Still Waters
Counseling

Initial Contact Information Sheet – Testing

Name:_____ DOB:_____Date of Contact: _____

Home Address: _____

Phone numbers / Leave message? : _____

Method for Reminder Messages: ☐ Phone:_____ ☐ E-mail: _____

Emergency Contact: Name of person_____ Phone #:_____

Insurance Company:_____Policy #: _____

Subscriber Name / DOB:_____ Group #:_____

Subscriber's Employer: _____

Referral Source / Phone: _____

Type of Testing Requested: _____

Credit Card Used to Secure Payment: ☐ Visa ☐ MC ☐ Discover ☐ HSA

Name on Card: _____

Card #:_____Exp. Date:_____CVV Code: _____

Medications: _____

Previous Treatment and Providers: _____

Previous Psychological Testing: _____

Persons in Household (names, ages, gender): _____

_____

Children who visit household: _____

Notes: _____

_____

Still Waters
Counseling

Billing Information Form

Client Name: _____
Client DOB: _____
Relationship to insured: _____
Marital Status: _____
Vocational Status: _____
Condition Related to: ☐ Employment? ☐ Auto Accident? ☐ Other Accident?
If yes, explain: _____
Insured's Name: _____
Insured's DOB: _____
Insured's Address: _____
Insured's Phone #: _____
Insured's Employer: _____
Name of Insurance Company: _____
Policy Number: _____
Group Number or FECA Number: _____
Insurance Company Phone: _____
Billing Address: _____

_____
Coverage (deductible, copayment, number of sessions per year, etc):

_____

_____
Is there another Health Plan? ☐ Yes ☐ No
If yes, which plan is primary? _____

Secondary Insured's Name: _____
DOB: _____
Address: _____
Phone #: _____
Employer: _____
Name of Insurance Company: _____
Policy Number: _____
Group Number or FECA Number: _____
Insurance Company Phone: _____
Billing Address: _____

_____
Coverage (deductible, copayment, number of sessions per year, etc):

_____

_____
Notes:

Still Waters
Counseling

Still Waters is seeking to improve the scope and quality of our services, by developing programs and materials to support ongoing individual or family therapy.

If you would like to receive information about these programs and materials from us, please indicate your preferred method of communication below:

1. By e-mail
   E-mail address _____

2. By U.S. Mail
   Mailing address _____

   _____

3. Other (specify): _____

4. None of the above

Your Name: _____

Signature: _____

Today's Date: _____

Still Waters
Counseling

Consent for Treatment

I agree to receive psychological services at Still Waters Counseling. These services may include individual counseling, family counseling, relationship counseling, group counseling, and psychological testing. I understand that if Still Waters Counseling does not provide a service which is requested or necessary, I will be referred to an appropriate provider of that service.

I understand that all information that I share with my counselor will be kept confidential and will not be released without my written consent. I understand that the professionals of Still Waters Counseling regularly consult with one another in order to provide me with the highest quality care possible, and may share information about my case for purposes of consultation. Information may also be shared with my insurance company to the extent necessary to secure payment for services.

I understand that confidentiality is not absolute, that in some circumstances my counselor or psychiatrist may be required by law or by the ethical standards of the American Counseling Association the American Psychological Association to share information about my case. Information may be released without my consent in situations where there is reason to believe that I might harm myself or others, or in the case of actual or suspected child abuse or neglect.

I understand that although participation in mental health services will likely result in significant benefit, there are also risks involved. I understand that talking about personal issues in counseling may be upsetting, and in the short term may increase my level of discomfort. However, despite these risks, I understand that the process of mental health treatment is often helpful in making positive changes in my life and my relationships with others.

I hereby certify that I have read and fully understand the above authorization and agree to participate in services at Still Waters Counseling. I further understand that I can withdraw from services at any time.

_____

Client Name (please print)

_____ _____

Client / Parent / Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical, mental health and substance abuse information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Still Waters Counseling is committed to protecting the privacy of your medical, mental health and substance abuse information. We create a record of the care and services that you receive from us. This information is needed to provide you with quality care and to comply with certain legal requirements. We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices. We are also required to comply with the terms of this notice.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care options and for other purposes that are permitted or required by law. This notice also describes your rights regarding the information that we maintain about you and a brief description of how you may exercise those rights.

