Boston Child Study Center

Expert Mental Health Treatment, Training, & Research

Application Checklist:

Please complete, sign, and return the following documents, prior to your initial consultation, to Ashley Flynn by fax: (866) 496-3029 or email: AFlynn@bostonchildstudycenter.com

1. Completed Application For Services (pages 2-5) _______

2. Signed Consent for Services (page 6-10) _______

3. Signed Consent for Release of Information (page 11) _______

4. Signed Billing Agreement/Authorization (page 12) _______

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Application for Services

Today's Date:______________

Potential Patient Information:

Patient Name: __________________________________ Age: _____ Date of Birth: _______________

Gender Identity/ Preferred Pronouns: ____

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(s) for which you are pursuing services:

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

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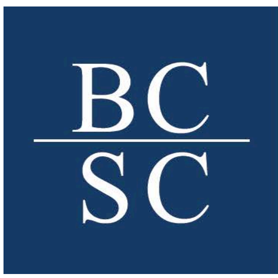

Educational History:

Current School:____ Grade:___________

All Previous Schools:____

____

Has your child had any special testing or tutoring? Y / N If yes, please indicate:

Reason for testing/ tutoring: Dates: Outcomes/ Recommendations:

____

____

____

Does your child have an IEP or 504? _____________ Other school-related concerns: ________________________________

____

Developmental History (please attach additional pages if needed):

Was your child exposed to antibiotics, medications, alcohol, drugs, or tobacco during pregnancy? Y / N If yes, please indicate:

____

Was the pregnancy a full 40 weeks? Y / N If not, please explain: ____

____

Were there any complications during pregnancy (e.g. fetal distress, emergency C-section, pre-eclampsia, nuchal cord)? Y /N If yes, please indicate: ____

Were any special services required at the time of your child's birth (e.g. lights for jaundice, ICU care)? Y /N If yes, please indicate:

____

Were there any concerns/ delays in feeding, sleeping, walking, talking, or motor skills? Y /N If yes, please indicate:

____

____

Did your child participate in Early Intervention services? Y /N If yes, please indicate dates and reason: ________________________

____

Describe your child's social functioning as a toddler? ____

What concerns, if any, do you currently have about your child's ability to socialize/ get along with peers, adults, and family members?

____

Please list major life events your child has experienced (e.g. moving, parent change in work, change in school, deaths, births, divorce):

Date of Occurrence: Life Event: Patient's Response:

____

____

____

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<u>Patient Medical History</u> (please list all diagnoses and attach additional pages if needed):

Past:____

Current:____

<u>Patient Mental Health History</u> (please list all diagnoses and attach additional pages if needed):

Past:____

Current:____

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

Dates: Circumstances/Reason: Hospital/Program: Discharge Recommendations:

____

____

____

____

Has the patient received <u>other psychological services</u> for these or other problems? Y / N If yes, please indicate:

Dates: Type of Service: Response to Treatment: Name/Profession of Provider:

____

____

____

____

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

____

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

____

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

____

Does the patient have a history of <u>substance abuse</u>? Y / N If yes, please describe:________________________________

____

<u>Past & Current Medications</u> (please attach additional pages if needed):

Medication: Dose: When: Problem Treated: Response: Name of Prescriber:

____

____

____

____

____

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Family Medical History:

Are there any biological family members with medical conditions (e.g. cardiac, diabetes, cancer)? Y / N If yes, please describe:

Relationship to Child: Medical Condition: Treatment/ Other Information:

____

____

____

____

Family Mental Health History:

Are there any biological family members with mental health conditions (e.g. anxiety, depression, schizophrenia, bipolar, learning disability, autism, ADHD, eating disorder, substance abuse)? Y / N If yes, please describe:

Relationship to Child: Mental Health Condition: Treatment/ Other Information:

____

____

____

____

Has anyone you or your child known attempted or completed suicide? Y / N If yes, please explain: ____________________

____

Is there any legal history including past or current involvement with DCF? Y / N If yes, please describe: ________________

____

This application will be reviewed by the clinical team at 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 (617) 800-9610 or email us at AFlynn@BostonChildStudyCenter.com.

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CONSENT FOR SERVICES

Welcome to the Boston Child Study Center, located at 729 Boylston Street, 5th floor in Boston, MA. This statement provides important information about the services provided by the Boston Child Study Center, practice policies and procedures, and your 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 an initial consultation, which may take place over one or more visits depending on your needs and the discretion of the clinical team. This consultation 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. This initial appointment typically consists of meeting with a specialist in the area of concern and may also include an additional structured diagnostic assessment for caregivers and your child which may take up to three hours to administer. The goal of this process is to assessing your child's functioning including their ability to regulate their emotions and behaviors, to gather 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 evaluation is $375 per scheduled meeting.

After the consultation, the therapist will give you feedback, make recommendations for further services, and describe various treatment options that may be the 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 do not feel our services are a fit for you and your family. 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.

