

LUCY DANIELS CENTER FAMILY GUIDANCE SERVICE  
REGISTRATION INFORMATION

Family Information

**Child:**

Full name / Nickname \_\_\_\_\_ Gender \_\_\_\_\_  
Date of birth / Place of birth \_\_\_\_\_  
Resides with: \_\_\_\_\_

**Parent / Guardian # 1:**

Full name \_\_\_\_\_  
Address/City/State/Zip \_\_\_\_\_  
Telephone Numbers Home \_\_\_\_\_ Cell \_\_\_\_\_ Business \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Date of birth / Place of birth \_\_\_\_\_  
Occupation / Place of business \_\_\_\_\_

**Parent / Guardian # 2:**

Full name \_\_\_\_\_  
Address/City/State/Zip \_\_\_\_\_  
Telephone Numbers Home \_\_\_\_\_ Cell \_\_\_\_\_ Business \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Date of birth / Place of birth \_\_\_\_\_  
Occupation / Place of business \_\_\_\_\_

**Sibling One:**

Full name / Nickname \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

**Sibling Two:**

Full name / Nickname \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

**Sibling Three:**

Full name / Nickname \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

**Family Guidance Service**  
**Consent for Evaluation and Treatment**

I hereby give permission for the Family Guidance Service (FGS) of the Lucy Daniels Center to provide evaluation, treatment and consultation services as necessary and as agreed upon for my child:

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

I understand that, within the parameters of my child's right to confidentiality, I may obtain information regarding the progress and outcome of the above-named services by contacting my child's therapist directly.

I understand that I may revoke, in writing, this consent at any time except to the extent that action based on this consent already has been taken. This consent will expire 365 days after the date below. This authorization and request is fully understood and made voluntarily on my part. By signing below, I affirm that I am legally authorized to give consent on behalf of my child.

**Please note that in cases of shared legal custody, or in the absence of documentation regarding custody, consent to evaluate and provide treatment must be provided by both parents.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Date

LUCY DANIELS CENTER REPRESENTATIVE SIGNATURE / DATE: \_\_\_\_\_

# Family Guidance Service

## Consent to Release Personal and Medical information

**Lucy Daniels Center**  
9003 Weston Pkwy Cary NC 27513

Office: 919-677-1400 Fax: 919-677-1489  
[www.Lucydanielscenter.org](http://www.Lucydanielscenter.org)

**Client's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Physician name and Group:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Is this the referring Pediatrician or Physician?** Yes  No

**Pediatrician:** It is customary for the Lucy Daniels Center to send a letter to your child's pediatrician(s) or family physician(s) to notify them that you have accessed services at our Center on your child's behalf, or to send them a report of your child's evaluation. We do this because your child's overall health care will benefit when your child's physician is knowledgeable about your child's emotional health.

LDC has permission to **release**  **Obtain**  **Release and Obtain**  **No Permission**   
information with my child's **Pediatrician**. (Check one) Other: \_\_\_\_\_

**School or other source Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Did the school other source refer you to Lucy Daniels Center?** Yes  No

**School or other source:** It is often helpful for the Lucy Daniels Center to obtain information from your child's teacher(s), other school personnel or agency that has direct involvement with your child. On many occasions, it is helpful for LDC to obtain information from your child's school, after-school care provider or other source.

LDC has permission to **release**  **Obtain**  **Release and Obtain**  **No Permission**   
information with my child's **School or other source**. (Check one) Other: \_\_\_\_\_

**Description of Information to be Disclosed** (Client should initial each item to be disclosed)

\_\_\_\_\_ Assessment and Diagnosis    \_\_\_\_\_ Psychological Testing    \_\_\_\_\_ Treatment Plan and Final summary

I understand that the information named in this consent will be used for the purposes of the evaluation and treatment of my child. My right to confidentiality has been explained to me and I understand what information will be released or obtained, the need for the information, and that State statutes and regulations protect the confidentiality of authorized information. I understand that I may revoke, in writing, this consent at any time except to the extent that action based on this consent already has been taken. This consent will expire 365 days after the date below. The authorization and request is fully understood and made voluntarily on my part. By signing below, I affirm that I am legally authorized to give consent on behalf of my child.

