Campbell
PSYCHOLOGICAL SERVICES

Intake Packet for Trauma-Focused Mental Health Assessment

For Youth Age 14+

Name of Youth: _____

☐ Referral Form – *to be completed by Probation Officer*

Give to Caregiver (no signature required)

- ☐ Trauma Assessment FAQ
- ☐ Carlisle Building Access & Parking

Forms signed by the youth:

- ☐ Authorization to release information to JPO – *all fields must be completed; must be signed by youth and by JPO staff person requesting the release and staff person name/agency written clearly where indicated*
- ☐ Service Agreement
- ☐ Privacy Policy
- ☐ Consent to Electronic Communication
- ☐ Default ROI for Caregiver Youth Ages 14+

Forms completed by caregiver:

- ☐ Parent Acknowledgement of Intake forms
- ☐ Intake Questionnaire – *if information in the Questionnaire has already been provided on another JPO form that is being sent with the packet, it does not need to be completed twice*

(over)

Please send the following with the referral, if available:

☐ Any court documents, written allegation(s), etc.

☐ Social History

☐ MAYSI

☐ YLS

☐ CTS

☐ School records

☐ Mental health records including past evaluations

Fax completed packet, including this checklist, to (717) 620-0536.

Questions? Call (717) 422-6440. Press option 8 for Intake.

REFERRAL FORM
for JPO-involved youth

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CHECK ONE:

☐ Referral has been discussed with youth/family. Family agrees with referral and caregiver is expecting a call from Campbell Psychological to schedule.

☐ Caregiver will contact Campbell Psychological to schedule.

REFERRAL IS FOR: (select only one to start)

☐ Outpatient Therapy

☐ Trauma-Focused Mental Health Assessment

☐ Psychological Evaluation

Have you consulted with someone at our office about this referral? ☐ Yes ☐ No

YOUTH

Name: _____ DOB: _____

Address: _____

Gender: _____ Age: _____ Grade: _____ School: _____

Primary Language: _____

Can the youth speak and understand English fluently? ☐Yes ☐ No ☐ I'm not sure

CAREGIVER

Name: _____ Relationship: _____

Address: _____

Phone: _____ (cell / home / work)

Primary Language: _____

Can the caregiver speak and understand English fluently? ☐Yes ☐ No ☐ I'm not sure

REFERRAL SOURCE

☐ Cumberland County Juvenile Probation Office

☐ Cumberland County Children & Youth Services

Contact Person: _____ Title: _____

Phone Number: _____ Email: _____

CHECKLIST (mark box if attached – please attach as much information as possible)

- ☐ Copy of youth's insurance card (for evaluation and therapy referrals)
- ☐ Release of Information for Juvenile Probation – ***For youth <14 years old, the release must be signed by a legal guardian. For youth 14+, the youth must sign.***
- ☐ Results of YLS and MAYSI (if available)
- ☐ Social History
- ☐ Other: _____

REASON FOR REFERRAL (feel free to attach additional pages/information)

If youth has an identified trauma history, please provide any information you have about the trauma experienced by this youth:

Please provide any additional information you have regarding emotional or behavioral concerns.

OTHER SERVICES

Please list all services/programs that are currently in place or to which the youth has already been referred and any other county agencies that are involved.

_____ ☐ Referred ☐ Currently receiving

_____ ☐ Referred ☐ Currently receiving

_____ ☐ Referred ☐ Currently receiving

_____ ☐ Referred ☐ Currently receiving

_____ ☐ Referred ☐ Currently receiving

Return referral forms via fax to (717) 620-0536.
Questions? Call us at (717) 422-6440.

TRAUMA-FOCUSED MENTAL HEALTH ASSESSMENT
Information for Families

Campbell
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Your child has been referred by Cumberland County Juvenile Probation Office (JPO) for a Trauma-Focused Mental Health Assessment. This is not a therapy appointment. The assessment is a one-time appointment to identify current mental health needs and make treatment recommendations.

Below are answers to Frequently Asked Questions, so that you understand the reason for the referral and what to expect.

Why has my child been referred for this assessment?

Based on information gathered by the Juvenile Probation Office, your child may have experienced some type of trauma. A trauma-focused assessment will help determine if these experiences are currently impacting your child in a negative way and might play a role in your child's current difficulties. Sometimes JPO will refer youth with mental health concerns, but no known trauma.

The goals of the assessment are:
1) make recommendations about the type of treatment service(s) that might be most helpful
2) provide JPO with information that might be helpful in case planning.

Where do we go for the assessment?

The appointment will be at Campbell Psychological Services, 46 East High Street, Carlisle. Metered street parking is available in front of the building.

Your appointment reminder will include a 4-digit code at the bottom, which is needed to enter the building. There is no receptionist; a clinician will come to the waiting room to greet you at your appointment time.

Who needs to attend the assessment?

Your child *must* be present for the entire appointment. A parent or caregiver is also expected to attend the appointment, so Dr. Campbell can gather information from them as well. ***If this is not possible, please contact your child's Juvenile Probation Officer.***

How long will the appointment take?

The assessment takes 2 ½ to 3 hours. Assessments are scheduled from 9 AM to 5 PM on weekdays.

Please arrive 15 minutes before your appointment time. If you are more than 15 minutes late, it will be cancelled and counted as a missed appointment. If you are running late, please let us know by calling (717) 422-6440, option 8.

What if we can't make it to the appointment?

If you are unable to keep your scheduled appointment, call Campbell Psychological Services right away at (717) 422-6440, option 8. Please provide at least 24 hours' notice when cancelling. **Appointments will not be rescheduled more than once.**

What happens at the appointment?

