

Client Name Harry Potter Medicaid # 1234567891  
Birthdate 7/31/03 Insurance # 84356297

## Intake Enrollment Packet

Select and print the forms that apply to your client's care

1. Upload the following documents to the Client Set-up in the Electronic Medical Records System/**client signature is required:**

- ☒ Permission for Treatment
- ☒ Payment Plan and Insurance Information
- ☒ Primary Care Physician form
- ☒ N/A Scan of front and back of each insurance card - not available
- ☒ Treatment Plan Signature Page

2. Consider obtaining the following release of information forms as they apply to your client's needs.

- ☒ For child ages 12 to 17 giving consent to discuss behavioral healthcare information with parents
- ☒ Pediatrician
- ☐ Psychiatrist or Prescribing Physician
- ☒ Educational System (School)
- ☐ Psychiatric Hospital for previous treatment records and/or possible future admissions
- ☐ Child Care Provider
- ☐ Legal Representation
- ☐ Release to External TCM
- ☐ Release to the External BHP
- ☐ Release to the External CSA
- ☐ Release to DCBS / DJJ
- ☐ Natural Resource persons
- ☒ Emergency Medical Care
- ☒ External Supervisor for Provider Release (for associates and CSWs under clinical supervision)
- ☒ Transportation Form
- ☒ Authorization to Record/Video Tape (for associates under clinical supervision)

3. The following information is to be given to the client:

- ☒ Mission Statement
- ☒ Health Information Privacy
- ☒ Quality Assurance Program

4. The following pages are tools that maybe used to assist in screening and diagnosis. The scores should be added to the diagnostic evaluation and treatment plan. The completed forms do not need to be saved to the client chart.

- ☒ Screening and Mental Status Exam for Children and Teens
- ☐ Screening and Mental Status Exam for Adults
- ☒ PHQ-9 Depression Inventory for Teens and Adults with diagnosis of depression or dysthymia, **HEDIS requirement**
- ☐ The provider may choose to use other diagnostic tools. More are available through our website at [Tools for Assessment, Diagnosis, and Referral](#).

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## Permission for treatment/services

### Freedom of Choice

I understand that the choice of providers is my responsibility and right as the client or guardian. I further understand that I have the right to contact the providers prior to selection so that I may determine the best provider. I also understand that I may at any time choose another provider for this service by notifying my current provider.

### Informed Consent

I understand that participation in treatment does not guarantee anticipated outcomes. I understand that there may be unintended results of treatment affecting the client and other family/household members. I understand that providers are legally bound to report suspected abuse of the client or of other family members. I also understand that the providers have a duty to warn any intended victim of a threat to harm.

### Persons Participating in Home and Community Based Services

I understand that I am giving permission to include in the client's treatment sessions any persons present in the home, school or community at the time of service. This includes but is not limited to myself, parents, spouses, step-parents, paramours, siblings, children, extended family, household visitors, caregivers, playmates and classmates. I also understand that I have the right to dismiss anyone from participating in a session at any time and that I have the right to exclude anyone from the ongoing treatment process by written notice to the provider.

### Privacy Practices

I understand that Transformations adheres to the Health Information Privacy Act and I agree to these practices. I agree that this information has been made available to me for me review.

### Responsibilities

I understand my responsibility is to: 1) provide accurate information and report any changes in client wellbeing, 2) to keep all appointments and to give 24 hour notice of a need to reschedule, 3) to maintain the client's insurance coverage and report any lapse in coverage to the service provider, 4) to contribute to a plan of treatment and to follow through with agreed upon interventions.

I understand that I am financially responsible for any services received. I agree to report all primary and secondary insurance coverages. I agree to pay any co-pay, deductibles, and co-insurance agreed upon with my insurance company. I give permission to file insurance claims on services provided with any insurance companies with which I or my child is enrolled. I give Transformations permission to file treatment plans to request authorization for services. I also understand that a treatment plan may include information such as diagnosis, symptoms, treatment goals, and progress reports. This release includes any dependents for which Transformations staff is also providing treatment

Permission is hereby given to Transformations staff and its service providers to render screening, assessment, treatment and support services to the above-named client and under the above-named conditions.

Harry Potter  
Signature of Client

Rubeus Hagrid  
Signature of Parent or Legal Guardian

DCBS/Guardian  
Relationship to Client

Minerva McGonagall, LPC 3/19/19  
Witness Date



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## Client and Payment Information

Client Address 4 Privet Dr City/State/Zip Louisville, Ky 40299  
Client SS#: 1789-10-1112 Guardian name /address Rubeus Hagrid - DCBS worker  
Phone # 502-595-5651 Email rhagrid@ky.gov  
Foster parent/ address/phone Petunia + Vernon Dursley (Aunt + Uncle) 4 Privet Dr Lou Ky 40299  
(502) 495-1696

I understand that I am financially responsible for any services received. I agree to pay Transformations any co-pay, deductibles, and co-insurance agreed upon with my insurance company. I give Transformations permission to file insurance claims on services provided with any insurance companies with which I or my child is enrolled. I give Transformations permission to file treatment plans to request authorization for services. I also understand that a treatment plan may include information such as diagnosis, symptoms, treatment goals, and progress reports. This release includes any dependents for which Transformations staff is also providing treatment.

### PRIMARY INSURANCE: Provider must obtain a copy of both sides of all insurance cards

☒ Medicaid ☐ Private Insurance (primary over Medicaid) ☐ Medicare (primary)  
Policyholder (if other than client) \_\_\_\_\_ Policyholder's Date of Birth 7/31/03  
Policyholder address (if different from client) \_\_\_\_\_  
Primary Insurance Company Name Passport  
Policyholder's Employer (if applicable) \_\_\_\_\_  
Policy Number 84386297 Group # \_\_\_\_\_  
Social Security # of Policyholder (if other than client) \_\_\_\_\_ Payor ID \_\_\_\_\_

### SECONDARY INSURANCE:

☐ Medicaid (secondary to other insurances) ☐ Private Insurance (secondary to Medicare)  
Policyholder \_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_  
Policyholder address (if different from client) \_\_\_\_\_  
Secondary Insurance Company Name \_\_\_\_\_  
Policyholder's Employer \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Social Security # of Policyholder (if other than client) \_\_\_\_\_ Payor ID \_\_\_\_\_

### CLIENT PAYMENT RESPONSIBILITIES

Private pay agreement \_\_\_\_\_

Transformations accepts credit cards, checks, money orders and cash payments. Payment is expected at the time of service and arranged with your service provider.

Client or Guardian Signature Rubeus Hagrid Date 3/19/19

Witness Minerva Mc Honagall LPA Date 3/19/19

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## Authorization to Share Information with Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services, KRS 304.17A-555, and under the federal regulations governing of Alcohol and Drug Abuse patient Records 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This Authorization to Share Information will automatically expire one year after the date of your signature.

Electronic Records are preferred. Send by Fax to 502-899-5411 or  
Secure Email at [office@transformationsllc.net](mailto:office@transformationsllc.net)

Select one:

☒ I give permission to my Physician and to Transformations to share any applicable information from my Protected Health Information including immunization, treatments, behavioral health treatment plans, recommendations and other health care records.

☐ I do not give my Physician and Transformations permission to share my protected health care information.

Primary Care Physician Name, Address, Email Address & Fax Number

Poppy Pomfrey, APRN Phone: (502) 899-3322  
Hogwarts Pediatrics Fax: (502) 899-3321  
3347 Magic Lane Ste 102 Louisville Ky 40207  
Rubeus Hagrid 3/19/19  
Patient or Guardian signature please date

Date of consult 3/19/19

Diagnosis with Code F25.1 Schizoaffective Disorder depressive type  
and a brief description of presenting problem  
Symptoms of paranoia, delusions, hallucinations,  
and significant shifts in emotional state

Recommendations:

☒ Medication evaluation and monitoring for benefits, side effects and safety. for antipsychotic and/or antidepressant medication  
☐ Medical monitoring for health concerns:  
Other: individual psychotherapy, target case management services  
home & community-based psychotherapy services

Signature of Provider/credentials Minerva McGonagall Date Faxed or Mailed 3/19/19  
LECA

Transformations  
4010 Dupont Cir, Ste 582  
Louisville, KY 40207



Poppy Pomfroy  
Hogwarts Pediatrics  
38714 Magichero Ste 102  
Louisville, Ky 40207



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## Treatment Plan Signature Page

### TEAM MEMBERS' SIGNATURES

I agree with the treatment plan and acknowledge that I had an opportunity to participate in the development of the plan. I have also been made aware of my right of Freedom of Choice among sub-providers authorized to provide each service on the treatment plan.

Rubens Harold 3/19/19 Harry Potter 3/19/19  
Parent/Legal guardian/Caregiver (if child is under 18) Date Client Date

As a team member, I understand that I am to keep all information shared about the child confidential.