\_\_\_\_\_  
Signature of legal guardian:

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Date:

**Family Guidance Service  
Insurance Information**

Client Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**POLICY HOLDER'S INFORMATION**

Primary Insurance Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Gender:  Male  Female

Social Security #: \_\_\_\_\_ Policy ID# (if different from SSN): \_\_\_\_\_

Group number: \_\_\_\_\_ Group Name: \_\_\_\_\_

Client's Relationship to Policy Holder: Self  Spouse  Child  Other

**Client Has No Active Insurance**

We participate with some insurance plans. **We do not file claims to any insurance in which we do not participate.** Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits. PLEASE REMEMBER: The agreement of the insurance carrier to pay for health care is a contract between you and the insurance company.

I authorize the disclosure of clinical and/or medical information necessary to process payment including but not exclusive to, commercial insurance companies, Medicaid, Health Choice and request payment of benefits to The Lucy Daniels Center. I request that payment for benefits be made on my behalf to The Lucy Daniels Center for any services furnished for me. I authorize release to the center for Medicaid and insurance companies and its agent of any medical information about me needed to determine these benefits payable for related services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Date

# Family Guidance Service Fee Agreement

CHILD'S NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**Families are responsible for paying their full current financial obligation on each date of service. Please understand that we maintain this expectation under all circumstances without exception.**

**I: INSURANCE PROVIDERS:** Lucy Daniels Center contracts with most major insurance providers. If you are covered by an insurance provider with whom we contract, you will be responsible for any deductible and co-payments required by your insurance provider. The Center will bill and collect payments from your insurance provider, and send you a monthly statement that summarizes all payments. You are responsible for full payment for uncovered services, including sessions beyond the limits covered by insurance providers.

We accept Medicaid for recipients who do not have other third-party coverage. We do not accept Medicaid for recipients who have other third-party coverage.

Occasionally we do not contract with a family's insurance provider. In that event, you would be responsible for the full payment of all fees at the time of service (see fee schedule.) The Lucy Daniels Center will submit claims to your insurance provider if you have out-of-network benefits, and reimburse you for payments that the Center may receive.

Families without health insurance or who choose not to use the insurance are responsible for all fees.

Families covered by Medicaid or North Carolina HealthChoice will not have any out-of-pocket financial obligation of any sort for any services, covered or uncovered.

## **II: NON-COVERED SERVICES (BY INSURANCE PROVIDERS)**

**Many services necessary to provide care for your child are "non-covered" by insurance providers.**

- **Diagnostic Fee (\$150):** On many occasions, we recommend that we conduct a diagnostic assessment on a child so that we can achieve a better understanding of the child's challenges and how to help. All evaluations (except those for families covered by Medicaid) will have a diagnostic fee of \$150 that helps to cover our cost for many non-covered activities beyond the clinician's visits with parents and child. These non-covered services include: establishing the records and billing, communicating (administrator and/or clinician) with insurance provider, clinician reviewing records including developmental history, clinician contacting school or other professionals by phone or letter, clinician record keeping, and clinician phone conversations with parents. This Diagnostic Fee will always be part of any diagnostic evaluation, except for clients covered by Medicaid. The following non-covered fees may or may not be a part of any particular evaluation:
- **School observation (\$150):** Provided by a Lucy Daniels Center child development specialist, including approximately one hour observation, travel time, report generation, and consultation with clinician.
- **School consultations (\$150/hr.):** Any conference or consultation with school personnel, in person or by telephone, including travel time.

Although you can expect that the diagnostic fee, school observation, and school consultation will not be covered services by your insurance company, there are rare exceptions, and we will inform you in those instances.

## **III: PSYCHOLOGICAL TESTS**

There are occasions when we recommend that we administer and interpret psychological tests. These tests are provided by our psychological staff. These are generally covered, at least to some degree, by health insurance. There is a great deal of variability with regard to out-of-pocket expense for psychological testing, depending upon an individual's insurance coverage and the particular testing required. We will provide information about the expense of the recommended testing before we begin the testing so that you would know the estimated expense.

**Family Guidance Service Fee Agreement (continued)**

**IV: UNDISCOUNTED FEE SCHEDULE**

The Lucy Daniels Center undiscounted fee schedule applies to families who are in the deductible period, who are not using insurance with an insurance provider with whom Lucy Daniels Center contracts, or who are paying out of pocket. Although we accept contracted (discounted) amounts with providers with whom we have contracted as full payment due (in addition to the co-payments) *for covered services*, our statements to the insurance providers will generally show our full, undiscounted fee.