Your child will be meeting a licensed clinician. The clinician will come to the waiting room to greet you. The appointment will include:

- Reviewing the purpose of the assessment and what information will be shared with probation
- Talking with you and your child to gather some background information. Your clinician will ask about your child's thoughts, feelings, and relationships. They will also want to know if your child or family has had any stressful or traumatic life experiences. They typically spend some time talking with the youth alone and may also want to speak with the parent alone.
- Completing rating scales to provide additional information about mood and behaviors
- Discussing the clinician's impressions and recommendations. They will provide information about how to obtain any services that are recommended.

What happens after the appointment?

Depending on the services recommended, we may help facilitate the referral or we may provide you a list of providers to contact.

Campbell Psychological only provides outpatient therapy. If outpatient therapy is recommended *and* we have openings, you may choose us as your provider. However, you may also choose to get therapy somewhere else.

What information will Campbell Psychological Services share with JPO?

With permission from the youth (or a parent/guardian, if the youth is under 14), we will provide JPO with a short summary that includes service recommendations. We may consult with your probation officer regarding your child's case planning and to help them better understand your mental health needs. The goal is for JPO to have information about your child's mental health treatment needs, to create an effective service plan.

Who will pay for the assessment?

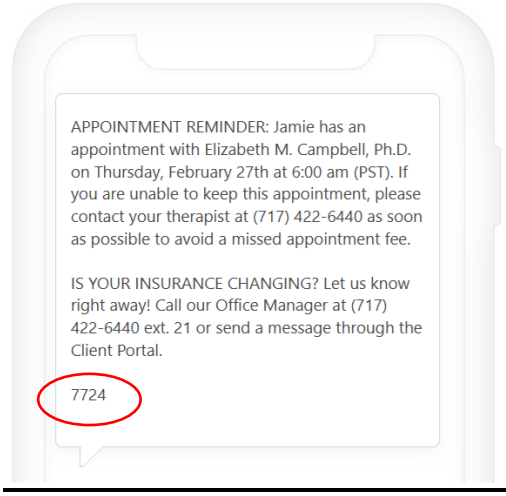
The assessment is funded by Cumberland County JPO. There will be no cost to you. If additional mental health services are recommended, those will be the responsibility of your family.

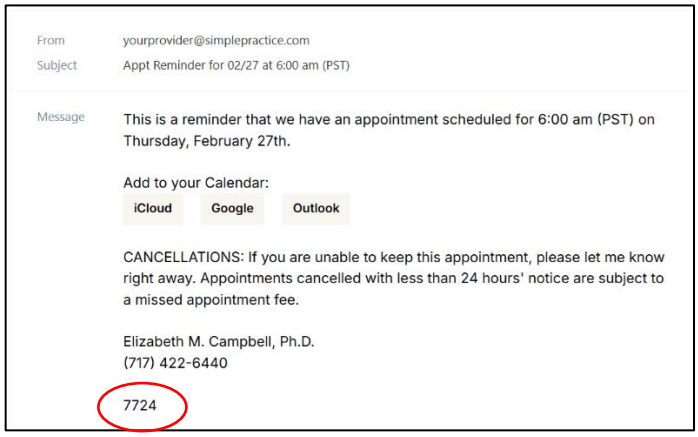
CARLISLE OFFICE

Our Carlisle office is located at 46 E. High Street, Carlisle, PA 17013. Please review this document for important information and parking and about building access.

BUILDING ACCESS

The building requires a 4-digit passcode to enter the main doors. This passcode will be found at the bottom of your appointment reminder(s), as shown below. **The code will change periodically, so be sure to check your reminder before each appointment for the current code.** If someone else brings your child to an appointment, you'll need to make sure they have the code.





If you do not have the passcode, you will need to contact your therapist directly. Sending a secure message is best. ***Everyone entering must do so using the passcode. For security, please do not let others into the building.***

WAITING ROOM

Once you come into the building, please wait in the waiting room until your therapist comes to get you. There is a bathroom in the front hallway, under the stairs.

Parents are always responsible for supervising their children in the waiting room. Please do not allow children to play in the hallway, in the bathroom, or on the stairs. Do not go upstairs unless you are accompanied by your therapist.

PARKING

Please allow yourself extra time to park, especially your first time visiting our office.

