Jonathan Brush Ph.D.

Licensed Psychologist

1419 Beacon Street
Suite 13
Brookline, MA 02446

617-277-4300
JBrush@JBrushPhD.com
www.JBrushPHD.com

Dear Parents,

I am glad you have chosen to work with me to help your child. In order to provide you with the most efficient and effective help, I need to collect some information, and I need to inform you about my practice. Over the years, I have found that the best way to do this is in advance of the first session, or online.

For your convenience, I have listed below the forms and surveys.

You can access the following printable forms at www.jbrushphd.com/Newchild/ , complete them as indicated at home, and bring them to your first session.

1. **Family Information**: This form is one page which asks who is in your family, including pets. If a family member is living outside the home, for example in college or boarding school, please include that individual.
2. **Client Information, Privacy and Financial Disclosure**: This is a multiple page document which describes my responsibilities regarding protected health information, as well as my practice policies.
3. **Children's History**: This packet has four pages, and asks for information about your family's history, including children's health, stressful life events, and previous counseling experience. The reason this is important is so that I can understand your child's life experience in all these areas.
4. **Fee Schedule**: This is my current schedule of charges, including those not covered by insurance. This schedule will change from time to time, depending on the cost of doing business.

I will give you information about these checklists at the first session:

5. **Behavioral Checklists:** These are detailed checklists about behavior and emotional states which are completed at a secure online site. Checklists are completed by parents, teachers, and others who know your child well. Children over the age of 11 are also asked to complete a checklist. These forms have been scientifically developed and allow me to gain an understanding of your child's functioning and behavior in multiple settings.

Thanks in advance for your help. You can ask me any questions at the first session.

Sincerely,
Jonathan Brush PhD

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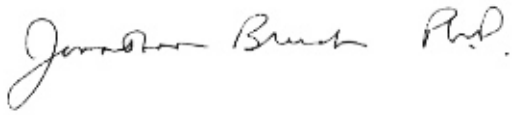
Dear Parents:

Attached is an intake form I would like you to complete. The information you provide will help me to help you, your family and your child. Please bring this form with you to your first appointment.

This form will be part of your child's confidential mental health record. It cannot be released to anyone without your written permission.

I trust that the information you provide will form the foundation of a productive working relationship around your current concerns and problems.

Thank you.



Jonathan Brush, PhD

Date: _ _-_ _-_ _ _ _

Patient Name: _____ DOB_ _/_ _/_ _ _ _ _

Mother's Name: _____

Address : _____

_____ **Phone No.: (_ _ _) -_ _ _ - _ _ _ _**

_____ **DOB_ _/_ _/_ _ _ _ _**

Marital Status: ___ **Single** ___ **Married** ____ **Divorced** ___ **Separated** ___ **Widow** ___

Father's Name: _____ Phone No.: (_ _ _) -_ _ _ - _ _ _ _

Address : _____

_____ **DOB_ _/_ _/_ _ _ _ _**

_____

Marital Status: ___ **Single** ___ **Married** ____ **Divorced** ___ **Separated** ___ **Widow** ___

Primary Care Doctor: _____ Phone No.: (_ _ _) -_ _ _ - _ _ _ _

School Name: _____

Grade : _____ School Phone #: .: (_ _ _)-_ _ _ - _ _

Teacher's Name: _____

Childrens' History Form

Please answer the following questions for each child in your family even though you may be contacting us with concerns regarding one particular child. Write the name of each child at the top of a column below. Put a check in the box to answer "YES". Leave it blank if the answer is "NO".

Example:				
Children's Names:	Joey	Anna	Max	Paul
Did baby have colic?		✓		
Children's Names:				
I. Is your child adopted?				
II. During pregnancy did mother:				
1. Have any medical problems?				
2. Use medication?				
3. Use alcohol?				
4. Take drugs?				
5. Smoke cigarettes?				
III. Delivery:				
1. Was baby born premature?				
2. Was labor difficult?				
3. Was baby bom by C-Section?				
4. Was baby jaundiced?				
5. Did baby leave hospital with mother?				
6. Was baby in intensive care?				
7. What was approximate birth weight?				
IV. Infancy and Childhood:				
1. Did baby have colic?				
2. Were there feeding problems, etc?				
3. Could you comfort baby?				
4. Did baby have constipation?				
5. Did child do things such as crawling, walking, talking, etc on time?				
6. Was child overactive?				
7. Did child speak simple sentences by age 2?				
8. Was child toilet trained by age 3?				
9. Was toilet training difficult?				
10. Did child tie shoes by age 6?				