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As a condition of 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, mental health counselors, clinical psychology trainees, and trained support paraprofessionals. Typically, families initially meet with a specialist in the area of concern for an initial consultation to determine a preliminary diagnosis, start to possibly 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), Parent-Child Interaction Therapy (PCIT), and Individual-Intensive Outpatient Program for Complex Care (I-IOP) each offer a comprehensive team approach which may include a combination of evaluation, individual therapy, family therapy, exposure coaching, skills training/coaching, and/or parent coaching to address your identified treatment goals. 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 elsewhere.

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/ Anxiety/ Emotional Processing 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 declared 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 claim on your taxes, and current out of pocket monthly mental

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health expenses. 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 your insurance company may require for you to submit for "out-of-network" reimbursement. Note, we do not guarantee that any portion of the fees will be reimbursed. Further, academic and learning based services and services delivered by paraprofessionals/clinical assistants while assisting licensed providers in the delivery of a you child's overall treatment plan are not reimbursed by insurance companies. 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 enter into 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 your therapy services rate and not reimbursable by your insurance company.

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. We require that all clients provide a credit or debit card on file to be used as a primary method of payment or as a backup payment for late or outstanding bills. You may select to have your card billed as a primary method of payment which will be billed through our monthly auto-pay system or you may select to pay by check each month and use your card as a backup payment method for late or outstanding bills. If payment by check is not received within 30 days of the previous billing period your backup card on file will be processed for the outstanding balance due on your account. After your account is processed you will receive a statement via email unless you specify another preference for receiving your statements, which will serve as your receipt of payment. If you would like to request a statement citing services rendered and/or the balance on your account you may do so in writing at any time by emailing Emily Hartson at EHartson@BostonChildStudyCenter.com.

Missed appointments or cancellations made less than 24 hours in advance (except for declared snow or weather emergencies) are billed at your 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:

Sample of Standard Patient Fees:

Initial Consultation:	$15 - $750
Comprehensive Neuropsychological Assessment:	$1,900 - $4,500
Functional Cognitive Behavior Assessment:	$750 - $1,500
Individual/Family CBT:	$15 - $250
Individual/Family DBT:	$15 - $300
Group Intake/ Orientation:	$15 - $250
Group Therapy:	$15 - $125
College Admissions Coaching Intake:	$15 - $650
College Admissions Coaching:	$15 - $275
Executive Functioning Coaching:	$15 - $250
Professional Training/Talk 1-3 Hours:	$750 - $1,400
Professional Training/Talk 4 Hours-Full Day:	$2,400 - $4,400

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 documentation of each patient contact are required to be kept and vary in detail. 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.

Emergencies:

The Boston Child Study Center clinical hours of practice are typically 9 am to 7 pm Monday through Thursday and 9 am to 5 pm 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.) and 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.

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STATEMENT OF AGREEMENT:

By providing consent, I am indicating my understanding that the purposes of the initial consultation 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: AFlynn@BostonChildStudyCenter.com

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

Fax: (855) 496-3029

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AUTHORIZATION FOR EXCHANGE OF INFORMATION

I, ______________________________, authorize clinical communication between 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

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Payment Authorization and Agreement

Boston Child Study Center accepts payment through check, debit or credit card. We require that all clients provide a credit or debit card on file to be used as a primary method of payment or as a backup payment for late or outstanding bills. 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 Emily Hartson at EHartson@BostonChildStudyCenter.com.

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 I am enrolled in auto-pay, my card will be processed for the balance on my account and I will receive a statement documenting the services and charges. I understand that I may choose to pay by check and will mail checks to Boston Child Study Center, LLC, 729 Boylston Street, 5th Floor, Boston, MA 02116. I understand that if I do not submit payment by check within 30 days of the last day of the billing period my card on file will be billed for the amount due and I will receive a statement documenting these services and charges.

_________________________________ ____

Printed name of Parent/Guardian/Self (if 18+) Signature of Parent/Guardian/Self (if 18+) Date

Debit/Credit Card Authorization

Please complete the below fields to provide your debit card, credit card, or flex spending debit card 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 or as a backup payment if you choose to submit payments by check.

Card Type: V / MC / D / AMEX Cardholder's 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:

☐ **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.

☐ **Backup Use Only:** I prefer to pay by check and I understand that I am authorizing the Boston Child Study Center to retain my credit/debit card information on file and to charge the indicated credit/debit card for any outstanding balance on my account that is 30+ days late. Example: If my January statement is not paid in full by the end of February I will be charged on March 1st for the outstanding balance.

Authorization:

I hereby authorize the Boston Child Study Center to charge the indicated credit/debit card. I agree that this is either a periodic or backup charge that will be processed as I 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 Boston Child Study Center, LLC.

Signature of Cardholder: ______________________________________ Date: _______________

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