"Protected Health Information" means medical, mental health and substance abuse information, including identifying information about you that we have collected from you or received from others.

The privacy practices in this notice apply to all Still Waters Counseling staff, contract workers, students and volunteers.

Your Rights: You have the following rights regarding your protected health information.

- **Confidential Communications** You may ask that we communicate with you in a particular way, or at a certain location, such as calling you at work rather than at home, to maintain your confidentiality.
- **Inspect and Copy** You have the right to review and/or receive a copy of the information in your record. Under certain limited circumstances, we may have to deny your request. If we deny your request, you may ask for a review by contacting the Still Waters Counseling Office Manager.
- **Addendum** You may ask us to add an addendum to the information in your records if you feel that the information is incorrect or incomplete. Your request may be denied if we did not create the information. You may prepare a statement that will be included in our clinical record if you do not agree with information in your record.
- **Accounting of Disclosures** You may request a list of disclosures that we have made of your protected health information with the exception of treatment, payment and healthcare operations described in this notice, or information that was released with your authorization.
- **Requesting Restrictions** You may ask us to limit our use or disclosure of your protected health information. We are not required to agree to your request, but if we do, we will honor your request unless the information is needed to provide emergency treatment for you.
- **Receiving a Copy of this Notice** You may receive a paper copy of this notice at any time upon request.

How We Will Use and Disclose Your Protected Health Information

Uses and Disclosures that may be Made for Treatment, Payment, and Healthcare Operations

- **For Treatment** We may use and disclose your protected health information to provide, coordinate, and manage your care and services. Information about you may be shared with Still Waters Counseling staff, contract workers, students, or volunteers who are involved in your care or services. This information will be shared on a "need to know" basis.

  We also may use your health information in order to remind you about an appointment at Still Waters Counseling or to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

  Business Associates: There may be some services provided through contracts with "business associates." We may need to share information about you with our "business associate" in order to coordinate and manage your services. To protect the privacy of your health information, "business associates" are required to abide by all aspects of this Notice of Privacy Practices.

- **For Payment** Your protected health information will be used and disclosed, as needed, to obtain payment for your services. For example, a bill for services sent to you or to a third-party payer such as a Medicaid HMO, might include identifying information about you such as your name, your diagnosis and services received.
- **For Health Care Operations** We will use or disclose, as needed, your protected health information to support and improve the activities of Still Waters Counseling. For example, Still Waters Counseling staff may use information in your clinical record to evaluate the care that you received. This information would then be used in efforts to improve the quality and effectiveness of services provided by Still Waters Counseling.

Uses and Disclosures That May Be Made Only With Your Specific Authorization

- Other uses and disclosures of your protected health information will be made only with your specific written authorization, unless otherwise permitted or required by law as described below. For example, your written authorization would be required for us to share your confidential information with a member of your family or with your family doctor except in circumstances specified in this notice. You may revoke this authorization at any time, in writing, except to the extent that we have already taken an action to use or disclose your information, relying upon our authorization.

Uses and Disclosures That May Be Made Without Your Authorization

- **As Required by Law** We may be required by federal, state, or local law to disclose your protected health information. For example, if you have threatened to harm another person, we may be required to notify the local police department and the threatened person.
- **For Public Health Activities** We may need to disclose your protected health information to a public health authority that is required by law to receive the information. Such disclosures would be made for the purpose of controlling disease, injury, or disability. For example, a disclosure regarding HIV/AIDS status would be made to the local Department of Public Health if necessary to protect the health of an individual, diagnose and care for the mental health consumer or to prevent further transmission of the virus.
- **Abuse or Neglect** We may be required to disclose your protected health information if we suspect that you or another person has been abused or neglected.

- **Health Oversight** We may be required to disclose your protected health information for an audit, inspection, investigation or other health care oversight activity.
- **Judicial and Administrative Proceedings** We may have to disclose your protected health information if we receive a court order or subpoena or for risk management purposes.
- **Law Enforcement** We may have to disclose your protected health information in connection with a criminal investigation by a federal, state, or local law enforcement agency, or to authorized federal officials who provide protective services for the President or other persons.
- **Serious Threat to Health of Safety** We may be required to disclose information about you when it is necessary to prevent a serious threat to your health and safety or that of another person or of the public.
- **Coroner or Medical Examiner** We may need to disclose your protected health information to help identify a deceased person or to determine a cause of death.
- **Research** We may disclose your protected health information to researchers if their research proposal includes protocols to insure the privacy of your health information and has been approved by the appropriate research review board.

If you believe that your rights have been violated, contact the Still Waters Counseling Director or the Office of Civil Rights. Your services will not be affected in any way if you file a complaint.

To file a complaint with Still Waters Counseling or if you have any questions or want more information, call or write:

Director
Still Waters Counseling
137 Keveling Dr.
Saline, MI 48176
734-944-3446

To file a complaint with the Office of Civil Rights, call or write:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201
1-877-696-6775 (toll free)

Still Waters
Counseling

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____(client name), acknowledge that I have received a copy of Still Waters Counseling's Notice of Privacy Practices.

My signature below indicates that I have received the notice and that I have been provided an opportunity at ask questions about the agency's privacy practices as they pertain to my protected health information.

_____

Signature Date

Still Waters Counseling

FEE AGREEMENT

Initial Assessment	$195.00
Individual/Family Counseling	$165.00 (60 min); $110.00 (45 min); $85.00 (30 min)
Crisis Intervention Contact	$165.00 / hour; $85.00 (each additional 30 min)
Group Therapy	$ 45.00 / hour
Psychological Testing	$150.00 / hour (including interpretation & write-up time)
Biofeedback Session	$165.00 (60 min); $100.00 (30 min)
Court Appearance	$300.00 / hour (including travel and preparation time)
Completion of Paperwork for Outside Entities (e.g., disability forms) - $50.00 per hour	

Clients are responsible for payment of all fees. We will be happy to submit a claim to your insurance company or provide you with a receipt for submitting your insurance claim. However, clients are ultimately responsible for payment of their bill.

Fees are payable at the time of service. A $75 broken appointment fee will be charged for counseling appointments canceled without a 24 hour notice or if an appointment is missed without notice. For Monday appointments, 24 hour notice means calling prior to your appointment time the Friday prior to your appointment.

For psychological testing sessions the broken appointment fee is $195 and cancelling/rescheduling requires 72 hour notice due to the large block of time that has been reserved.

There will be a $20.00 fee for each check returned for insufficient funds or other reasons, plus any fees charged to us by our bank.

If payment becomes problematic for you, we are willing to develop an individualized payment agreement with you. However, if you fail to communicate with us about your bill or do not follow through on the payment plan, we reserve the right to turn your account in to collections. Your signature below gives us the right to report any unpaid amounts to a credit reporting agency, to obtain a copy of your credit report to help us or our agent to collect any amounts not paid by you. You also agree that you may be held liable for attorney fees, court costs, collection fees or other costs involved in collecting any unpaid amounts.

I have read and agree to the terms of the above fee policy.

_____ _____

Client / Parent / Legal Guardian Name / Date (please print) Client / Parent / Legal Guardian Signature

The form of payment I prefer to use is: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Savings Account

I would like to use the following credit/debit card for the purpose of making automatic payments (optional):

Name on Card: _____ Card #: _____

Exp. Date: _____ CVV Code: _____ Signature: _____

Still Waters Counseling

Understanding Psychological Testing

At Still Waters Counseling, we are aware that when you schedule psychological testing you are making an investment, and want to you get as much value from it as possible. We believe that a comprehensive psychological testing package is the best value, but we also offer a brief screening that is less expensive. You will have the option of choosing either of these. In order for you to make an informed choice, the factors to consider are discussed below.

The Goals of Psychological Testing

The first goal of comprehensive testing is to come to clinically valid and reliable conclusions about a person's functioning - including detailing a person's strengths, weaknesses, and diagnoses. Once this is known, you can move forward with the second goal: obtaining appropriate treatment. It is certainly common sense that you shouldn't treat something until you know what you are going to treat. If you went to your doctor and he told you he didn't know what was causing your symptoms, but wanted you to try a medicine based on a hunch, you certainly wouldn't take it. Psychological treatment is the same. You don't want to waste time and resources by trial and error - you want to know what the cause of the problem is, so that the first treatment you try is the correct one.

Comprehensive testing looks at many different possible causes of difficulties, including depression, anxiety, ADHD, learning disabilities, autism spectrum disorders, addiction, reaction to trauma, personality traits, and environmental factors (e.g., home or school environment). Through this method we can not only make accurate diagnoses, we can also "rule out" other problems. This is important because people can have more than one problem at a time. For example, people diagnosed with ADHD have a much higher chance of also having an Autism Spectrum Disorder or a Learning Disability than do people without ADHD. Knowing all the conditions that exist allows you to seek the appropriate combination of treatments. Knowing both what is going on and what isn't going on allows us to make very specific recommendations that are the most likely to be effective and efficient.

Only comprehensive testing can provide the above information. As opposed to this, a screening looks at one particular diagnosis and determines whether or not it appears to be present. There are certain situations in which a screening might be desirable and sufficient. For example, if a person was diagnosed with ADHD as a child, but now that they are an adult their insurance company wants confirmation of the diagnosis, a screening looking only at ADHD symptoms may be sufficient for that purpose. The down side is that a screening cannot be definitive because it can't rule out other possible causes of the symptoms. Only a comprehensive evaluation can do this, although it takes longer and is more expensive. Your psychologist will discuss this with you as it relates to you or to your child so that you can make the right choice for your circumstances.

The Process of Psychological Testing

The first step is to come to a mutual understanding about what questions need answering through testing. For example, questions might include "why is Jane doing so poorly in school,"

"why is John always getting in trouble," or "do I have Bipolar Disorder?" Once we know the questions, we can start gathering the information needed to answer them.

The methods used to gather the information for psychological testing are many. They include giving standardized psychological tests and questionnaires, getting information about a person's physical and intellectual development, getting the perspectives of several different people about what strengths and what difficulties a person is having, and reviewing any records of past psychological or treatment or testing. Documents such as report cards, workplace evaluations, and others will also be reviewed (if available). The psychologist will also observe the person during the course of the evaluation to find clues regarding their strengths and weaknesses.

Once all of the information is gathered, the psychologist will score and interpret the data, then come to conclusions about the diagnoses. They will write a report that details the results of each test and a conclusion about diagnosis. The psychologist will then set up a feedback session where they will go over the report with you and answer any questions you may have about the findings. Treatment recommendations will included in the report and discussed with you at the feedback session. The psychologist wants you to understand how they came to the conclusions they did, and will gladly address any questions or concerns.

How Much Will Psychological Testing Cost?

The initial assessment costs $195.00 and is used to understand the situation, discuss the needs of the person, and determine what type of testing is needed. A comprehensive psychological assessment usually takes 18-20 hours of the psychologist's time to complete, and costs $2,500 - $3,000. Since the fee is based on the total time spent (including interpretation and write-up time), we cannot give you an exact estimate prior to the testing. However, our administrative staff will contact your insurance company to get a rough estimate of the cost to you, based on your benefits, deductible, and copayment amounts. The feedback session costs $160.00, which can also be billed to your insurance. In the feedback session your psychologist will give you a summary of the results, what they mean, and make recommendations for treatment. This time is also used to answer any questions you might have about the testing and results.

It is possible that your insurance won't pay for all of the tests / instruments that are needed, but will pay for others. For example, some insurance companies will not pay for "educational testing" such as measures of intelligence testing or learning disabilities. Some people do not want their insurance involved at all, usually for privacy reasons, and prefer to pay the entire cost themselves. Our office staff and your psychologist can help you make any decisions regarding payment. If you can't afford to pay your entire balance at the time of the testing, we are happy to set up a payment plan. We don't want money to get in the way of you receiving the information you need to make important decisions about your treatment.

We look forward to meeting with you and answering any questions you might have.

Brian Pearson, Ph.D.
Fully Licensed Psychologist
Clinical Director, Still Waters Counseling

Psychological Testing – Parent Packet #1

Directions: Please fill out the following forms as completely as you can.

Try to answer every question, and be as honest as possible with each one.

Do not try to make your child "look good" or "look bad." We need as accurate a picture as possible so that we can make our evaluation as helpful as possible.

If you have any questions, mark the items you aren't sure of and discuss them with the person conducting the evaluation.

Please return this packet to the person conducting the evaluation, or drop it off at our Saline office.

Thank You!

Still Waters Counseling

PEARSON DEVELOPMENTAL HISTORY PROTOCOL

Child's Name: _____ Date this form was completed: _____

Name of Person Answering Questionnaire: _____

Child's Date of Birth: _____ Place of Birth (city / state / country): _____

Child's Current Grade Level / School: _____

Who Referred You for Testing? _____

Is this child your: ☐ biological child ☐ Step-child ☐ Adopted child ☐ Foster child ☐ Other (specify):

With which parent does the child live? ☐ Both ☐ Mother only ☐ Father only ☐ Other (specify):

Do you have legal custody of this child? ☐ Yes ☐ No (if parents divorced, proof of legal custody required)

Names and relationship of other adults living in the home: _____

_____

How many children are in the family? _____

First names and ages of all children living in the home: _____

_____

PARENTAL CONCERNS ABOUT THE CHILD - REASONS FOR THE EVALUATION

What concerns brought you in to seek testing for your child? _____

_____

Is there a specific incident that triggered you to bring him/her in? _____

_____

What type of information or treatment do you hope to get from this evaluation? _____

_____

Does your child have any of the following?	At Home	At School	In the Community
Behavior problems?	☐	☐	☐
Academic or learning problems?	☐	☐	☐
Social problems?	☐	☐	☐
Attention problems?	☐	☐	☐
Drug or alcohol problems?	☐	☐	☐

Problems controlling emotions? ☐ ☐ ☐

Other concerns: _____

_____

_____

DEVELOPMENTAL HISTORY

Pregnancy and Birth

Was the pregnancy full-term? ☐ Yes ☐ No If not, specify time and reason: _____

Were there any problems at birth or in the first two weeks after delivery? ☐ Yes ☐ No

If yes, specify: _____

Describe any serious childhood illnesses or injuries: _____

_____

Describe any traumatic experiences your child was exposed to: _____

_____

Did your child ever receive a blow to the head strong enough she that he/she lost consciousness, vomited, or was dizzy? ☐ Yes ☐ No If so, please detail: _____

_____

Were there any lasting effects from these injuries? ☐ Yes ☐ No If so, please detail: _____

_____

Developmental Milestones (as well as you can, please fill in the age at which each milestone was reached)

Sitting up _____
Standing _____
Walking _____
First word _____
Using 3-4 word sentences _____
Potty trained during day _____
Potty trained at night _____

Problems in Development (please list any problems or concerns you have had about your child's development)

Sensory (impairments in vision, hearing, sense of touch or smell; abnormal reactions to sensory stimuli, etc.)

_____

Motor (coordination, gait, balance, posture, fine motor coordination, tics, gestures, nervous habits, etc.)

Language (delays, comprehension problems, speech difficulties)

Emotional (overreactions, mood swings, extreme or unpredictable moods, unusual fears or anxieties, etc.)

Thinking (has odd ideas, preoccupations, fixations, unusual fantasies, delusions, etc.)

Social Behavior (aggressive, rejected, bullied, shy, socially anxious, doesn't talk to others, no friends, etc.)

Intelligence / Academic Skills
(delays in mental development, problems with memory, specific delays in reading, math, or other academic areas)

PARENTING METHODS

What types of discipline do you use in your household (list most common methods first, and so on):

If these methods do not work and the behavior continues, what are you most likely to do then?

Are the parents in agreement about and use the same discipline strategies? ☐ Yes ☐ No

If no, please describe:

PREVIOUS EVALUATION AND TREATMENT

Has your child ever been evaluated for psychological, developmental, behavioral, or learning problems?

☐ Yes ☐ No

If so, what type of evaluation was it, who did the evaluation, and what were you told about the results? _____

Has your child ever received any psychiatric or psychological treatment? ☐ Yes ☐ No

If so, what type of treatment did he/she receive and how old was he/she at the time? _____

How long did the treatment last? _____

Who provided the treatment? _____

Has your child ever received any *medications* for his/her behavior or emotional problems? ☐ Yes ☐ No

If so, what medications did he/she take, and at what age? _____

Who prescribed the medications? _____

Which medications were most effective? _____

Least effective? _____

Did any medications make things worse? ☐ Yes ☐ No

If yes, please describe: _____

SCHOOL HISTORY

Please describe your child's behavior and performance in school, starting from pre-school / kindergarten. Describe when problems began and ended, and in what grades. What have teachers told you about your child?

