Janet R. O’Donnell, PsyD – Child Psychologist – #38958

104 Maverick Street, Aledo Texas 76008

Office: 425-419-4993 / Fax: 817-476-4090

[www.childpsychservices.org](http://www.childpsychservices.org) // drjanet@childpsychservices.org

**CLIENT REGISTRATION**

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (MI) (Nickname)

Gender: M / F Age: \_\_\_\_\_ Grade Level: \_\_\_\_\_\_

**Parent/Guardian Information**

**Father’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mother’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are parents- Married\_\_\_ \_\_\_\_Separated Divorced Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parenting Plan:** Yes No Letter of Guardianship: Yes No Foster/Adopt Yes No

Guardian ad lidem: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Copies of any and all custody documents is required prior to a child receiving services; if custody requires both parents consent, this must be obtained prior to child receiving services)*

Please list other immediate family members, and other’s, who live in the home:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_ Lives in home: \_\_\_\_\_\_ Lives out of home: \_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_ Lives in home: \_\_\_\_\_\_ Lives out of home: \_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_ Lives in home: \_\_\_\_\_\_ Lives out of home: \_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_ Lives in home: \_\_\_\_\_\_ Lives out of home: \_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_ Lives in home: \_\_\_\_\_\_ Lives out of home: \_\_\_\_\_\_\_\_

**Home Address (if divorce, please list both locations of child’s homes)**

(Street/PO Box) (City) (State) (Zip)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mothers Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer/Occupation**  \_\_\_\_\_ **Job Title** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fathers Cell** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer/Occupation**  \_\_\_\_\_ **Job Title** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IN CASE OF EMERGENCY NOTIFY:**

NAME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO CLIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### FINANCIAL POLICIES AGREEMENT

**INSURANCE BILLING:** Child Psychological Services PLLC and Dr. Janet R. O’Donnell, is contracted with Blue Cross Blue Shield and Aetna. As a courtesy, we will bill client insurance companies provided the client has completed the necessary insurance information. We do not bill secondary insurance companies. It will be the client’s responsibility to seek reimbursement from a secondary insurance policy. In addition, for whatever reason, client’s insurance company does not pay for the services billed, the client shall be responsible for all unpaid portions of service provided. In the event the client’s insurance company denies the payment claim; payment arrangements may be requested. For non-contracted insurance plans (out of network), we require payment at the time of service and as a courtesy we will submit your claims to your insurance carrier. **The client is responsible for payment of deductibles, differences in reimbursements and cost of any services not reimbursed by insurance companies. Any necessary referrals must be on file prior to billing of insurance**.

Please submit a copy of your insurance card (front and back) via email to [drjanet@childpsychservices.org](mailto:drjanet@childpsychservices.org) prior to your intake visit to process your insurance verification. Please include your child’s name and date of birth. We will verify coverage and deductibles.

**FINANCIAL RESPONSIBILITY:** Full payment of services is expected at the time of service unless other contractual arrangements apply. We accept cash, debit/credit cards, and HSA Cards. All services rendered will be billed to you or to your contracted insurance plan. Co-payments or coinsurance percentages are due at the time of service if we are billing your insurance company. Payments for account balances are collected on Fridays of date of service, and a receipt will be emailed to you.

Monthly account statements are not sent out, as services are paid at time of service; however, for those with balances due (such as for psychological testing), a statement can be requested. All payments are due within 30 days of the billing date. Accounts over 60 days will be assessed a $15.00 fee, and all further sessions will require full payment at the time of service until the account is brought current. Accounts 90 days and over will occur a monthly fee of $25 until brought current. There will be a $30.00 fee for payments returned as non-sufficient or non-payable.

