let me know if you have any problem with my services. It is more constructive to work out concerns earlier than later. If you have unresolved concerns about my professional social work services, you can contact The Texas State Board of Social Worker Examiners in Austin at (512) 719-3521.

Keep for your records.

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CLIENT INFORMATION – CHILDREN & ADOLESCENTS

Complete all pages.

Today's Date: _____ Referring Person's Address: _____

Referred by: _____ Referring Person's Phone #: _____

(Print)

Child's First Name: _____ MI _____ Last Name: _____

Child's SS#: (if applicable) _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Cellular Phone: _____

Home Phone: _____ Work Phone: _____ Pager: _____

Where does your child live _____ Grade _____ School _____

In an emergency contact: _____ Relationship to child: _____ Phone: _____

Mother's Name _____ **Mother's SS#** _____

Mother's Occupation: _____ Mother's Employer: _____

Mother's DOB _____ Mother's Phone: _____

Father's Name _____ **Father's SS#** _____

Father's Occupation: _____ Father's Employer: _____

Father's DOB _____ Father's Phone: _____

Siblings: *(Complete on back if additional space is needed)*

Name(s) _____ DOB _____

INSURANCE INFORMATION *(if applicable)*

Primary Insured Person _____ Insured's SS# _____ Employer: _____

Insurance Co: _____ Account #: _____ Group #: _____

Insurance Co Address: _____ Effective Date: _____ Insured's DOB: _____

City: _____ State: _____ Zip: _____ Phone: _____

Secondary Insured Person _____ Insured's SS# _____

Insurance Co: _____ Account #: _____ Group #: _____

Insurance Co Address: _____ Effective Date: _____ Insured's DOB: _____

City: _____ State: _____ Zip: _____ Phone: _____

PROBLEM DESCRIPTION & HISTORY

1) Provide a brief statement about your child's problem(s) for which you are seeking help:

2) Why do you think the problem(s) exists? _____

3) Have you sought help before with this problem(s)? Where, when, and how?

4) What were the results?

5) What would signal to you as a parent that the current problem is resolved?

6) Is your child currently seeing any other mental health provider(s) ? Yes No

If yes, please give names, addresses, and phone numbers _____

7) Who is your child's primary care physician / pediatrician? _____

Please provide their address and phone: _____

8) Is your child taking any prescribed medications? Yes No

If yes, please list types, dosage and the prescribing physician(s): _____

9) Does your child use...

Alcohol: Yes No Frequency of use _____ Amount _____

Drugs Yes No Frequency of use _____ Amount _____

Types _____

Tobacco Yes No Frequency of use _____ Amount _____

Caffeine Yes No Frequency of use _____ Amount _____

10) Do you or your spouse/partner use...

Alcohol: Yes No Frequency of use _____ Amount _____

Drugs Yes No Frequency of use _____ Amount _____

Tobacco Yes No Frequency of use _____ Amount _____

Caffeine Yes No Frequency of use _____ Amount _____

11) Describe any physical problems your child has complained of during the past month:

12) Describe your expectations of how therapy will help your child: _____

13) What does your child do for fun? _____

14) What are your child's special interests or hobbies? _____

15) What does your family do for fun?: _____

16) Describe your family: _____

17) What spiritual practices are used in your family? _____

18) Please describe your child: _____

19) How does your child perform in school?: _____

20) Has your child been exposed to violence in the home: _____

21) Has your child ever been assaulted? _____

22) Describe your child's use of TV? (number of hours, favorite shows, etc.) _____

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FEE INFORMATION AND CONTRACT

The following list shows my fees for professional services.

Psychotherapy (Child & Adolescent)

25 minutes	\$55
50 minutes	\$100
75 minutes	\$125

Conjoint Family Therapy

50 minutes	\$125
75 minutes	\$150
90 minutes	\$180

Reports, letters

up to 20 minutes	\$40
up to 45 minutes	\$75
greater than 45 minutes <i>(will be discussed on an individual basis)</i>	

Court or Deposition Services..... \$250/hr

These fees do not reflect any contracted discounts with managed care plans or individuals. The total fee, or the agreed upon co-payments, are due at time of service unless alternative arrangements have been made with Mr. Glaser.