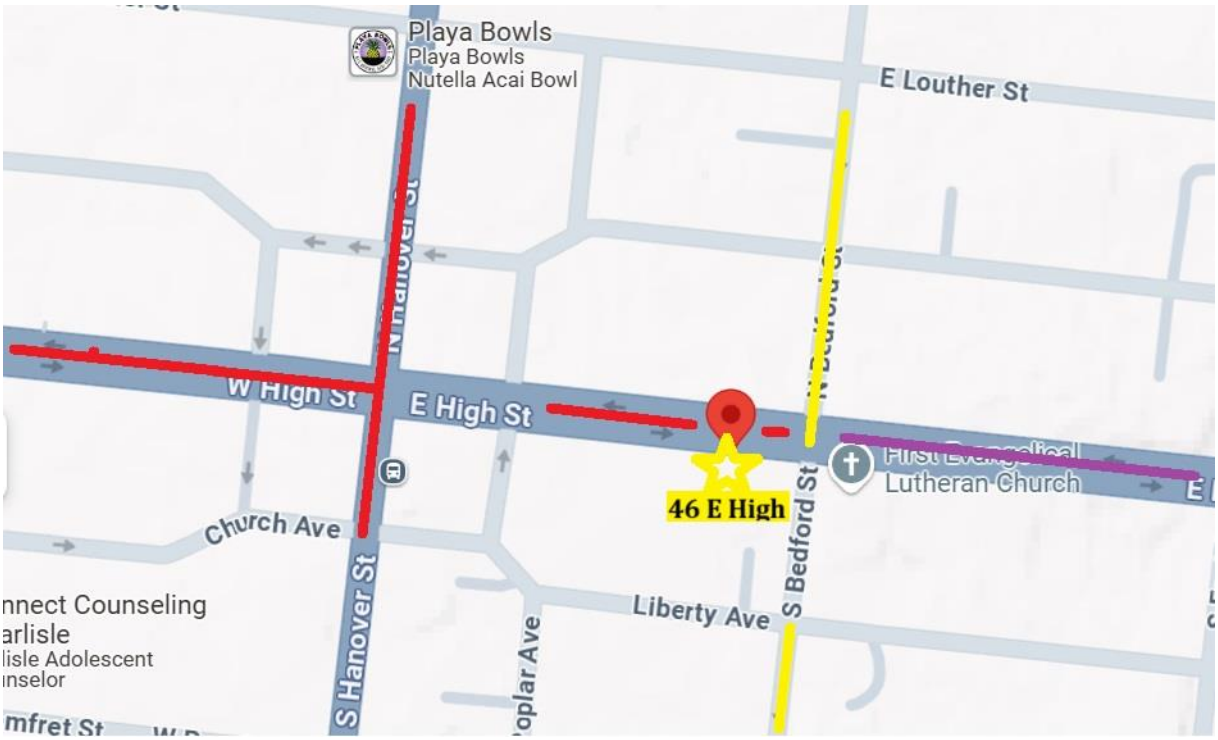
Parking Options

— There is **kiosk parking** along East High St. The cost is 75 cents/hour if paying with coins and $1.50/hour if paying with a credit card. **(RED line)**

— There is **gold meter parking** on North and South Bedford Street, right around the corner from the building. These meters are 25 cents/hour with coins and $1.05 cents/hour if paying by credit card. **(YELLOW line)**

— Parking is **free** on the next block of East High Street past our building. **(PURPLE line)**

— Finally, the **Pomfret Street Garage** is about 3 blocks to our office (about a 5-10 minute walk).



How to Pay – 3 Options

— Meters and kiosks both accept quarters. (Paying cash is the cheapest option.)
— Kiosks accept credit cards.
— The ***Flowbird*** parking app can be used to pay by credit card. Download and set up the app in advance. To avoid being routed to a suspicious website, search for the app through the App store, NOT your web browser.

New - 4/2025

Campbell
PSYCHOLOGICAL SERVICES

46 East High Street
Carlisle, PA 17013
Ph (717) 422-6440
Fax (717) 620-0536

I _____ with the Date of Birth _____/_____/_____
Client's Name Month Day Year

authorize **Campbell Psychological Services** to exchange information from my record(s) and care, verbally or in writing, as described in Sections I and II below, with the following individual or entity:

Person or Entity: Cumberland County Juvenile Probation Office

Address: 16 West High Street, Carlisle, PA 17013

Phone: (717) 240-6265 Fax: (717) 240-7880

I: Campbell Psychological Services may release the following information to the party listed above:

- ☑ Attendance in treatment
- ☐ Intake Summary
- ☑ Treatment Plan & Recommendations
- ☐ Progress Notes
- ☑ Evaluation and/or Assessment results, including written report
- ☐ Treatment Summary & Progress
- ☐ Discharge Summary
- ☑ Other: status of referral, consultation for purposes of case planning
- ☐ ALL RECORDS

II: Campbell Psychological Services may receive the following information from the party listed above:

- ☐ Attendance in treatment
- ☐ Intake Summary
- ☐ Treatment Plan & Recommendations
- ☐ Treatment Summary / Progress
- ☐ Progress Notes
- ☐ Assessment / Evaluation Results
- ☐ Discharge Summary
- ☐ Social History
- ☐ Medical Record
- ☐ Medication Management Notes
- ☐ Academic Records including 504 Plan/IEP
- ☐ Teacher Observations / Feedback
- ☐ Completed Rating Scales
- ☐ Court Records
- ☐ Other: _____
- ☑ ALL RECORDS

Information is to be used for the purposes of:

☐ Treatment planning ☐ Coordination of care ☑ Assessment or Evaluation ☑ Other: JPO Case planning

This authorization is valid for one year starting from the date of execution unless a different expiration is provided:

☐ Expiration: _____ ☐ Expires upon discharge from services at Campbell Psych. Services

I understand that I have the right to cancel this authorization at any time, by providing such request in writing or verbally to a staff member at *Campbell Psychological Services,* 46 East High Street, Carlisle, PA 17013. However, my revocation will not be effective to the extent that information has already been shared based upon this release or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider generally may not require that I sign an authorization in order to receive services, unless the services are being provided to me for the purpose of creating health information for a third party.

I understand I have a right to inspect the materials to be released according to this authorization. I further understand that the potential exists for re-disclosure of my private mental health information by the recipient of that information. Once disclosed, the information may no longer be protected under the HIPAA privacy regulations.

_____ _____
Signature of client, if 14 years or older Date

_____ _____ _____
Signature of legal guardian, if under 14 Date Printed Name

_____ _____ _____
Signature of staff person Date Printed Name (and Agency if not Campbell Psychological)

Client has been offered a copy of this release and has ☐accepted ☐declined

Service Agreement - Office-based Services

Welcome to Campbell Psychological Services! This document contains important information about our professional services and business policies. It serves as consent for services and an agreement between you and Campbell Psychological. Please read it carefully and let us know if you have any questions. In this Agreement "you" refers to the individual identified as the client and, if applicable, the client's parents/caregivers.

BENEFITS & RISKS OF SERVICES

Our therapists provide assessment, evaluation, and psychotherapy; we do not prescribe medication. Services may be provided in one of our offices or online (telehealth/video appointments) when clinically appropriate.

Outpatient Therapy: Therapy typically begins with an assessment to help your therapist better understand your concerns. This may take one or more sessions to complete, at which point your therapist will work with you to develop therapy goals and a plan.