**Please note, if sessions are cancelled by you less than 24 hours prior to the scheduled session, you will be billed for that session in full scheduled fees. No fee will be incurred if the counselor or agency is required to cancel your session.**

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Guarantor Name: Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (MI)

Guarantor Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO BILL INSURANCE**

**I hereby give my consent for Child Psychological Services, PLLC to bill my insurance company for services rendered to me and my child by health care provider, Dr. Janet R. O’Donnell. I authorize my insurance company to pay medical benefits directly to Child Psychological Services, PLLC / Dr. Janet R. O’Donnell. I authorize, Child Psychological Services, PLLC to release necessary medical information to my insurance company and/or to their designated managed care company as is required by my insurance company to process my insurance claims. I understand that if I leave therapy with an unpaid balance, Child Psychological Services will make every effort to collect these debts. Any attorney fees or costs resulting from collection efforts will be an additional charge to my balance owing. I understand my obligations under this agreement, and fully agree to pay for my service at my established rate.**

**AGREED AND ACCEPTED:**

Guarantor Signature Date

Spouse / Parent / Guardian Signature Date

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**Client Information and Consent to Treatment Agreement**

*Thank you for choosing Child Psychological Services, PLLC. We are committed to giving you the best care possible. To acquaint you further with the procedures and policies, we are providing the following information.*

**APPOINTMENTS**: If you need to cancel an appointment, a minimum of 24 hours notice is required; otherwise, you are subject to full charge for the appointment. In the evenings and on weekends, you may leave a message on the voice mail, which will accurately record the date and time you placed the call. We will do our best to be punctual for your appointment unless there is an emergency. We ask that you be punctual as well. If you are late, for any reason, please call the office to inform us. This is necessary so we can see following patients at their scheduled times. ***Please note***: Insurance does not cover missed appointment charges.

**EMERGENCIES**: We do not provide 24/7 crisis counseling services. The number for the Suicide & Crisis Center of North Texas is (214) 828-1000 (24 hr services).

**CONFIDENTIALITY:** Your client records are the property of Child Psychological Services, PLLC and shall be treated as confidential according to state and federal law. No information about you is released from this agency to anyone without your written permission, except as required by law or court order. We are required by law to report suspected child abuse (regardless of when it occurred), and clear, concrete evidence of planned acts of violence.  **Exception: If you have requested your records be available to a third party, you will need to complete, sign and date an “Authorization to Release (Verbal/Written) Information” form that details information to be disclosed and provides a specific time frame for this to occur.**

**WRITTEN RECORDS:** Child Psychological Services, PLLC maintains written files about your service for seven (7) years, or till your child reaches age 21 years-old. You have the right to review your file and provide written documentation if you disagree with the contents which will be kept with the file. If so desired, please arrange such a review with Dr. Janet R. O’Donnell.

***I/We, the undersigned, certify that the information concerning my resources is correct. I have read and understand my rights and responsibilities as outlined in this document and other supplementary documents completed as addendum to this document. I do hereby request and consent to treatment for my child with Child Psychological Services PLLC, and Dr. Janet R. O’Donnell. I will participate in the development of a treatment plan that best addresses my child’s needs or situation. I also verify that I have received the required state disclosure information. I understand that nothing in this Patient Information and Consent to Treatment agreement shall be interpreted to limit or modify my rights and obligations under the State Required Disclosure Form. I understand I may stop services when I choose, with no obligation to continue if I so choose.***

Client Signature Date

Parent / Guardian Date

Parent / Guardian Date

Therapist Date

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**CONSUMER RIGHTS STATEMENT**

As a client or a prospective client of Child Psychological Services PLLC, you have the right to:

1. Be treated with respect, dignity, and privacy;
2. Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;
3. Be free of any sexual exploitation or harassment;
4. Develop a plan of care and services which meets your unique needs; and to refuse any proposed treatment;
5. Make an advance directive, stating your choices and preferences regarding your mental health treatment if you are unable to make informed decisions;
6. Confidentiality, as described in Chapters 611.002 of the Texas Health and Safety Code;
7. To be informed, and agree to, being recorded via audio or video:
8. Review your clinical record and be given an opportunity to make amendments or corrections, or document your disagreement;
9. You have the right to be informed in advance of all estimated charges being made, the costs of services provided, and limitations of length of services. You shall be provided a detailed statement of services rendered upon request by contacting;

Dr. Janet O’Donnell, [drjanet@childpsychservices.org](mailto:drjanet@childpsychservices.org).

1. You have the right to lodge a complaint if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. You may contact the Texas Behavioral Health Executive Counsel, Discipline and Complaints for filing a grievance. 1-800-821-3205.

Client Signature: Date:   
  
Parent /  
Guardian Signature: Date:   
  
Therapist Signature: Date: