Boston Child Study Center
LOS ANGELES
Expert Mental Health Treatment, Training & Research

APPLICATION CHECKLIST

Please read, complete, and sign the following documents prior to your initial consultation. Please return these documents by email to bcscla@BostonChildStudyCenter.com or by fax to 866.496.3029.

COMPLETE Application For Services (Pages 2-7)

READ Description of Services (Pages 8-9)

READ Practice Policies (Page 9)

READ Statement Regarding Confidentiality (Page 12)

SIGN Consent for Services (Page 13)

SIGN Authorization for Release of Information (Page 14)

SIGN Payment Agreement and Credit Card Authorization Form (Page15)

SIGN Telehealth Consent Form (Page 16)

11400 West Olympic Boulevard : Suite 200 : Los Angeles, California 90064
www.BostonChildStudyCenterLosAngeles.com
(888) 225-1995

APPLICATION FOR SERVICES

Today's Date:____________

PATIENT INFORMATION:

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

Gender Identity/ Preferred Pronouns: ____

Patient Phone: ____________________ Patient Email: ____

Home Street Address:__________________________________City:________________________Zip:_____________

Current School:____Grade:_________________________________

PARENT/GUARDIAN INFORMATION (IF APPLICABLE):

Parent 1 Name:____________________Profession:__________ Phone: _______________ Type: _________________

Email Address: ____May we contact you over email?__________

Home Address (if different from patient):______________________________City:__________________Zip:__________

Parent 2 Name:____________________Profession:__________ Phone: _______________ Type: _________________

Email Address:____May we contact you over email?

Home Address (if different from patient):______________________________City:__________________Zip:__________

Parents' marital status:______________If separated, are legal proceedings in process or anticipated:________________

Siblings and ages:____

Additional family members/individuals living in the home: ____

If parents are not married please describe the current legal and physical custody status: __________________________

How were you referred to Boston Child Study Center-Los Angeles?____

PRESENTING CONCERNS:

Please describe the nature of the problem(s) for which you are seeking services:

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

____

____

____

EDUCATIONAL HISTORY:

Previous Schools Attended:

Name:	Grade(s) Attended	Dates Attended:

Please provide any past neuropsychological testing reports along with this application.

Please indicate any history of educational testing/evaluation or tutoring:

Type of evaluation/tutoring:	Reason for testing/tutoring:	Dates:	Outcomes/ Recommendations:

Does the patient have an IEP or 504?___________Other school-related concerns___________________________________

____

DEVELOPMENTAL HISTORY (please attach additional pages if needed):

Was the patient exposed to antibiotics, medications, alcohol, drugs, or tobacco during pregnancy?

If yes, please indicate: ____

____

Was the pregnancy full term?

If not, please explain: ____

____

Were there any complications during pregnancy? (e.g. fetal distress, emergency C-section, pre-eclampsia, nuchal cord)?

If yes, please indicate: ____

____

Were any special services required at the time of the patient's birth (e.g. lights for jaundice, ICU care)?

If yes, please indicate:____

____

DEVELOPMENTAL HISTORY continued:

Were there any concerns/delays in feeding, sleeping, walking, talking or motor skills?

If yes, please indicate:____

____

Did the patient participate in Early Intervention Services?

If yes, please indicate dates and reason:____

____

Please describe the patient's social functioning as a toddler:____

____

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

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

____

____

____

____

Please describe any current concerns about the patient's ability to socialize/get along with peers, adults, & family members: ____

____

____

PATIENT MEDICAL HISTORY (please list all diagnoses and attach additional pages if needed):

Current:____

____

Past:____

____

PATIENT MENTAL HEALTH HISTORY (please list all diagnoses and attach additional pages if needed):

Current:____

____

Past:____

____

Has the patient been hospitalized in the past for mental health reasons?

If yes, please indicate:

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

Has the patient received other psychological services for these or other problems?

If yes, please indicate:

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

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

____

____

Does the patient have a history of self-injury? If yes, please describe: ___________________

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

Does the patient have a history of substance abuse? If yes, please describe: ___________________

Does the patient have a history of eating disordered behaviors? If yes, please describe:

PAST & CURRENT MEDICATIONS:

Medication:	Dosage:	Symptom treated:	Response:	Name of Prescriber:

FAMILY MEDICAL HISTORY:

Are there any biological family members with medical conditions (e.g. cardiac disease, diabetes, cancer, etc.)?

If yes, please describe:

Relationship to Patient:	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)?

If yes, please describe:

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

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This application will be reviewed by the clinical team at the Boston Child Study Center-Los Angeles to ascertain whether our practice is the best treatment match for your needs. You will be contacted within 7-10 business days regarding the disposition. Please call 888.225.1995 or email bcscla@bostonchildstudycenter.com with any questions about our services or the completion of this form.

