Application Checklist:

Please complete, sign, and return the following documents, prior to your initial consultation, to Ashley Flynn at info@BostonChildStudyCenter.com or aflynn@bostonchildstudycenter.com

1. Completed Application For Services (pages 2-4) _____
2. Signed Consent for Services (pages 5-9) _____
3. Signed Consent for Release of Information (page 10) _____
4. Signed Billing Agreement/Authorization (page 11) _____

BC SC
Boston Child Study Center
729 Boylston Street, 5th Floor, Boston, MA 02116 | P: (857) 400-9211 | F: (866) 496-3029
www.BostonChildStudyCenter.com

Application for Services

Today's Date:_____

Potential Patient Information:

Patient Name: _____ Age:_____ Date of Birth:_____ Gender: _____

Patient Phone: (_____) _____-_____ Patient Email: _____

Home Street Address: _____ City: _____Zip:_____

School Name & Grade: _____

Parent/Guardian Information (If Applicable):

Parent 1 Name: _____ Profession: _____ Phone: (____)_____-_____Type: C/H/W

Email Address: _____ May we contact you over email? Y / N

Home Address (if different from patient):_____ City: _____Zip:_____

Parent 2 Name: _____ Profession:_____ Phone: (____)_____-_____ Type: C/H/W

Email Address: _____ May we contact you over email? Y / N

Home Address (if different from patient):_____ City: _____Zip:_____

Parents' marital status: _____ If separated, are legal proceedings in process or anticipated: Y / N

Siblings and ages:_____

Additional family members/individuals living in the home: _____

If parents are not married please describe the current legal and physical custody agreement: _____

How were you referred to the Boston Child Study Center?_____

Please describe the nature of the problem for which you are pursuing services:

Symptoms (e.g., anxiety, depression, suicidal ideation): Onset: Triggers:

_____

_____

_____

_____

_____

Educational History:

Current School:_____ Grade:_____

All Previous Schools:_____

_____

Does your child have an IEP or 504:_____ School related concerns:_____

_____

Patient Medical History:

Previous diagnoses (please include all medical and psychological diagnoses):

Past:_____

Current:_____

Medications: Name & dose Dates Problem treated Response Name of prescribing physician

_____

_____

_____

_____

_____

Patient Psychiatric History:

Previous diagnoses (please include all medical and psychological diagnoses):

Past:_____

Current:_____

Has the patient received psychological services for this or another problem before? Y / N If yes, please indicate:

Dates of service Problem treated Response to treatment Name/profession of previous providers

_____

_____

_____

Does the patient have a history of trauma/abuse? Y / N If yes, please briefly describe/state the traumatic experience(s):_____

_____

Does the patient have a history of self-injury? Y / N If yes, please describe:_____

_____

Does the patient have a history of suicidal behaviors/attempts? Y / N If yes, please describe:_____

_____

Does the patient have a history of substance abuse? Y / N If yes, please describe:_____

_____

Has the patient been hospitalized in the past for mental health reasons? Y /N If yes, please indicate:

Dates Circumstances/reason Hospital/Program Discharge Recommendation

_____

_____

_____

_____

The Boston Child Study Center is a comprehensive treatment team with some services available exclusively in Boston. Is the potential patient able to travel to this location? _____

Please indicate days and times for which the potential patient and family are available:

Monday	8:00am-12:00pm	12:00pm-3:00pm	3:00pm-6:00pm	After 6:00pm
Tuesday	8:00am-12:00pm	12:00pm-3:00pm	3:00pm-6:00pm	After 6:00pm
Wednesday	8:00am-12:00pm	12:00pm-3:00pm	3:00pm-6:00pm	After 6:00pm
Thursday	8:00am-12:00pm	12:00pm-3:00pm	3:00pm-6:00pm	After 6:00pm
Friday	8:00am-12:00pm	12:00pm-3:00pm	3:00pm-6:00pm	After 6:00pm
Saturday	8:00am-12:00pm	12:00pm-3:00pm	3:00pm-6:00pm	After 6:00pm

This application will be reviewed by the Directors of the Boston Child Study Center to ascertain whether our practice is the best treatment match. The application will be reviewed within 7-10 business days after which time you will be contacted regarding the disposition. If you have any questions about completion of this form or our services, you may contact us at (857) 400-9211 or email us at info@BostonChildStudyCenter.com.

CONSENT FOR SERVICES

Welcome to the Boston Child Study Center, located at the Prudential Tower in Boston and Belmont, MA. This statement provides important information about the services provided by the Boston Child Study Center, practice policies and procedures, and you and your child's rights and responsibilities as patients. Please read this document thoroughly and be sure to raise any questions or concerns with your therapist as soon as is feasible.

Description of Practice:

The Boston Child Study Center specializes in evidence-based treatment for anxiety, behavioral, and mood disorders. As such, your therapist will make every effort to provide the most appropriate evidence based interventions or will provide the necessary referral information if he/she is not able to provide such care personally. The Boston Child Study Center does not discriminate against any individual on the basis of race, color, ethnicity, religion, sex, age, national origin, sexual orientation, or socioeconomic status.

Nature of Services:

Initially, you and your child will meet for a two-part diagnostic evaluation. This evaluation will help determine the nature of your child's symptoms, concerns, and difficulties, as well as whether the services provided by the Boston Child Study Center are appropriate for your family's needs. The first part of the intake consists of a structured diagnostic interview for caregivers and the child which takes approximately three hours to administer. The second visit consists of an interview to focus on assessing your child's symptoms including their emotions, behaviors, past/current psychological functioning, past/current psychiatric treatment, as well as academic, social, and family functioning in order to determine the best course of treatment. If your child has a current treatment provider, your therapist may ask for your written consent to speak with that person if it is likely to help in making

assessment or treatment decisions for your child's care. The fee for this two-part evaluation is $750 unless otherwise discussed or revised through the sliding scale before the meeting is held.

After the evaluation, the therapist will give you feedback, make recommendations for further services, and describe various treatment options that may be a best fit for your child's needs. If you are offered services through the Boston Child Study Center, we will describe what will be required of you and your child, what you and your child can expect in treatment, and address any concerns or questions you may have. If you accept treatment with the Boston Child Study Center, a fee will be set based on the standard fees applicable to the services and provider(s) you are assigned unless otherwise stated or revised through the sliding scale (see below). You will either be placed on a treatment waitlist or begin working with a therapist at their and your earliest convenience. You may also request referrals at any time during the treatment process if you are either not interested in waiting for services or if you are unhappy with services in any way. The Boston Child Study Center encourages you to bring up any questions or concerns during the treatment process, as many issues can be problem solved effectively together. You are free to withdraw from treatment at any time.

As a condition of your receiving services with the Boston Child Study Center, your information will be stored confidentially in a password protected electronic medical record database. This database may be used for retrospective research (if so all of your information will be de-identified), quality assurance checks, and program evaluation purposes. This information is utilized in such a way that protects your anonymity and keeps your personal records confidential. You may also be asked to participate in other research projects conducted either by the Boston Child Study Center or an affiliated associate, but you will not be included in an additional project without your written consent. Clinical services with the Boston Child Study Center are strictly voluntary.

Policies and Fees:

The Boston Child Study Center is an evidence-based, fee-for-service, faculty practice comprised of psychologists, neuropsychologists, social workers, and clinical psychology trainees. Typically, families initially meet with our directors, Dr. Madigan or Dr. Lambright, for an initial consultation to determine a preliminary diagnosis, conduct a functional cognitive behavioral assessment to identify underlying causes of symptoms presented, determine the appropriate level of care, and identify the best treatment team/program for you and/or your child. Our Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), and Parent-Child Interaction Therapy (PCIT) programs offer a team approach comprised of comprehensive evaluation, individual therapy, family therapy, exposure coaching, skills training/coaching, and parent coaching to address your identified treatment goals. Additionally, the individual therapist typically serves as the point-person between you and your treatment team.