Your therapist will use their knowledge, skills, and expertise to provide you with the best treatment they are able. Psychotherapy has been shown to have positive benefits for many people, including reduced distress, better relationships, improved coping skills and self-awareness, and the resolution of specific problems. Therapy requires an investment of your time, energy, and resources to be most effective. Children are most likely to make progress when their caregivers are involved in their therapy and help apply new ideas and skills at home and in the community.

As with any treatment, there are potential risks. These include, but are not limited to, uncomfortable feelings, discussing sometimes unpleasant or challenging aspects of life, and the possibility that therapy will not resolve the issues for which you are seeking help.

Psychological Evaluations & Assessments: Mental health assessments and psychological evaluations are intended to get a clear picture of what type of difficulties you are having, why you are having them, and how to address them. Evaluations may take three or more sessions to complete. Keeping your scheduled appointments and promptly completing any forms provided to you will help the evaluation to be completed in a timely manner.

Evaluations are intended to answer specific questions regarding diagnosis or treatment needs. Because each person is unique and complex, at times our evaluators are unable to answer the evaluation question. If that happens, you may be referred for further testing or specialized evaluation with another provider.

CONSENT TO TREAT & RELEASE INFORMATION FOR MINORS

There are specific laws and regulations regarding the treatment of individuals under the age of 18 years, including who can provide consent to treatment and who makes decisions about sharing information from the youth's treatment record.

- For youth under 14 years of age, decisions are made by the parents/legal guardians.
- For youth 14 to 17 years old, consent to treat can be provided by either the youth *or* the parents/legal guardians. With a few exceptions, the youth decides with whom information may be shared. The information we can share with the parent/guardian may be limited.
- When there is custody agreement or court order and the parents/guardians are the ones providing consent to treat, Campbell Psychological Services requests consent from all parties with legal custody before beginning services.

For youth under age 14 with multiple legal guardians:

- Each adult may make their own choices regarding whether to use electronic communication (see Consent for Electronic Communications).
- Any guardian may consent for information to be exchanged with outside parties; we do not require all guardians to give consent. This includes, but is not limited to, physicians, schools, and caseworkers. The exception is consent to share information with private attorneys. We require consent from all legal guardians before sharing information or speaking with private attorneys.

PROFESSIONAL FEES, BILLING & PAYMENT

Please see the *Financial Responsibility Agreement*.

CONTACTING YOUR THERAPIST BETWEEN APPOINTMENTS

Our therapists are typically in appointments throughout the day and not immediately available by phone. If you need to reach your therapist, please leave a voicemail so that they can return your call. Calls will generally be returned within one to two business days, between 9 am and 5 pm.

Between-session calls are appropriate for scheduling appointments or urgent matters. Updates and other concerns should be saved for your appointment time.

There is a charge for calls longer than 10 minutes. If your appointments are not long enough to meet your needs or you are needing a lot of support between sessions, please speak with your therapist about meeting more frequently.

EMERGENCY PROCEDURES

If you are experiencing a non-life-threatening emergency or urgent situation and are not able to reach your therapist by phone, please leave a message letting your therapist know the matter is urgent. Your therapist will call you back as soon as they are able.

If you have a crisis that cannot wait for a return call or it is outside of normal business hours (Mon-Fri, 9 am – 5 pm), please utilize local Crisis Intervention services, which provide around-the-clock crisis coverage. In case of a life-threatening emergency, call 911.

- Cumberland County: (717) 243-6005

- Franklin County: (717) 264-2555

If you have thoughts or plans of hurting yourself or others, it is important to share this information with your therapist. Your therapist will help you to create a plan to reduce risk and make it less likely you'll need crisis care.

DISCHARGE FROM SERVICES

Ideally, clients are discharged from therapy because they have met their therapy goals. However, clients may be discharged for other reasons, including:

- ***Attendance:*** This includes not attending therapy appointments consistently, repeatedly cancelling scheduled appointments, or repeatedly missing appointments. See our Attendance Policy for specific details.
- ***Lack of contact:*** We require clients be seen at least once per month. If it has been more than 45 days since you last attended an appointment, you will be discharged.
- ***Needing a different level of care***: If outpatient therapy can't meet your mental health needs, your therapist will let you know and refer you to a more appropriate level of care.
- ***Online Therapy is not appropriate:*** If you have requested online therapy but your therapist determines it is not appropriate for your situation, you may be referred to in-person services and discharged from Campbell Psychological Services.
- ***Inability or refusal to pay for services:*** If your insurance lapses or changes to a plan we do not contract with, and you are unable or unwilling to self-pay for services, you will be discharged. Similarly, if you are unwilling to pay an outstanding balance, you will be discharged.
- ***No longer meeting medical necessity:*** If you are doing well and therapy is no longer necessary (from a medical perspective), we cannot bill your insurance for it. You may continue appointments, but "supportive" or "personal growth" therapy is self-pay. Your therapist will let you know, if you reach this point.

BUILDING POLICIES

As a general rule, animals are not permitted in the building, including emotional support animals. The only exception is trained service dogs. There are no weapons allowed in the building, period.

Caregivers must stay in the building during appointments unless other arrangements are made with the therapist.

SOCIAL MEDIA

Therapists do not accept friend or contact requests from current or former clients on any social networking site (e.g., Facebook, Snapchat, Instagram, etc.). This is to protect your confidentiality and to keep the relationship with your therapist a professional and therapeutic one.

If you choose to follow Campbell Psychological on social media, we will never disclose on social media that you are client of the practice. However, if you choose to follow the practice on social media, you assume any risks associated with doing so.

RELEASE OF INFORMATION TO INSURANCE

Your insurance plan may request medical records, including your treatment plan and progress notes, to confirm that services are medically necessary and verify eligibility for payment. In order to bill insurance, your therapist must provide you with a mental health diagnosis.

By signing this form, you authorize the release of information regarding your care to your insurance plan for payment of claims, certifications, health management decisions, and other purposes related to the administration of benefits of your insurance plan.

CONFIDENTIALITY

In general, the privacy of all communication between clients and mental health service providers is protected by law. Information about you can only be shared with your consent. There are a few exceptions, which are outlined in the *Notice of Privacy Practices*. These exceptions include, but are not limited to:

- ***Suspected Abuse:*** Our staff are mandated reporters under Pennsylvania Law. If we suspect that a child coming before us is the victim of abuse, neglect, or maltreatment, we must make a report to authorities. If a person tells staff of a situation that raises concern a child is being or has been abused,, we are also required to make a report to authorities.

- ***Serious Threat to Health or Safety:*** Staff may disclose confidential information to protect a client or others from a serious threat of harm by the client. This may include, but is not limited to, calling the police, seeking appropriate hospitalization, or notifying a potential victim.

- ***Certain Legal Situations:*** In most legal situations, you have the right to deny permission to release any information about your treatment. However, in some circumstances, a judge may require (court order) the release of written records or testimony by a therapist.

In the situations above, your therapist will do their best to tell you in advance when they need to make a disclosure, unless they believe telling you will increase the risk of harm to you or another person.

Confidentiality & Consultation: Our therapists may consult with professionals within the practice or from other organizations, including other licensed mental health professionals, for the purposes of improving care to clients and our professional growth. During such consultation, we may discuss specific clients. When consulting with a professional outside the practice, we take reasonable efforts to avoid revealing the identity of the client; the consultant is also legally bound to keep the information confidential. If you have any questions or concerns about this, please let your therapist know.

INVOLVEMENT IN COURT PROCEEDINGS

Families involved in court proceedings are expected to disclose this to Campbell Psychological Services. If you are involved in a divorce proceeding or custody dispute, you will be asked to review and sign the *Therapy Agreement for Court-Involved Families.* Please note that we do not make custody recommendations. All time spent responding to court-related requests is charged our rate for court-related activity and is not covered by insurance.

I have read and understand the information in the Service Agreement for Campbell Psychological Services. My signature below indicates that:

- **I consent to participate in outpatient mental health services with Campbell Psychological Services / I consent to my child's participation in services at Campbell Psychological Services.**
- **I agree to abide by the terms of the Service Agreement.**
- **I authorize the release of any information necessary to process insurance claims, and I authorize payment of health benefits directly to Campbell Psychological Services for any service rendered.**
- **I authorize the use of this signature (as a "Signature on File") on all insurance submissions.**

Client Name: _____ DOB: _____

Signature: _____ Date: _____

Printed Name: _____

Relationship to Client: _____

Notice of Privacy Practices - All Locations

NOTICE OF POLICIES & PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

CAMPBELL PSYCHOLOGICAL SERVICES - 46 E. High Street, Carlisle, PA 17013 - (717) 422-6440

This notice describes how your mental health information may be used and shared with others. It also explains how to access your information. Please review this form carefully. If you need help understanding this notice or have questions, please let your therapist or the Director know. They will review it with you. In this document, "Campbell Psych" and "we" refer to both Campbell Psychological Services and your therapist (or other clinician) at our office.

IMPORTANT DEFINITIONS

Authorization: This is written form giving us permission to share specific information with a specific person or organization. Who can give us the permission depends on the client's age and custody or guardianship status.

Abuse: This includes physical, sexual, and emotional/verbal abuse. It may also include situations where someone is acting in a way that places a child at risk for harm.

PHI: PHI stands for Protected Health Information. This refers to information in your health record that could identify you.

WHEN CAMPBELL PSYCHOLOGICAL SERVICES CAN USE & DISCLOSE YOUR PHI

We may use or disclose your protected health information (PHI) in the following ways without an authorization. You agree to this when you sign our Service Agreement and/or begin services with us:

- ***To bill for your services:*** We can use and share your health information to bill and get payment for your healthcare. Example: Campbell Psych can share your PHI with your health insurer so it will pay for your health care. We can use your healthcare information to provide invoices.
- ***To run the practice***: We can use your health information to run the practice, improve your care, and contact you when necessary. These are activities that relate to the performance and operation of the practice. Examples: Quality assessment and improvement activities; business-related matters such as audits and administrative services; case management and care coordination.

USES & DISCLOSURES THAT REQUIRE AUTHORIZATION

If we want to use or share your PHI for reasons besides payment and health care operations, we must get an authorization first. Examples: Permission to share your PHI with another health care provider, such as your family doctor or psychiatrist, to coordinate care. Permission to speak with school personnel, to consult with them regarding school-related problems.

You may cancel an authorization at any time. To do this, please submit a written request to *Campbell Psychological Services, LLC,* at 46 E. High Street, Carlisle, PA 17013 or send an email to ClientCare@CampbellPsychPA.com.

There are some limits to your ability to revoke an authorization:

- If we have already shared information based on the authorization, we cannot "un-share" the information.
- If the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

USES & DISCLOSURES THAT DO NOT REQUIRE AUTHORIZATION

In the following circumstances, we may use or disclose PHI without your consent or authorization:

- **Child Abuse:** We are required by law to report suspicions of possible child abuse or neglect to the appropriate authorities. We also must make a report if we suspect a "third party" may be a victim of abuse or neglect. For example, if you tell us the child who lives next door is living with a registered sex offender, we must make a report. It also includes reporting any sexual activity involving a child under 14 and any non-consensual sexual activity involving someone currently under age 18.
- **Other Abuse:** If we have reasonable cause to suspect an elderly or disabled person is the victim of abuse or neglect, a report will be made to the appropriate state agency.
- **Board Complaints:** If you make an inquiry or complaint about your therapist's professional conduct to the Pennsylvania Department of State or the state licensing Board, we may be required to provide your confidential mental health records as part of the investigation process.
- **Court Order:** We may have to disclose your PHI and/or healthcare records, if ordered to do so by a judge.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we can only share your healthcare information with a written authorization from you or a court order.
- **Serious Threat to Health or Safety:** We may disclose your confidential information to protect your safety. For example, if you have imminent plans to seriously harm or kill yourself. We may also disclose your confidential information if we believe there is a serious possibility that you will harm someone else. For example, if you share plans to injure, attack, or kill someone.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- ***You can ask Campbell Psych to limit what we use or share:*** You can ask us not to use or share certain health information for payment or practice operations. However, we are not required to agree to your request; we may say "no" if it would affect your care. If you choose to self-pay for a service or product out-of-pocket, you can ask us not to share that information with your health insurer. We will say "yes" unless a law requires us to share that information.
- ***Request confidential communications:*** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- ***Get an electronic or paper copy of all or part of your record:*** You can ask to see or receive a copy of your healthcare record or to have your record shared with a third party, such as your doctor or a caseworker. You may ask for a specific part of the record or all of it. However, we may deny the request under certain circumstances, such as when providing a copy of the record is likely to cause harm to the client. Information about how to request your record can be found below.
- ***Ask Campbell Psych to correct your record***: You can ask us to correct health information about you that you think is incorrect or incomplete. We may so "no" to your request. If we say no, we will provide an explanation of the denial in writing within 30 days. Your request and the reason for the denial will be saved to your record.
- ***Get a list of those with whom Campbell Psych has shared information***: You can ask for a list (accounting) of the times we have shared your health information, who we shared it with, and why. We will include all disclosures except those about payment or health care operations and certain other disclosures (such as those you asked us to make). We may charge a reasonable, cost-based fee, if you ask for more than one accounting within a 12-month period.
- ***Right to a Paper Copy***: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will promptly provide you with a paper copy.

OUR DUTIES

- We are required by law to maintain the privacy of PHI.
- We are required by law to provide you with a notice of our legal duties and our privacy practices with respect to PHI and to maintain a copy of this notice on the home page of our website.
- We reserve the right to change the privacy policies and practices described in this notice. However, unless we notify you of changes, we are required to comply with what is stated in the current policy.
- If we revise our policies and procedures and you are still an active client at our office, we will provide you with an updated copy. If services have ended, you may request an updated copy to be sent to you by mail.

HOW TO REQUEST YOUR PHI

You can make a verbal request to your therapist to see or receive a copy of your PHI. You can also make a request in writing, by completing our PHI Request Form and returning it to our main office via the contact information below. The PHI Request Form is available upon request by contacting the main office at (717) 422-6440.

46 E. High Street

Carlisle, PA 17013

FAX (717) 620-0536

ClientCare@CampbellPsychPA.com

COMPLAINTS

If you are concerned that we have violated your (or someone else's) privacy rights, or you disagree with a decision we have made about access to your records, please contact our Director at (717) 422-6440, ext 21.

If you do not feel comfortable doing this, you may file a complaint with the Pennsylvania Department of State at https://www.pa.gov/agencies/dos/file-a-complaint.html. You may also call the Pennsylvania State Psychology Licensing Board at 717-783-7155 or the Pennsylvania Board of Social Workers, Marriage and Family Therapists and Professional Counselors at 717-783-1389 with your questions or complaint.

Finally, you may file a complaint with the Office for Civil Rights (OCR) in the US Department of Health and Human Services. They can be reached at (800) 368-1019.

EFFECTIVE DATE

This notice will go into effect on January 1, 2023.

CHANGES TO PRIVACY POLICY

We reserve the right to change the terms of this notice and to make the changes effective for all PHI that we maintain. We will provide you with a revised notice through our Client Portal. If you do not have access to the Client Portal, we will provide you with a paper copy at your next session or by mail. We will provide a copy within 1 week of the date of revision. If you are no longer in services with us, we will provide a revised notice only if you make a written request.

I have received a copy of this office's *Notice of Privacy Policies & Practices*. I understand that this Notice is available electronically at https://CampbellPsychPA.com and is also available in paper format upon request.

Client Name: _____ DOB: _____

Signature: _____ Date: _____

Printed Name: _____

Relationship to Client: _____

Consent to Electronic Communication

** indicates a required field*

This form allows you to opt-out of certain types of electronic communication with our office, such as appointment reminders, secure messaging, and email.

Limits to Electronic Communication

Electronic communication is not a replacement for face-to-face therapy. Detailed or sensitive conversations should be reserved for in-person meetings.

Electronic communication should never be used to communicate in the case of an emergency. Therapists are in appointments throughout the day. If it is after-hours, they may not check their messages until the next workday. Please do not expect an immediate response to electronic communication.

All electronic communication will become a part of your clinical healthcare record.

Benefits of Electronic Communication

Electronic communication such as email can be a useful and convenient way to communicate about appointments and billing or to occasionally share information between appointments.

Risks of Electronic Communication

Electronic communication that is sent through “non-secure” or “unencrypted” methods may pose a risk to confidentiality. Someone may intercept the communication, such as a third-party monitoring internet traffic or your school or employer, if you use your work or school email. If someone else has access to your phone or email account, they may be able to access your communication with our office.

APPOINTMENT REMINDERS

For your convenience, appointment reminders are sent automatically from our electronic record system. For telehealth appointments, these reminders include a link to your video appointment.

These reminders are delivered via unencrypted (non-secure) email and/or by text. You may choose to opt-out of these reminders.

If you do NOT want appointment reminders, please check the box to opt out. (If you are doing telehealth, you will need to log into the portal each time to find the link to your appointment.)