- **For most types of sessions, our undiscounted fee is:**
- **Clinical Social Worker (L.C.S.W.): \$125.00/45-50 minute session**
- **Psychologist (Ph.D. or Psy.D.): \$150/45-50 minute session**
- **Psychiatrist (M.D.): \$150 – \$250/ 45-50 minute session**

**V: ADDITIONAL POLICIES**

- Account must be paid in full at each visit with personal check, debit card, or credit card. Payment by check is strongly preferred. An administrative fee of \$35 applies on each occasion that account is not paid in full.
- Statements will be mailed or emailed monthly. Balances that are shown on the statements may change subject to the resolution of insurance claims.
- We charge a \$25.00 fee for checks returned for non-payment for any reason.
- We have a sliding scale fee (need based fee reduction) for qualifying families who do not have insurance coverage.
- We ask that you make every effort to keep appointments. **We charge a \$50.00 fee for appointments that are cancelled. These sessions cannot be submitted for insurance reimbursement.**
- There are two circumstances under which we will waive the cancellation fee:
- Grace period: We will waive the fee if the appointment is cancelled no later than 48 before the time of the appointment.
- Illness: On an honor system, parents will not be charged for appointments that are canceled because of illness on the part of parent or child, up to the time that the appointment is scheduled to begin. Please cancel a session when your child has any symptoms that we describe in our guidelines. The session must be canceled in advance of the session time in order for the cancellation fee to be waived.

**There are absolutely no exceptions to this policy.** We understand that conflicts will come up that will make it difficult or impossible for you to keep an appointment. Nevertheless, we will charge under any and all circumstances, other than the exceptions described above. Our staff does not have the discretion to make exceptions to this policy. Our \$50.00 fee for cancellations is a compromise amount that takes into account the possibility that the cancellation was unavoidable and that we cannot use that cancelled hour for revenue generation. The fee for a missed session is due at the time of the next appointment in accordance with our policy that your account is paid in full at the time of each session.

**I have read and agree to the provisions of the Lucy Daniels Center fee policies as described above**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Date

## Family Guidance Service Communications

From time to time the Lucy Daniels Center for Early Childhood sends communications like newsletters, e-newsletters, and invitations to Center events to our clients, alumni, volunteers, friends and supporters. With your permission, we would like to include you in these mailings. Each mailing will provide an opportunity to cancel future mailings, if for any reason you decide that you no longer want to receive the communications.

- I **would like** to receive Center communications:
- I prefer **not to** receive Center communications:

The Lucy Daniels Center also makes grant applications to major employers in the Triangle area. In many cases they ask us to provide names of clients and/or volunteers who are affiliated with the Center and employed by them. We are committed to preserving the confidentiality of your consultation, and our solution is to provide information to these employers in a **statistical** form. This information will be reported only in a numerical and aggregate form: for example, we might report to Cisco that we have four Cisco parents of students and/or clients affiliated with the Center. (No other information will be provided.) Please let us know if you give your permission to be represented on these grant applications.

- I **give** the Lucy Daniels Center for Early Childhood permission to report to my or my spouse's employer as part of a grant application process from the Center that my child/children have been served by the Lucy Daniels Center for Early Childhood:
- I prefer **not** to be represented:

Your permission will be for this restricted use only. For your information, whether you provide this permission or not, the Center will never sell or trade your name and address information with any other organization.

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Print Name/s

E-mail address

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Signature/s

Date

Lucy Daniels Center Family Guidance Service  
9003 Weston Pkwy Cary, NC 27513  
919-677-1400

The Family Guidance Service is evaluating our work to help us understand how we can better serve parents and families.

We are asking parents to complete surveys to help us learn more about our services and treatment. Participation in this evaluation is voluntary. A code will be used to identify surveys in order to provide confidentiality of personal information. The surveys that we gather will be examined by our research team and will not be shared with your clinician. Your participation is greatly appreciated.

**To participate:**

We ask that you take 5 – 10 minutes to complete this survey and bring it with you to your first appointment.

Please circle the answer that best fits the question. Instructions are provided above each section.

We may ask you to fill out some forms at some future times, if we continue to serve you and your child. These will also just take a short time to complete.

Thank you very much.

## Ohio Youth Problem, Functioning, and Satisfaction Scales

### Parent Rating – Short Form A (Intake)

Date: \_\_\_\_\_ Child's Age: \_\_\_\_\_ Child's Grade: \_\_\_\_\_ Child's Sex:  Male  Female

ID#: \_\_\_\_\_  
Completed by LDC Staff

Form Completed By:  Mother  Father  Step-mother  Step-father  Other: \_\_\_\_\_

<b>Instructions:</b> Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
8. Lying	0	1	2	3	4	5
9. Can't seem to sit still, having too much energy	0	1	2	3	4	5
10. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
11. Talking or thinking about death	0	1	2	3	4	5
12. Feeling worthless or useless	0	1	2	3	4	5
13. Feeling lonely and having no friends	0	1	2	3	4	5
14. Feeling anxious or fearful	0	1	2	3	4	5
15. Worrying that something bad is going to happen	0	1	2	3	4	5
16. Feeling sad or depressed	0	1	2	3	4	5
17. Nightmares	0	1	2	3	4	5
18. Eating problems	0	1	2	3	4	5

**(Add ratings together) Total** \_\_\_\_\_  
Completed by LDC Staff

**Instructions:** Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. How capable of dealing with your child's problems do you feel right now?

1. Extremely capable
2. Moderately capable
3. Somewhat capable
4. Somewhat incapable
5. Moderately incapable
6. Extremely incapable

3. How much stress or pressure is in your life right now?

1. Very little
2. Some
3. Quite a bit
4. A moderate amount
5. A great deal
6. Unbearable amounts

4. How optimistic are you about your child's future right now?

1. The future looks very bright
2. The future looks somewhat bright
3. The future looks OK
4. The future looks both good and bad
5. The future looks bad
6. The future looks very bad

**Total:** \_\_\_\_\_

<b>Instructions:</b> Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
4. Keeping neat and clean, looking good	0	1	2	3	4
5. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
6. Controlling emotions and staying out of trouble	0	1	2	3	4
7. Being motivated and finishing projects	0	1	2	3	4
8. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
9. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
10. Completing household chores (cleaning room, other chores)	0	1	2	3	4
11. Attending school and getting passing grades in school	0	1	2	3	4
12. Feeling good about self	0	1	2	3	4
13. Thinking clearly and making good decisions	0	1	2	3	4
14. Concentrating, paying attention, and completing tasks	0	1	2	3	4
15. Doing things without supervision or restrictions	0	1	2	3	4
16. Accepting responsibility for actions	0	1	2	3	4
17. Ability to express feelings	0	1	2	3	4

Dear Parent(s):

Individuals, corporations, foundations and others in our community generously provide charitable funds that help support the Lucy Daniels Center because the combined payments from parents and insurers generally do not cover the full cost of the quality care that we provide. Charitable funders often request information about the population we serve. We sincerely request your help so that we can provide this information. Your participation is entirely optional. Your information will not be identifiable in any way, including to Lucy Daniels Center staff. Thank you for taking a few extra minutes to provide this information.

**1. Birth Year of Child:** \_\_\_\_\_

**2. Number of household members:**  2  3  4  5  6  7  8 or more

**3. Gender of child:**  Female  Male

**4. Heritage (check all that apply):**

- White  African American  Hispanic  East Asian  South Asian  
 Native American  African  Multicultural  Other

**5. City and County:** \_\_\_\_\_

**6. Zip Code:** \_\_\_\_\_

**7. Total household income (Gross unadjusted salaries before deductions):**

- Under \$30,000  \$30,000 – \$49,999  \$50,000 – \$75,000  
 \$75,000 – \$100,000  over \$100,000

**8. Please indicate how you decided to consult the Lucy Daniels Center (check more than one if appropriate):**

- Recommendation from pediatrician  
 Recommendation from mental health professional  
 Recommendation from childcare professional  
 Recommendation from teacher in kindergarten, elementary or middle school  
 Recommendation from another organization (specify)

\_\_\_\_\_

- Recommendation from prior client of Lucy Daniels Center  
 Recommendation from friend  
 Recommendation from insurance company or insurance panel list  
 Website  
 Carolina Parent articles  
 Media Source other than Carolina Parent  
 Lucy's Book Club

Other (specify) \_\_\_\_\_