Children's Names (again):				
V. Medical History:				
1. Did child ever have tubes in ears?				
2. Has child ever had hearing problems?				
3. Has child ever had seizures?				
4. Has child ever had chronic headaches?				
5. Has child ever had a head injury?				
6. Does child have any neurological disease?				
7. Is child on any medication?				
8. Has child had any operations?				
9. Has child had a medical hospitalization?				
10. Has child had a psychiatric hospitalization?				
11. Does child have any allergies to food or drugs?				
12. Has child ever had broken bones, fractures, etc., due to an accident, fall?				
VI. Behavioral/Emotional Checklist:				
1. Is child overactive?				
2. Does child have difficulty paying attention?				
3. Has child ever had temper tantrums?				
4. Has child ever been accident prone?				
5. Is child sad or depressed?				
6. Does child have difficulty making friends?				
7. Does child get easily frustrated?				
8. Has child ever had problem with bedwetting?				
9. Has child ever had a problem with bowel control?				
10. Has child ever been sexually molested?				
11. Has child engaged in unusual sex play?				
12. Has child been physically abused?				
13. Has child ever had a problem with lying?				
14. Has child had problem with stealing?				
15. Has child ever made a suicide attempt?				
16. Does child have eating problems such as bulimia or anorexia?				
17. Has child ever had phobias or unusual fears?				

Children's Names (again):				
VII. School/Learning:				
1. Is child mentally retarded?				
2. Has child had a CORE evaluation?				
3. Did child have difficulty learning to read?				
4. Has child had difficulty with hand-writing?				
5. Does child have short attention span?				
6. Does child frustrate easily when doing schoolwork?				
7. Did child have trouble separating from parents when starting school?				
8. Has child ever repeated a grade?				
9. Does child have learning disabilities?				

Briefly describe what concern/problem brings you here now: _____

_____

_____

What have you tried already to help solve this problem? _____

_____

What do you think may help now? _____

_____

Has your child, or anyone in the family, had previous counseling? When and where?

_____

Have there been any major losses or changes in the family in the past 3 years (job losses, separation or divorce, moves, deaths, etc.? _____

_____

_____

Are there any other significant problems the family has been dealing with? _____

_____

_____

Please check if there is any family history of the following (this applies to parents, grandparents, aunts, uncles, etc.). Please note beside each item checked, **all** family members who have had that difficulty.

___ Attention Deficit Disorder

___ learning disabilities

___ seizures

___ eating disorders (anorexia, bulimia)

___ survivor of child sexual abuse

___ survivor of child physical abuse

___ anxiety attacks or phobias

___ Tourettes Syndrome or Tic Disorder

___ depression

___ suicide

___ Bipolar Disorder (manic depressive illness)

___ schizophrenia

___ psychiatric hospitalization

___ alcohol abuse

___ drug abuse

___ problems with the law

___ gambling

___ Obsessive Compulsive Disorder

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Date_ _ /_ _ /_ _ _ _

Family Information

Name _____ **DOB**_ _/_ _/_ _ _ _ **Gender M F**

Address _____ **Home Phone #** ( ) _ _ _ - _ _ _ _

_____ **Work Phone #** ( ) _ _ _ - _ _ _ _

Mobile Phone # ( ) _ _ _ - _ _ _ _

Legal Guardian/Custody, if Child _____

Emergency Contact and Phone # _____

Referred by: _____

Marital Status: S M D W Other please specify _____

Family Member's Name	DOB	Relationship to patient
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
Others Living in Household		
	/ /	
	/ /	
Pets		
	/ /	
	/ /	

Physician: _____

Date of last physical exam: _ _/_ _/_ _ _ _

Significant Medical History/Medications both prescribed and over the counter:

_____

_____

_____

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CLIENT INFORMATION AND FINANCIAL AGREEMENT

Please read carefully and sign this agreement. I will provide a copy to you at your request. Feel free to discuss it with me if you have any questions or concerns.

APPOINTMENTS:
Standard appointments are 45 minute long. Extended sessions and telephone appointments are available by prior agreement; these are **NOT** covered by insurance and are billed at my hourly rate.

TELEPHONE CALLS and E-MAIL:
I may be reached and messages left at the number above. I make every effort to return messages within a few hours or at most on the same day. On rare occasions my voicemail may fail to record messages in full, so if I haven't returned a message within 24 hours, please call again. If you have a medical emergency requiring immediate attention, please seek help as directed by your medical insurance carrier or at your nearest emergency room.

Extended telephone calls (more than 5 minutes) will be billed at my hourly rate, but brief calls and appointment scheduling are not billed.