We place a top priority on matching your needs to the appropriate evidence-based treatment and may provide outside referrals if we determine that a better treatment match exists.

Group policies: DBT Skills Training Groups require a 24 week commitment. Missing 4 groups will require an individual session to learn the missed group content and reestablish commitment prior to returning to group. DBT Skills Integration Groups require a 16 week commitment. Missing 3 groups will require an individual recommitment session prior to returning to group. DBT/CBT Skills Training and Skills Integration Groups for Parents require a 12 week commitment. Missing 3 groups will require an individual session to learn the missed group content and reestablish commitment prior to returning to group. New members are admitted to the groups on a rolling basis based on availability. Group members may have the opportunity to continue in group for additional time if treatment goals are established. Members of DBT Skills Training and Skills Integration Groups for Adolescents and Young Adults are required to be in ongoing individual DBT with skills coaching. Those in ongoing individual CBT may also be admitted to the group on a case by case basis. An intake session is required before starting any group. Parents agree to inform group leader of any changes in patient's treatment team. Attendance policies and other group requirements may differ based on the specific group and will be communicated to you and/or your child prior to starting in any group. Missed appointments or cancellations made less than 24-hours in advance are billed at the standard session rate, except for snow or weather emergencies.

Our service rates are "fee-for-service" as we do not accept insurance. We offer a sliding scale which is granted on a need basis. If you wish to apply for the sliding scale we request that families provide documentation of your total family income, the number of legal dependents that you are financially responsible for, and the number of family members currently enrolled in fee-for-service treatment. After review of these documents, we will provide an adjusted fee for you to review before deciding whether to proceed with services. We also provide "insurance-friendly" statements that include many of the service codes and information you may require to submit for "out-of-network" reimbursement. Note, we do not guarantee that any portion of the fees will be reimbursed. While we try to provide you with the information needed or requested by many insurance companies, we do not work directly with insurance companies nor do we negotiate single case agreements. If appeals paperwork or communication is required, this time will be billed directly to your family and will not be covered by your insurance company. Telephone, email, completion of outside paperwork (paperwork requested for outside BCSC use such as, your insurance company, school, etc.), travel, and video-conferencing consultation is billed at the therapy rate. Payment is due at the end of each month for the balance on your account and can be payable by check, debit card or credit card (Visa, MasterCard, Discover, Amex), or flex-spending debit card. If you select to pay using a credit or debit card, you will need to complete the billing authorization form. Your card will be charged for all outstanding services rendered on your account and a statement will be emailed to you, which will serve as your receipt of payment. If you would like to request an invoice citing services rendered and/or the balance on your account you may do

so in writing at any time by emailing Brinna Durney at info@BostonChildStudyCenter.com. Missed appointments or cancellations made less than 24-hours in advance (except for snow or weather emergencies) are billed at the standard session rate. A snow or weather emergency qualifies if the school district in which you reside is closed due to weather on the day of your appointment. Most standard treatment fees are listed below:

Standard Patient Fees:

Initial Consultation:	$15 - $750
Comprehensive Neuropsychological Assessment:	$1,600 - $4,500
Functional Cognitive Behavior Assessment:	$750 - $1,500
Intensive Anxiety Treatment Program:	$1,600 - $3,800
Individual/Family CBT Doctoral/Masters Clinician:	$15 - $250
Individual/Family CBT Supervised Clinical Extern:	$15 - $150
Individual/Family DBT Doctoral/Masters Clinician:	$15 - $275
Individual/Family DBT Supervised Clinical Extern:	$15 - $200
Individual/Parent Group Therapy:	$15 - $125
College Counseling:	$15 - $275
Executive Functioning Coaching:	$15 - $250
Professional Training/Talk 1-3 Hours:	$1,400
Professional Training/Talk 4 Hours-Full Day:	$2,400

Confidentiality:

All clinical records are kept in a secure electronic medical record or secure filing cabinet. The information you provide during the course of your child's evaluation is confidential and will not be revealed outside of the Boston Child Study Center without your written permission, with a few exceptions that are described below:

1) Brief written summaries of each patient contact are required to be kept. These records could be subpoenaed by a court of law under certain conditions;
2) If your therapist has reason to believe that your child or another child/elder/disabled person is being abused, or if you have any information regarding such abuse or neglect to another, your therapist is required by law to notify the appropriate Child or Adult Protective Agency;
3) If your therapist has reason to believe that your child is at risk of making a serious and/or imminent attempt to hurt or kill him/herself or someone else, we are required by law to notify related emergency personnel or victims. In such

cases we may be required to complete paperwork with the state involuntarily hospitalizing your child;

4) If there is a criminal or civil legal action related to sanity or competence;
5) If you initiate legal action or ethical charges against the Boston Child Study Center;
6) If you request disclosure by signing release of information form;
7) Sometimes children and adolescents may choose to share personal information with their therapist. Typically, the specific content of the therapy sessions will not be shared with their parent unless the adolescent agrees to it, or unless it is necessary due to adolescent evidencing imminent risk of harm to self or others. However, if parents or guardians ask, we are required by law to keep parents or guardians informed of the child's progress.

Emergencies:

The Boston Child Study Center clinical hours of practice are typically 9am to 7pm Monday-Thursday and 9am to 5pm on Friday. If your therapist is not available to immediately answer your call during those hours, he/she will return your call as soon as possible during operating hours. Email should only be used for scheduling updates and not used to provide your therapist with clinical or personal information (as email is not a secure mode of communication) nor should email, text, or voicemail be used in emergencies. The Boston Child Study Center staff has limited availability to respond to crisis situations (i.e., while working with another family, overnight, weekends, holidays, etc.) For this reason, it is crucial that you are aware of other services available in the community in the event of a crisis or emergency. If you experience crisis or an emergency you should call 911 or go to your local emergency room. Upon arrival to the emergency room, you can call your therapist to provide an update around the status of your emergency care (name of the hospital, name of provider at hospital, number where you can be reached) and we will, at our earliest availability, get in touch with you and your provider (upon written or verbal consent for release of information). If you or your therapist believe that your child's well-being may be at risk due to limitations in your therapist's availability and/or crisis coverage, please let your provider know both in person and in writing and he will help you find a more suitable site to provide your care.

STATEMENT OF AGREEMENT:

By providing consent, I am indicating my understanding that the purposes of the initial evaluation are to assess my child's or my current difficulties, help determine the best plan for addressing my child's or my mental health needs, does not ensure that my child or I will necessarily be assigned to work with a specific staff member of the Boston Child Study Center, that the Boston Child Study Center does not ensure that your insurance provider will reimburse you for the services rendered with the Boston Child Study Center, and that I will be given referrals if it is determined that the Boston Child Study Center is not a suitable match

to address my child's needs. I understand that if I have any questions about the evaluation, treatment, or its use, I may ask my therapist, Dr. Madigan, or Dr. Lambright about them at any time.

By signing this statement I am indicating that: 1) I have read the Boston Child Study Center's Consent for services form in its entirety, 2) I have had any questions or concerns regarding this form addressed by the Boston Child Study Center staff, 3) I fully understand all information contained therein, and 4) I freely agree that my child and I may participate in the services offered.