☐ I do NOT want appointment reminders

For youth ages 14-17: If you do NOT want your parent/guardian to receive appointment reminders, please check the box to opt out.

☐ I do NOT want my parent to receive appointment reminders.

SECURE MESSAGING IN CLIENT PORTAL

Secure messaging through our Client Portal is our preferred method of communication with clients. Therapists can view client messages throughout the workday and respond more quickly.

RISKS: The Client Portal will send you an email each time there is a message waiting for you. The email is not encrypted. It includes a link to access your Client Portal without entering a username and password. While convenient, this means if someone has access to your email, they could access your Client Portal.

If you do NOT want to use secure messaging, please check the box to opt out .

☐ I do NOT want to use secure messaging

EMAIL COMMUNICATION

By default, any email communication sent by our office will be encrypted for security. An encrypted message requires that the person who receives the message enter a unique password to decrypt ("unlock") the email. However, if someone has access to your email account, they may still be able to see who the message is from. Unencrypted text and email messages are less secure, for the reasons describe under Risks above.

*** Please indicate your email preferences. This preference will apply to emails sent directly from the practice and does not apply to emails sent from the Client Portal.**

- ☐ Please encrypt all emails.
- ☐ Please send all emails unencrypted.
- ☐ Do not send me emails. (Please note that you may still receive emails sent from our Client Portal.)

COMMUNICATION WITH CAREGIVER

For Clients Ages 14-17 Years: The secure message and email preferences on this form will also apply to communication with your parent/caregiver. If you do NOT want these preferences to apply to your parent/caregiver, please check below and then explain in the Comments.

- ☐ I do NOT want these preferences to apply to my parent/caregiver

I have reviewed the Consent to Electronic Communications.

- I understand the risks, including but not limited to my confidentiality in treatment, of transmitting my Protected Health Information electronically.

- Except where I may have opted-out above, I authorize Campbell Psychological Services to communicate with me using email and text appointment reminders, secure messaging through the Client Portal, and encrypted email.

- I understand that I am not required to sign this agreement in order to receive treatment and I may terminate this authorization at any time.

- I understand all electronic communication will become a part of my clinical record.

Client Name: _____ DOB: _____

Signature: _____ Date: _____

Printed Name: _____

Relationship to Client: _____

Preferred Cell Number for Appointment Reminders:

Client: _____

Caregiver: _____

Preferred Email Address for Appointment Reminders & Client Portal:

Client: _____

Caregiver: _____

AUTHORIZATION TO RELEASE INFORMATION TO CAREGIVER, FOR CLIENTS AGES 14-17

Campbell
PSYCHOLOGICAL SERVICES

When it comes to mental health care in Pennsylvania, clients ages 14+ are in many ways treated like adults. If you have provided consent to treatment, you then have control over where and with whom our office can share information about your therapy.

However, our office policy is that we must be able to communicate with your parent(s), caregiver(s) or guardian(s) about some basic information. This is information that we need in order to coordinate services. This includes:

—***Scheduling and attendance at therapy***: We need to be able to disclose whether you are receiving therapy at our office and coming to appointments.

—***Billing***: A responsible adult must sign the Financial Responsibility Agreement before therapy begins. We need to be able to talk to that person, if there are issues with payment or insurance.

By default, your parent, caregiver, or legal guardian will also serve as your emergency contact. If you would like a different adult to be your emergency contact, please let your therapist know.

Besides the information listed above, what is shared will depend on what you and your therapist decide together. Your therapist will not share other information about your therapy without your permission.

If you wish to revoke or change this authorization, you must to notify your therapist. If you sign an additional authorization form to share information with one of the people list above, it will not replace this authorization form.

I understand the information above and I give Campbell Psychological Services permission to share information about attendance, scheduling, and billing with:

—my parents or caregivers

—my legal guardian(s), if different from my parents/caregivers

—the adult who signed the Financial Responsibility Agreement

I give Campbell Psychological Services permission to contact my caregivers, parents, and/or legal guardians in the case of a clinical crisis or other emergency.

Client Name: _____ **DOB: _____**

Signature: _____ **Date: _____**

Parent Acknowledgement of Intake Forms for Ages 14-17

When it comes to mental health care in Pennsylvania, clients ages 14 and older are in many ways treated like adults. Once they turn 14, teens can consent to their own treatment. They also control who has access to their healthcare information.

We understand that parents/guardians often play a key role in supporting their teens' involvement in therapy. It is important that you are familiar with our Service Agreement and other forms that your teen signs before starting services with us.

Copies of these forms are available at https://campbellpsychpa.com/caregiver-copies/. You may also request copies be sent to you.

These forms include:

1. Service Agreement
2. Attendance Policy
3. Authorization to Release Information to Parent/Caregiver
4. Notice of Privacy Practices
5. Consent to Electronic Communication
6. Consent to Telehealth
7. If your child's therapist is not licensed: Notice of Supervisee Status
8. If your child has Medical Assistance: Freedom of Choice Form; Member Rights & Responsibilities Notice

I understand that that the forms my teen is asked to sign are available to me at https://campbellpsychpa.com/caregiver-copies/ and by request. I understand that it is my responsibility to review these forms and to contact Campbell Psychological Services if I have questions about them.

Client Name: _____ **DOB: _____**

Signature: _____ **Date: _____**

Printed Name: _____

Relationship to Client: _____

Campbell
PSYCHOLOGICAL SERVICES

Client Name: _____ DOB: _____

Intake Questionnaire for Minors

Campbell PSYCHOLOGICAL SERVICES

The questions below will provide your therapist with some initial information about your child and family. This questionnaire asks about many different parts of your child's life. Depending on your child's age and your family situation, not all of the questions will apply. Just answer as best you can. Many of the questions are personal and you may not be comfortable answering them before meeting your child's therapist. That is okay - please feel free to skip any questions you are uncomfortable answering.