Email can be sent to **jbrush@jbrushphd.com**. I usually check my email daily, but urgent messages and appointment changes are best made through my telephone number. Since I cannot guarantee that email messages are secure, please do not include sensitive personal information in such communications.

CANCELLATIONS and MISSED APPOINTMENTS POLICY:
Hours set aside for you or your family are not easily filled when they are cancelled on short notice. Therefore, you will be billed for appointments cancelled with less than **24 business hours** notice. That is, if you are canceling a Monday or Tuesday appointment you must call by the end of the previous week to avoid a charge. This gives me a chance to schedule your hour with another client. The charge for late cancellations and missed appointments will be **$150.00.** Please note that **insurance does not cover these charges.**

Exceptions to policy:
If you cancel with less than 24 hours notice and are able to reschedule within the same week at another time I have available, you will not be billed for the late cancellation. Other exceptions include cancellations due to sudden illness of yourself or your immediate family member, hazardous driving conditions, or certain other emergencies. Appointments missed or cancelled late due to work or school obligations will be billed to you; therefore, please schedule your appointments when your other commitments will not interfere.

INSURANCE and FEE PAYMENT: I will do whatever I can to clarify insurance matters and to provide documentation to secure insurance payment, but it is your responsibility to understand your insurance coverage, including coverage and copayments, and to pay for non-covered services. Please make payments at the beginning of each session. If you would like a receipt for payment please let me know in advance. For insurance plans and managed care contracts that I do not affiliate with, I will provide you with an itemized bill that you can submit for any reimbursement due you. Adjustments to fees and deferred payment arrangements can be negotiated for reasons of financial need if discussed in advance. Balances unpaid beyond 30 days are subject to charges of 1.5% **per month.**

EXTENDED TREATMENT and INSURANCE:
In order for treatment to be covered by insurance it must be considered "medically necessary". Medically necessary care is defined as treatment for a condition which causes significant emotional distress and/or impaired functioning, and for which treatment is appropriate and judged effective. This may cause confusion for the client who believes that he or she is entitled to a certain number of sessions under an insurance plan, but whose condition does not meet the above criteria. Additionally, many clients experience a reduction in symptoms and improvement in functioning but wish to continue therapy. In fact, the benefits of therapy extend beyond that considered medically necessary, but insurance is not designed to cover such treatment. It is important for each client to understand what insurance will and will not cover, as well as the option to contract for services beyond those limits. Please feel free to discuss these matters with me as you see fit.

SCHOOL VISITS and OTHER SERVICES:
School visits are not covered by insurance and are billed at my hourly rate. Extended clinical reports, court testimony, and other consultations are also not covered by insurance and are billed to the client, including travel time and waiting time.

AUTHORIZATION FOR BILLING and FINANCIAL AGREEMENT:
I hereby authorize Dr. Jonathan Brush to bill my medical insurance carrier, or other third party specifically designated by me, for services rendered, and I give permission to Dr. Brush to provide the diagnosis, type of service, and dates of service which are required to obtain payment from insurance providers and their reviewers. Any additional clinical information required for peer review or for extended benefits, will be released only after review by me, and under a separate release signed by me. If you do not wish for information to be disclosed to an insurance company or other party, you may choose to contract for services on a self-pay basis.

I also agree to assume full financial responsibility for all fees not covered by my medical insurance carrier or other third party. I understand that I will be charged directly at the prevailing hourly rate for all appointments cancelled with less than 24 business hours notice, and for appointments not kept, as well as for extended telephone calls and treatment not authorized and covered by insurance.

Rates of service vary depending on specific services rendered, and are adjusted from time to time due to inflation and other costs of doing business. See separate Fee Schedule.

Insurance Provider Behavior Health Information

Client Name: _____

Medical Insurance Carrier:

_____

Insurance Carrier Contact Info for Behavioral Health Coverage

Phone #: (_ _ _) _ _ _- _ _ _ _ _

Address:

_____

_____

_____

Employer:

_____

Plan Name:

_____

Policy #:_____

Cardholder Name:

_____

Cardholder SSN: _ _ _ - _ _ - _ _ _ _

Phone #: (_ _ _) _ _ _- _ _ _ _ _

Date Insurance Effective: _ _/_ _/_ _ _ _

Type of Policy: Individual Family (circle one)

Client Name _____

_____ _____

Date **Signature of client, parent, or authorized person.**

Witness Name _____

_____ _____

Date **Witness Signature**

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Authorization to Release Information

Name_____ **Date of Birth** _ _ / _ _ / _ _ _

Address_____

_____

_____

I, _____, hereby authorize the exchange of information between:

And

_____ Jonathan Brush PhD

_____ 1419 Beacon Street, Suite 13

_____ Brookline, MA 02446

_____

I understand why the Information is needed and I am satisfied that the material will be considered confidential.