I have read the *Office Information and Policies*, and *Fee Information and Contract* forms. I agree to participate in assessment and agreed-upon treatment services with Mr. Glaser. I understand the fees and payment policies, and agree to pay all professional fees in a timely manner as discussed with Mr. Glaser and as outlined on the above-mentioned forms.

Name (*print*): _____

Signature: _____

Date: _____

**Keep one copy of this form for your records;
return the other to me.**

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up to 45 minutes	\$75
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Name (*print*): _____

Signature: _____

Date: _____

**Keep one copy of this form for your records;
return the other to George Glaser.**

PROBLEM LIST

Child's Name: _____ Date: _____

	None	Mild	Moderate	Severe
Depressed Mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hopelessness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suicidal Thinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep changes (increase / decrease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite Changes (increase / decrease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Slowed Activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Significant Weight Change (increase / decrease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor Concentration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Argumentative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Agitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood Swings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotions Are Hard to Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obsessive Thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tense/Anxious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fearful (Phobic)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Complains of Physical Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inattentive at home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fidgety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty in sitting still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nightmares / Night Terrors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hallucinations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impaired Intellectual Functions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impaired Judgment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Long-term Memory Deficit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short-term Memory Deficit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inattentive at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delusions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nightmares	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hostile feelings towards other children or adults	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violence Toward Self or Others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Illegal Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conflict With Authority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Disruptive Conduct	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problems going to school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dissociative Episodes (amnesia, losing consciousness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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HIPPA NOTICE OF PRIVACY

Client Name _____ Date of Birth _____

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

Private Health Information may be used and disclosed in the following circumstances:

1. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman’s compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits by managed care companies.

As a client, you have rights to your Private Health Information, including,

1. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.
2. The right to request information of any party that has requested information pertaining to your private health information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

As a private practitioner, I have the responsibility to:

1. Make each client aware of the Privacy Notice.
2. At any time make the necessary changes to the Privacy Notice that are required by law.

If you as the client feel your privacy has been violated you have the right to complain by filing a written complaint with the Secretary of Health and Human Services in Washington, D.C.

I, _____, understand the above statements, and hereby authorize George Glaser, LCSW to release private health information on my child’s behalf to the following persons or company: _____

Do not release any Private Health Information to outside parties

Client/Legal Guardian Signature: _____ Date _____

Witness: _____ Date _____

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Client Name _____ Date of Birth _____

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Private Health Information (PHI) may be used and disclosed in the following circumstances:

1. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman's compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
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Form revised 2005-12-06

Please sign the first copy of the HIPPA Notice of Privacy form and return it to George Glaser. Keep this copy for your records.

My office is located in the **Jefferson Building**, located in north-central Austin at the intersection of Jefferson Street and 38th Street/Bull Creek.

From IH 35, take the 38 1/2 Street exit west to Shoal Creek Blvd. After crossing Shoal Creek, bear to the right for 1/4 mile until you reach the stoplight at Jefferson Street. The Jefferson Building is to the right on the northeast corner of Jefferson and 38th Street/Bull Creek.

From MoPac southbound, exit at 45th St., then turn left and go east under the Mopac overpass. Continue east for another block and turn right at Bull Creek. Take Bull Creek to the intersection of Jefferson Street and 38th Street/Bull Creek. The Jefferson Building is on the left as you go past the intersection.

From MoPac northbound, exit at 35th Street. Travel east on 35th for two blocks, then make a left on Jefferson Street. Go north one block to the intersection of Jefferson Street and 38th Street/Bull Creek. Make a right on 38th St. at the light. After the turn, the Jefferson Building is on the left.

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