Name of person completing this questionnaire:

First and last name

In a few sentences, what concerns do you have about your child? (Why are you seeking therapy at this time?)

FAMILY BACKGROUND Please describe your child's current living situation, including names and ages of everyone in the home, and any visitation/contact with parents or significant caregivers who do not live in the home.

Is your child adopted?

- Yes
- No

Please tell us about any cultural, spiritual, or religious beliefs or practices that are important to your family.

Please check any or all that apply.

- [ ] I am concerned about my child's learning
- [ ] I am concerned about my child's behavior at school.
- [ ] I don't have any concerns about how my child is doing at school.

SCHOOL What is your child's current school and grade?

School

Grade

Please mark all that apply:

- [ ] I am concerned about my child's learning
- [ ] I am concerned about my child's behavior at school
- [ ] I don't have any concerns about how my child is doing at school

Which of the following best describes your child's school arrangements? (mark all that apply)

- [ ] My child has an IEP.
- [ ] My child has a 504 Plan.
- [ ] My child attends an Alternative School.
- [ ] My child receives other emotional or academic supports.
- [ ] My child does not receive any special services or supports.

DEVELOPMENT Have you or your child’s pediatrician ever been concerned about how your child is developing? This could include communication, motor skills, social interaction, and so forth.

- No
- Yes

Has your child received any of the following? (please mark all that apply)

- Early Intervention Services
- Speech Therapy
- Physical Therapy
- Occupational Therapy
- Services through the local Intermediate Unit (e.g. CAIU)

PHYSICAL HEALTH Please provide the following information for your child's pediatrician or family doctor.

Name of practice

Doctor's name

Address

Phone Number

Is your child currently taking any medications?

- Yes
- No

Does your child have any allergies?

- ○ Yes
- ○ No

Has your child ever had any of the following medical concerns?

- ☐ Asthma
- ☐ High lead levels (now or in the past)
- ☐ Hearing loss / hearing difficulty
- ☐ Head injury or concussion
- ☐ Diabetes
- ☐ Frequent ear infections and/or tubes in ears
- ☐ Broken bones
- ☐ Stitches
- ☐ Seizures
- ☐ Vision difficulty
- ☐ Surgery
- ☐ Hospitalization
- ☐ Other medical condition
- ☐ None of the above

Do you have any concerns about your child's eating? (Over or undereating, extreme pickiness, etc.)

- ○ Yes
- ○ No

To your knowledge, is your child sexually active?

- Yes
- No
- I'm not sure

MENTAL HEALTH Has your child ever been in counseling or received mental health services of any kind?

- Yes
- No

Has your child ever taken medication for behavior or emotional reasons?

- Yes
- No

Has your child been diagnosed with a developmental or mental health condition? (For example, autism spectrum disorder, anxiety, ADHD, etc.)

- Yes
- No
- I'm not sure

Has your child ever expressed suicidal thoughts, attempted suicide, or engaged in self-harm (e.g., cutting)?

- Yes
- No
- I'm not sure

To your knowledge, does your child vape or use nicotine or THC/CBD products?

- ○ Yes
- ○ No

To your knowledge, has your child ever experimented with drugs or alcohol, or taken prescription drugs "for fun"?

- ○ Yes
- ○ No
- ○ I'm not sure

Has your child ever been hospitalized for mental health reasons?

- ○ Yes
- ○ No

Has your child ever been involved with any of the following?

- ☐ Juvenile Probation Services
- ☐ In trouble with the law or police
- ☐ Mental Health Case Management Services
- ☐ Student Assistance Program (through school)
- ☐ School counselor (group or individual counseling at school)

Mental health issues occur in many families. Please mark the box if your child has close relatives or family members with any of the following mental health issues and then indicate that person's relationship to the child (e.g., parent, aunt, sibling).

- [ ] Depression or frequent sadness
- [ ] Anxiety, nervousness, worrying a lot
- [ ] Bipolar disorder
- [ ] Problems with anger management, violence or aggression
- [ ] Eating disorder (anorexia, bulimia)
- [ ] Attention Deficit/Hyperactivity Disorder (ADHD/ADD)
- [ ] Learning disability
- [ ] Intellectual or developmental delays
- [ ] Autism spectrum disorder / Aspergers
- [ ] Hallucinations or delusions, psychosis, schizophrenia
- [ ] Drinking too much or using drugs
- [ ] Posttraumatic stress
- [ ] Other
- [ ] None that I am aware of

DAILY LIVING / ROUTINE How much "screen-time" does your child have on a typical day? Screen-time includes time on a tablet or smart phone, playing computer games or video games, and watching TV or movies. (Don't count time your child spends on a computer or the internet for school purposes, like researching a paper or doing homework.)

Is your child involved with any school or community activities, clubs, or teams? If so, please list below.

Please describe your child's sleep routine. (Bedtime, wake time, where he/she sleeps, what your child does before falling asleep)

How well does your child sleep? Please mark all that apply.

- [ ] Has trouble falling asleep
- [ ] Has difficulty staying asleep / wakes up in middle of the night
- [ ] Walks or talks in sleep
- [ ] Has frequent nightmares or night terrors
- [ ] Sleeps well, no concerns

OTHER INFORMATION Has Children & Youth Services (child welfare) ever been involved with your child or family, for any reason?

- [ ] No
- [ ] Yes, in the past
- [ ] Yes, CYS is currently involved

Has your family or child ever experienced any stressful life events? Examples might include separation or divorce; a major illness, injury, or death in the family; abuse or neglect; foster care; homelessness; a family members' mental health or substance use problems; or some other stressful situation.

Is there anything else would you like your child's therapist to know before you meet?