Portion of record to be released:

___ Medical Record

___ Psychological Test Report

___ School Record

___ Summary of contact with individual or family

___ Other (specify) _____

_____ _____

Date Signature

Witnessed:

_____ _____

Date Signature

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Fee Schedule

Initial Appointment (45-50 min):	$180.00
Follow-up Session (45-50 min):	$150.00
Extended Session:	$ 45.00 per 15 minutes or fraction thereof
Group Therapy (90 min)	$ 60.00
Family Therapy (90 min)	$250.00
Psychological Testing:	$150.00/hr, including report preparation
Extended Treatment Reports:	$150.00/hr
Telephone Consultation:	$ 45.00 per 15 minutes or fraction
School Visits, Court Appearances:	$180.00 per hour including travel and waiting time.
Missed Session/Late Cancellation:	$150.00

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully, then PRINT and SIGN at the bottom and BRING to your first appointment.

Protecting patient privacy is an important element of the trust between my practice and my patients, and an important legal and ethical obligation. I am deeply committed to protecting my patients' rights to privacy, and to safeguarding patient information.

Note regarding Minor Children: If the person under treatment is a minor child, this notice should be understood as applying to that child's Protected Health Information. In the case of an adolescent minor, I shall inform him or her of the information included in this Notice, if in my judgment this is developmentally appropriate.

My Responsibilities:

My practice is required to maintain the privacy of your Protected Health Information ("Health Information"). This includes medical information about you that is collected during the course of your treatment, such as your symptoms, examination and test results, diagnoses, treatment, and a plan for future care. Information about care that you have received from other providers may also be included in your medical record. Health Information also includes demographic information and payment information.

I am required by law to provide you with this Notice of Privacy Practices. This Notice describes how I use your Health Information within my practice, and disclose ("share") it with others. My practice must abide by the terms of the Notice currently in effect. I reserve the right to change the terms of my Notice and to make the new Notice provisions effective for all Health Information that it maintains. I will post my current Notice on my website: jbrushphd.com.

I. Uses and Disclosures of your Health Information:

The following are examples of the types of uses and disclosures of your Health Information that my practice is legally permitted to make.

A. **Uses and Disclosures of Health Information for Treatment. Payment and Operations**

Your Health Information may be used for your care and treatment. Your Health Information may also be used and disclosed as necessary for me to obtain reimbursement for care provided to you, and to support the operation of my practice.

1. **Treatment:** I may use your Health Information to provide and manage your health care. If I refer you for treatment - for example to another clinician or hospital - I will provide that health care provider with the necessary information to diagnose or treat you. In addition, I will ask your permission to share your Health

Information with other health care providers who care for you, or who may consult with us about your care. I believe this is critical to provide you the very best in health care and is necessary given the complexities of various illnesses and health conditions.

2. **Payment:** I may use and disclose your Health Information, as needed, to obtain payment for health care services. I may disclose information to your insurance company or third party payer in order to make sure your treatment is authorized, to verify eligibility or coverage for insurance benefits, and to permit the payer to review services provided to you for medical necessity.

3. **Healthcare Operations:** My practice may use or disclose your Health Information in order to conduct its business of providing health care. For example, if your insurance company requires information about your symptoms and/or functioning, in order to verify that services I provide are medically necessary and thus are covered by insurance, I will share only what information is necessary for this determination.

B. **Other Permitted and Required Uses and Disclosures of Your Health Information:**

In addition to treatment, payment and healthcare operations, there are other circumstances in which I am either permitted or required to disclose your Health Information, in accordance with applicable law.

1. **Involvement of Others in Your Health Care:** I will make an effort to ask you if I may share relevant Health Information about you with family members or any other person you identify. If you are not present, unable to communicate, or in an emergency situation, I may exercise my professional judgment to determine whether to share this information. In addition, I may need to disclose Health Information to notify a family member or any other person responsible for your care of your location, general condition or death. Finally, I may disclose your Health Information to an authorized public or private entity to assist in disaster relief efforts, and to coordinate efforts to notify someone on your behalf. Please be assured I will only do so if absolutely necessary and in the event of an emergency or disaster.

2. **Public Health:** I may disclose your Health Information for public health activities, including the following:
   - to report Health Information (e.g., infectious diseases, such as chickenpox) to prevent or control disease, injury, or disability
   - **to** report births and deaths
   - **to** report reactions to medications or problems with products
   - to notify a person who may have been exposed to a communicable disease, or may be at risk for contracting or spreading the disease

3. **Victims of Abuse. Neglect or Domestic Violence:** If I reasonably believe you are a victim of abuse, neglect or domestic violence. I may disclose your Health Information to an appropriate agency authorized by law to receive such reports.