DESCRIPTION OF SERVICES

Boston Child Study Center-Los Angeles (BCSC-LA) specializes in evidence-based treatment for anxiety, behavioral, and mood disorders in children, adolescents and young adults (ages 2-29). 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. Boston Child Study Center-Los Angeles does not discriminate against any individual on the basis of race, color, ethnicity, religion, sex, age, national origin, sexual orientation, or socioeconomic status.

Initially, the patient will meet for an initial consultation, which may take place over one or more visits depending on the patient's needs, presenting issues, and the clinical judgment of the clinical team. This consultation will help determine the nature of the patient's symptoms, concerns, and difficulties and whether services offered by BCSC-LA are appropriate for your and/or your family's needs. This initial appointment typically consists of meeting with a provider who specializes in your particular 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 assess the patient'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 the patient has a current treatment provider, your therapist may ask for written consent to speak with that person if it is likely to help in making assessment or treatment decisions for the patient's care.

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 the patient's needs. If you are offered services through BCSC-LA, we will describe what will be required of you, what you can expect in treatment, and address any concerns or questions you may have. If you accept and consent to treatment, 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 the therapist's 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. Boston Child Study Center-Los Angeles encourages you to bring up any questions or concerns during the treatment process, as many issues can be effectively problem-solved together. You are free to withdraw from treatment at any time.

As a condition of receiving services at Boston Child Study Center-Los Angeles, your personal information will be stored confidentially using HIPAA compliant electronic medical record software. These databases may be also used for de-identified retrospective research. Staff at BCSC-LA are committed to developing and advancing effective educational and intervention procedures for children and families, and, where appropriate, reporting these findings to the professional community. We occasionally use data contained in a client's file for archival research, quality assurance checks, and program development. This research is done in such a way that the identity of our clients cannot be identified or linked to the data used. If the data are used, it will be de-identified to protect your anonymity and to keep your personal records confidential. Information that may be used for research purposes may include details such as your age, diagnosis, de-identified background information (e.g., developmental history, history of presenting concern), detailed course of

treatment, and data collected through observation or questionnaires throughout the treatment process.

Boston Child Study Center-Los Angeles is an evidence-based, fee-for-service, treatment, training and research center comprised of clinical social workers, psychologists, neuropsychologists, mental health counselors, supervised clinical psychology trainees and clinical social work interns and trained support para-professionals. Typically, patients initially meet with a therapist who specializes in the area of concern for an initial consultation to determine a preliminary diagnosis, identify underlying causes of symptoms presented, determine the appropriate level of care, and identify the best treatment team/program for you. 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.

PRACTICE POLICIES

FEES AND BILLING

Our service rates are “fee-for-service” as we do not accept insurance. We offer a sliding scale fee structure which is granted based on financial need. To apply for a sliding scale fee, please complete the Sliding Scale Application and submit the two most recent tax returns. After review of these documents, we will propose a reduced fee based on an algorithm. We also provide “insurance-friendly” statements that include many of the service codes and information many insurance companies require for you to submit “out-of-network” reimbursement requests. *Please be familiar with your insurance coverage. We do not guarantee that any portion of the fees will be reimbursed by your insurance provider.*

Families are financially responsible for all services provided by BCSC staff and trainees regardless of the reason for a denial of reimbursement. Academic and didactic tutoring, and learning-based services that may augment your child's overall treatment plan are not eligible for reimbursement by insurance companies. These types of non-reimbursable services will appear with a 00000 CPT code. While we try to provide your family with the information needed or requested by many insurance companies, we do not work with or bill directly to 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.

Time spent for extended telephone and email communication, completion of outside paperwork (paperwork requested from your insurance company, school, etc.), travel, and video-conferencing consultation are billed at your standard therapy services rate and are not reimbursable by your insurance company.

Payments are processed at the end of each month for the balance on your account and can be payable by check, credit or debit card, 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 on a recurrent basis, or as a backup method payment for late or outstanding invoices. Financial information is stored and processed using PCI-compliant software. 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 without additional notice. The monthly billing period ends on the last day of each month. At the end of each billing cycle, you will receive a statement/receipt via email, unless you specify a preference for another means of receiving statements. This statement will serve as your receipt of payment and will include billing/clinical codes typically required for out-of-network reimbursement through your insurance company. You may request a statement citing services rendered and/or the balance on your account prior to the end of the month by emailing Wendi Jo Conley at wendi@bostonchildstudycenter.com.

MISSED APPOINTMENT POLICY

Missed appointments or cancellations made less than 24 hours in advance are billed at your standard treatment rate. Exceptions can be made for declared weather emergencies or *documented* medical illness. A weather emergency qualifies if the school district in which you reside is closed due to weather conditions on the day of your appointment.

GROUP POLICIES

New members are admitted to groups on a rolling basis based on availability. An intake session is required prior to your beginning group, in order to establish commitment and goals for group participation. Patients must agree to inform their group leader of any changes in their treatment team. Attendance policies and other group requirements may differ based on the specific group and will be communicated to you prior to starting in any group. Missed appointments or cancellations are the same as our BCSC-LA's practice policy (see above).

DBT SKILLS TRAINING GROUP provides DBT skills training for adolescents and young adults in the four basic modules of Dialectical Behavioral Therapy: *Mindfulness, Distress Tolerance, Emotion Regulation,* and *Interpersonal Effectiveness*, along with the new additional fifth skills module developed specifically for adolescents known as Walking the Middle Path. Each module is taught in a four-to-six-week curriculum, with a total of 24 weeks (6 months) to complete training in all five modules. This group takes a didactic approach with a focus on skills acquisition and strengthening.

Skills knowledge and practice is reinforced through in-session skills practice and weekly homework practice assignments. DBT Skills Training Group requires a 24-week commitment. Missing 4 consecutive groups will require an individual session to learn the missed group content and to reestablish commitment prior to returning to group.

DBT SKILLS INTEGRATION GROUP welcomes adolescents and young adults who have a solid foundational knowledge of the four basic modules of Dialectical Behavioral Therapy Skills (Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness) who seek a forum in which to reinforce, problem solve, and discuss the application of these skills to support their individual DBT Treatment. This agenda-based group focuses on group members' practice and integration of DBT skills in the relevant contexts of home, school, vocation, social relationships, and community.

The group structure includes a combination of peer skills-coaching, problem solving, and reinforcement of DBT skills practice. A smaller portion of the group will be focused on didactics, and review of DBT skills.

It is strongly recommended that clients are engaged in individual therapy with a trained DBT therapist when participating in this group. DBT Skills Integration Group requires a 16-week commitment. Missing 3 consecutive groups will require an individual session to re-establish commitment prior to returning to group.

PARENT DBT/CBT SKILLS TRAINING GROUP & SKILLS INTEGRATION GROUP offer parents an opportunity to receive training in all 5 modules of the DBT Skills curriculum, with a focus on skills particularly relevant for parents, as well as to continue to integrate DBT skills after acquiring DBT Skills. Both groups 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.

SAMPLE STANDARD PATIENT FEES:

Initial Consultation: $15 - $900
Group Intake/Orientation: $15 - $250
Group Therapy: $15 - $125
Individual/Family CBT: $15 - $250
Individual/Family DBT: $15 - $450
Exposure Coaching: $15 - $300
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
Senior clinician consultation/service rate: $15 - $450
Travel fee: $25 for every 15 minutes of clinician travel time, regardless of distance

EMERGENCIES

Boston Child Study Center-Los Angeles clinical hours of practice are typically 10 am-7 pm, Monday through Thursday, and 10 am-6 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. Please use email only for scheduling and administrative communications. Email is not a secure mode of communication, so please refrain from using email to communicate clinical or personal information. Please also refrain from using email, text, or voicemail in emergencies. BCSC-LA staff have limited availability to respond in crisis situations (i.e., while in session, overnight, weekends, holidays, etc.) and for these reasons 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 please call 911, or go to your local emergency room. Upon arrival to the emergency room, you can call your therapist to provide an update on the status of your emergency care (name of the hospital, name of provider at hospital, number where you can be reached) and we will, with your written or verbal consent, and at our earliest availability, get in touch with you and/or your provider. If you or your therapist believe that your 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/she will help you find a more suitable site to provide your care.

STATEMENT REGARDING CONFIDENTIALITY

All clinical records are kept in a secure electronic medical record or secure filing cabinet. The information you provide during the course of patient treatment and evaluation is confidential and will not be revealed outside of Boston Child Study Center-Los Angeles without your written permission, with the exception of the following circumstances:

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 you or another child, elder, or disabled person is being abused or neglected, or if you have any information regarding such abuse or neglect, your therapist is required by law to notify the appropriate child or adult protective state agency.
3. If your therapist has reason to believe that you are at risk of making a serious and/or imminent attempt to hurt or kill yourself or someone else, we are required by law to notify related emergency personnel, law enforcement, and the intended victim(s). In such cases we may be required to complete paperwork to initiate involuntary hospitalization.
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 Boston Child Study Center-Los Angeles or its staff.
6. If you authorize the release of information pertaining to your treatment by signing an Authorization for 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 the adolescent evidencing imminent risk of harm to self or others, or a pattern of behavior that may potentially lead to imminent risk or harm to self or others.

CONSENT TO TREATMENT

By providing consent to treatment, I am indicating my understanding that the purposes of the initial consultation are to assess my current difficulties, to help determine the most effective treatment plan for addressing my mental health needs, and does not ensure that I will necessarily be assigned to work with a specific staff member of the Boston Child Study Center-Los Angeles. I understand that Boston Child Study Center- Los Angeles does not guarantee that my insurance provider will reimburse me for the services rendered, and that I will be given referrals if it is determined that Boston Child Study Center-Los Angeles 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, or Lin-Ann Ching about them at any time.

By signing this statement I am indicating that: 1) I have read the following forms in their entirety: Description of Services, Practice Policies and Statement Regarding Confidentiality 2) I have had any questions or concerns regarding this form satisfactorily addressed by the Boston Child Study Center-Los Angeles staff, 3) I fully understand all information contained therein, and 4) I freely agree to participate in the services offered:

Patient Name or Parent/Guardian of Minor	Signature of Patient or Parent/Guardian of Minor	Date
Clinician Name	Signature of Clinician	Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________ (Name of Client name or Parent/Legal Guardian of minor under 18), hereby authorize Boston Child Study Center-Los Angeles staff to release information to and request/receive information from:

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 Boston Child Study Center-Los Angeles 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-Los Angeles in compliance with this authorization before receipt of my written, hard-copy, revocation. You may accept photocopies or facsimiles of this authorization.

______________________________ ____________ ______________________

Signature of Patient or Parent/Guardian of minor   Date   Relationship to Child

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PAYMENT AGREEMENT AND CREDIT CARD AUTHORIZATION

Boston Child Study Center-Los Angeles accepts payment by credit card and debit card. All clients are required to provide credit or debit card information that will be kept securely on file to be used for automatic recurrent billing, according to the policies below.

By signing below, I agree to authorize my credit or debit card to be kept securely on file, and authorize my credit or debit card to be automatically processed for the total amount due on my account at the end of each monthly billing cycle, which falls on the last day of each calendar month. I acknowledge that I understand that I will receive a statement and receipt documenting the services provided and fees charged.

By signing below, I acknowledge that I understand that if I prefer not to have my credit card automatically processed at the end of the monthly billing cycle, that I must submit payment by check prior to or on the last day of the monthly billing cycle. Checks should be made payable to: Boston Child Study Center-Los Angeles, and mailed to 11400 West Olympic Boulevard, Suite 200, Los Angeles, CA 90064.

I also agree to provide updated credit card information to Boston Child Study Center-Los Angeles in the event my credit card on file becomes inactive, expired, or otherwise unauthorized for use. I understand that I may change my method of payment at any time by re-submitting this form to Wendi Jo Conley at wendi@BostonChildStudyCenter.com.

______________________________ ______________________________ ________

Name of Patient or Parent/Guardian of minor   Signature of Patient or Parent/Guardian   Date

Please complete the below field below with your credit card, debit card, or flex spending debit card information:

Card Type:____________________ Cardholder's full name (as it appears on your card): _________________________

Card Number:____Expiration Date:__________

Security Code: _________ Billing Address:____

City:_________________________ Zip:__________

Billing Phone: (________)_______-___________ Email to send statement/receipt: __________________________

By signing below, I hereby authorize the Boston Child Study Center-Los Angeles to charge the above credit card as I indicated above. I understand that I must cancel recurrent billing process 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-Los Angeles.

Signature of Cardholder:____Date: ________________________

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TELE-HEALTH CONSENT FORM

I ___________________________________am electing to receive remote services, through the aid of web conferencing. I understand that web conferencing is a relatively new and increasingly utilized format with which to deliver evidence-based treatments in clinical psychology. I understand that I am free to decline participation in web conferencing as part of my treatment, and that this will not affect my ability to receive in-clinic care with my therapist, or for my therapist to work with me to identify clinic-based providers in my area.

I understand that, as in any online communication, there is a risk of loss of confidentiality. However, the web conferencing platform being used for my care (Zoom) is HIPAA compliant and uses advanced data encryption technology to minimize the chance of loss of confidentiality. In addition to using a secure web conferencing platform, I understand that my therapist will only conduct sessions from a password-protected network, and that I have been encouraged to do the same.

DOCUMENTATION OF CONSENT

“I have read the above information. I have had the opportunity to discuss it and to ask questions, and I am authorizing the release of my records and clinical material to me via Zoom. I have been informed that I may contact my therapist or one of the Directors of the Boston Child Study Center at any time to answer any questions I may have about the use of web conferencing for the delivery of my care.”

________________________________	___/___/___	______________________________
Signature of Patient or Legal Guardian (if patient is under 18)	Date	Name of Patient or Legal Guardian
________________________________	___/___/___	______________________________
Signature of Clinician Obtaining Consent	Date	Name of Clinician Obtaining Consent

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