Has this child ever received any special education services? ☐ Yes ☐ No

If so, what types of services did he/she receive and in what grades? _____

What are your child's best subjects? _____ Worst subjects? _____

Who was your child's favorite teacher? _____ Why? _____

What teacher did your child dislike the most? _____ Why? _____

CHILD'S PSYCHOLOGICAL & SOCIAL STRENGTHS

What are your child's personality characteristics, abilities, and social strong points? _____

What are your child's best subjects in school? _____

What hobbies, games, sports, or social activities does your child like to engage in? _____

What other positive points would you like us to know about your child? _____

FAMILY HISTORY

Many medical, psychological and learning disorders run in families. Being as honest as you can with the information you have, check which problems are/were present in members of your child's family.

BIOLOGICAL PARENTS

	Mother	Father
History of psychological or emotional problems?	☐ Yes ☐ No	☐ Yes ☐ No
History of behavior problems?	☐ Yes ☐ No	☐ Yes ☐ No
History of alcohol or substance abuse problems?	☐ Yes ☐ No	☐ Yes ☐ No
History of serious or chronic medical problems?	☐ Yes ☐ No	☐ Yes ☐ No
History of antisocial / illegal behavior?	☐ Yes ☐ No	☐ Yes ☐ No
History of legal problems or arrests?	☐ Yes ☐ No	☐ Yes ☐ No
Victim of Abuse?	☐ Yes ☐ No	☐ Yes ☐ No
Perpetrator of Abuse?	☐ Yes ☐ No	☐ Yes ☐ No
History of psychiatric hospitalization?	☐ Yes ☐ No	☐ Yes ☐ No
History of suicide attempt or completion?	☐ Yes ☐ No	☐ Yes ☐ No
Highest grade or degree attained:	_____	_____
Current or last job held:	_____	_____

Is there any other important parental history we should know about? ☐ Yes ☐ No

_____

_____

_____

_____

_____

_____

_____

_____

SIBLINGS / GRANDPARENTS / AUNTS / UNCLES

History of psychological or emotional problems? ☐ Yes ☐ No

If yes, who: _____

History of behavior problems? ☐ Yes ☐ No

If yes, who: _____

History of alcohol or substance abuse problems? ☐ Yes ☐ No

If yes, who: _____

History of serious or chronic medical problems? ☐ Yes ☐ No

If yes, who: _____

History of antisocial / illegal behavior? ☐ Yes ☐ No

If yes, who: _____

History of legal problems or arrests? ☐ Yes ☐ No

If yes, who: _____

Victim of Abuse? ☐ Yes ☐ No

If yes, who: _____

Perpetrator of Abuse? ☐ Yes ☐ No

If yes, who: _____

History of psychiatric hospitalization? ☐ Yes ☐ No

If yes, who: _____

History of suicide attempt or completion? ☐ Yes ☐ No

If yes, who: _____

Is there any other important family history we should know about? ☐ Yes ☐ No

_____

_____

_____

HOME ENVIRONMENT

How would you describe the relationships between the members of your family who live in the household?

How would describe the nature of the marital relationship?

☐ Excellent ☐ Good ☐ So-So ☐ Bad ☐ Terrible

Is there any history of abuse or domestic violence in your household? ☐ Yes ☐ No

Has anyone in the household had difficulties with alcohol or drugs? ☐ Yes ☐ No

How does your child get along with the other people in the household?

Please list all of the people who live in your household, their relationship to the child, their ages:

Please list all people who regularly interact with your child, such as grandparents, babysitters, etc. Describe any problems, if any, with your or your child's relationships with them:

Are you divorced or separated from your child's other biological parent? ☐ Yes ☐ No

If no, skip the last 3 questions.

If yes, please describe the custody and visitation arrangements:

How well do you get along with the other parent?

Are both of you able to cooperatively discuss and resolve your child, their needs, and any problems that arise?

☐ Yes ☐ No (If no, please describe):

If you would like to add anything further to your comments, please do so here:

- Thank You ! -

Parent Comments

Please include any comments you would like to make regarding your child.
Anything you can add that will help us understand your child will be VERY helpful.