4. **Legal Proceedings:** I may be required to disclose Health Information in the course of any judicial or administrative proceeding in response to a legal order or other lawful process, including a subpoena.

5. **Law Enforcement:** I may be required to disclose Health Information for law enforcement purposes.

6. **Coroners. Funeral Directors and Organ Donation:** I may be required to disclose Health Information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. I may also disclose Health Information to a funeral director or their designee, as necessary to carry out their duties. Health Information may also be disclosed to organizations that facilitate organ, eye or tissue donation and transplantation.

7. **To avert a serious threat to health or safety:** I may be required to use and disclose Health Information to prevent or lessen a serious threat to a person's or the public's health or safety. If I believe that there is a credible threat of harm to an identifiable person, I am obligated to take action to safeguard that person, including notifying the appropriate law enforcement authorities.

8. **Specialized Government Functions:** Under certain circumstances, I may be required to disclose Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State.

9. **Required By Law:** I may be required to use or disclose your Health Information to the extent that the use or disclosure is required by federal, state or local law. This includes any other law not already referred to in the preceding categories. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

10. **If I am unable to continue my practice:** In the unlikely event that I am incapacitated or otherwise unable to continue my practice, I have arranged for a competent and experienced colleague to provide interim consultation or other care to my patients. In order to provide this necessary care, my colleague will be provided access to your clinical and billing records. It is your right, of course, to select a clinician of your own choice, to continue your treatment.

C. Uses and Disclosures of Health Information Based upon Your Written Authorization

Uses and disclosures of your Health Information, other than those described above, will be made only with your written authorization.

In addition, federal and Massachusetts laws require that I obtain your specific written authorization for the use or disclosure of certain information about you. This information includes psychotherapy "process notes" as defined by federal law; communications with certain behavioral health professionals; communications between domestic violence victims and domestic violence counselors, and between sexual assault victims and sexual assault counselors; and information related to substance abuse treatment, HIV testing or test results, treatment of sexually transmitted diseases, and genetic testing or test results.

II. Your Individual Rights

Although your medical record at my practice is my property, health information contained therein belongs to you. The following is a statement of your rights with respect to your Health Information, and a brief description of how you may exercise these rights.

A. **You have the right to inspect and copy your Health Information.** At any time, you may inspect and obtain a copy of Health Information about you, including your medical and billing record, which may be used to make decisions about your care. Under limited circumstances I may limit your access to all or certain portions of your record. This includes, but is not limited to, psychotherapy "process" notes, or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. If you are denied access to portions of your record, in some circumstances you may have a right to have this decision reviewed. All requests to access your record must be made in writing to me, and will be processed within 30 days. If you request a copy of your records, I may charge you a fee to cover the copying and mailing costs.

B. **You have the right to request an amendment of your Health Information.** You may request me to amend your treatment and billing information if you think the information is incorrect or incomplete, for as long as I maintain the information.

C. **You have the right to request a restriction of your Health Information.** You have the right to ask in writing for restrictions on the use and sharing of your health information for treatment or payment. If this information is needed for insurance payment, you will be liable for any charges you incur. Despite the preceding, if you need to be treated in an emergency, I may be required to share information needed for your care. You may not ask me to restrict uses and sharing of information that I am legally required to make. All requests must be in writing to my office.

D. **You have the right to receive an accounting of certain disclosures I have made, if any, of your Health Information.** This right applies to disclosures for purposes other than treatment, payment or healthcare

operations as described in this Notice. It does not apply to disclosures I may have made to you, that were authorized by you, information provided to family members or friends about your care, or for notification purposes. You have the right to receive specific information regarding disclosures made by me that occurred after April 14, 2003. You can request an accounting of disclosures for a period up to six years, but only for disclosures made after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. Requests must be made in writing to me, and I will respond to your request within 60 days.

E. **You have the right to obtain a paper copy of this notice.** I will provide a paper copy of this Notice to you, upon request.

III. Effective Date: This Notice is effective on April 14, 2003.

IV. Complaint Process:

If you believe I have violated your privacy rights, please communicate your concerns to me at the earliest possible date. I will not retaliate against you if you file a complaint about my privacy practices, nor will it affect your rights or status as a patient with me. I will make every effort to respond to your concerns immediately and .professionally.

Please contact me if you have questions or concerns about this policy.

I _______________________________________ (print your name here)

have read this Notice of Privacy Practices.

____

Signature

Date _____________