_____
Name of Child (if applicable)

_____ _____
Name of Parent/Guardian/Self (if 18+) Signature of Parent/Guardian/Self (if 18+) (Date)

_____ _____
Name of Clinician Signature of Clinician (Date)

Please return this form to the Boston Child Study Center either in person or by:

Email: info@BostonChildStudyCenter.com **Fax: (855) 496-3029**

Mail: Boston Child Study Center, 729 Boylston Street, 5th Floor, Boston, MA 02116

BC SC
Boston Child Study Center
729 Boylston Street, 5th Floor, Boston, MA 02116 | P: (857) 400-9211 | F: (866) 496-3029
www.BostonChildStudyCenter.com

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I, _____, authorize clinical communication between the Boston Child Study Center staff and:
(Name of Parent/Guardian/Self if 18+)

Provider:	Name/Address:	Phone:
PCP / pediatrician	_____	(_____)_____
	_____	
Psychiatrist	_____	(_____)_____
	_____	
Individual therapist	_____	(_____)_____
	_____	
Family therapist	_____	(_____)_____
	_____	
School	_____	(_____)_____
	_____	
Case manager	_____	(_____)_____
	_____	
Other ( )	_____	(_____)_____
Other ( )	_____	(_____)_____

Communication may include any and all information in their possession acquired in the course of evaluation and/or treatment of the above named child/adolescent/patient. In addition, I authorize the staff of the Boston Child Study Center to share information with any emergency care givers who are involved in the care of my child in the event of a medical or psychiatric emergency. This authorization is voluntary and I have the right to refuse to sign it. I may revoke this authorization at any time by providing written notice of revocation; however such revocation would not affect any action taken by the Boston Child Study Center in compliance with this authorization before receipt of my written, hard-copy, revocation. You may accept photocopies or facsimiles of this authorization.

_____ _____
Signature of Parent / Guardian / Self (if 18+) (DATE) Relationship to Child

_____
Therapist / Staff / Witness (DATE)

BC SC
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Payment Authorization and Agreement

Boston Child Study Center accepts payment through check, debit or credit card. Please select the method of payment you prefer below. If you choose to change your method of payment, you may do so at any time by re-submitting this form to Brinna Durney at info@BostonChildStudyCenter.com.

Payment Agreement and Selection:

☐ I agree to pay by debit, credit or flex-spending debit card and have submitted my information below to authorize use of my credit/debit card.

☐ I agree to pay by check and mail payment at the end of each month for the balance on my account within 7 business days of receiving my monthly bill.

I agree to submit payment to the Boston Child Study Center for the amount due on my bill at the conclusion of each monthly billing cycle. I understand that the billing cycle ends on the last day of each month. If you are enrolled in auto-pay, your card will be billed and you will receive a statement documenting the services and charges billed to your account. If you prefer to pay by check please mail checks to Boston Child Study Center, LLC, 729 Boylston Street, 5th Floor, Boston, MA 02116.

_____ _____

Signature Name (printed) Date

Debit/Credit Card Authorization

If you selected to submit payment via debit card, credit card, or flex spending debit card please complete the below form to authorize the Boston Child Study Center, LLC to retain your card information on file and enroll your account in our monthly auto-payment system.

Card Type: V / MC / D / AMEX Cardholder full name (as it appears on your card): _____

Card Number: _____ Exp: _____ Security Code: _____

Billing Address: _____ City: _____Zip:_____

Billing Phone: (_____) _____-_____ Email to send statement/receipt:_____

Please Check the Appropriate Box:

☐ **One Time Use**: I hereby authorize Boston Child Study Center to retain my credit/debit card information on file and to charge the indicated credit/debit card for the amount due on my account. This is a one-time charge authorization. I am not authorizing BCSC to enroll my card in monthly auto-pay.

☐ **Recurring Billing**: I hereby authorize BCSC to retain my credit/debit card information and charge the indicated credit/debit card on a monthly basis for the amount due on my account. The recurring payment authorization shall remain in effect until canceled by me in writing.

Authorization:

I hereby authorize the Boston Child Study Center to charge the indicated credit/debit card. I agree that this is either a one time or periodic charge that will be made as indicated above. To terminate the recurring billing process, if selected, I must cancel in writing. I guarantee and warrant that I am the legal cardholder for this credit/debit card and that I am legally authorized to enter into this billing agreement with BCSC.

Signature of Cardholder: _____ Date: _____