Minerva McGonagall LPCA Transformations 3/19/19  
Behavioral Health Professional (Required) Agency NPI # 1957366421 Date

\_\_\_\_\_  
Supervisor Signature & Credentials Agency NPI # Date

\_\_\_\_\_  
Targeted Case Manager (Required) Agency NPI # Date

\_\_\_\_\_  
Supervisor Signature & Credentials Agency NPI # Date

\_\_\_\_\_  
Other Agency Date

\_\_\_\_\_  
Other Agency Date

\_\_\_\_\_  
Other Agency Date

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## **Transformations hope for today's families**

### **Mission**

To promote mental, emotional, social, and behavioral health for adults, children and families.

### **Values**

Supporting and sustaining families is fundamental to the healthy development of both children and adults. Children's needs are best addressed within their community setting. Parents are equal partners in decision making at every level. Greater progress and growth is achieved when strengths are acknowledged and interventions are designed to build on an individual's identified strengths. A cross-disciplinary team approach enriches creativity, problem-solving, and intervention. Collaboration among agencies creates enhanced resources, improved quality, and greater accountability in the community.

### **Rights**

Clients and their families have the right to be treated with dignity and respect: Transformations does not discriminate on the bases of race, ethnic group, religion, gender, sexual orientation, political ideation, ability, educational level or previous life condition. You have the right to contribute to the goals, objectives, and interventions of your service plan. You have the right to complain and to expect resolution. You have the right to refuse to continue services at anytime. You and your family have the right to confidentiality. Information about your treatment or services with Transformations can be released to you or others only with your written consent. Exceptions to this law apply when the client or family member is in danger of causing injury to self or someone else. In limited circumstances the courts can force a therapist or service provider to release records to the legal system.

### **Responsibilities**

As a client or client guardian, you have the responsibility to provide accurate and complete information and to report any changes in the client's well-being.

You have the responsibility to keep all appointments to the best of your ability and to give 24 hour notice to the provider if you are unable to keep an appointment.

You are responsible to maintain the client's insurance card and to report any lapse in coverage to the service provider.

You are responsible to contribute to the formulation of a treatment plan with its goals and objectives and to follow through with your agreed upon interventions.

You are responsible to pay any copays, deductibles or coinsurances that you have agreed upon with your insurance company.



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**TRANSFORMATIONS: HOPE FOR TODAY'S FAMILIES, LLC**  
**NOTICE OF PRIVACY PRACTICES**

02/26/2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING.

• Understanding your health information

When you/your child begins working with Transformations a record of treatment is made. Typically, this record contains you/your child's history, assessment, medical information, diagnoses, treatment, a plan for future treatment, etc. This information often referred to as you/your child's health or medical record, serves as:

- \*Basis for planning your/your child's care and treatment
- \*Legal document describing the care you/your child received
- \*Means by which you or a third party payer can verify that services billed were provided
- \*A source of data for health officials charged with improving the health of the nation, or needed services for the area
- \*A tool by which future or continual services can be approved

Understanding what is in this record will help you to ensure its accuracy, better understand who, what, when and why others may access you/your child's information and help to make more informed decisions when authorizing disclosure to others.

**YOUR HEALTH INFORMATION RIGHTS**

Although the health record is the physical property of Transformations, the information belongs to you. You have the following rights:

Right to Request a Restriction

You have the right to request a restriction on our use and sharing of you/your child's protected health information. Transformations can deny the request if it is unreasonable or would be detrimental to your/your child's treatment.

Right to a paper copy of this Notice

You have a right to obtain a paper copy of this notice. You may obtain a copy by notifying Transformations office at 502/899-5411 or mailing a request to 4010 Dupont Circle, Suite 582, Louisville, KY 40207.

Right to amend your/your child's health information

You have the right to request the agency to amend the health information we maintain about you/your child if you feel it is incorrect or incomplete for as long as the information is kept by Transformations. To request an amendment, you must submit a request in writing and state the reason that supports your request. The disputed information will remain in the record along with the amended information. Transformation may deny your request if the request is not submitted in writing, does not contain a reason to support the request, the information that is being questioned was not originated by Transformations, it is not part of the information which you are permitted to inspect or copy, or it is currently accurate and complete.

Right to an accounting of disclosures

You have the right to obtain an accounting of the disclosures Transformations made of health information about you/your child. This does not include disclosures made for treatment, payment, or health care operations, made directly to you, made for national security reasons, or made to corrections or law enforcement personnel. Your request must state a time period that must be no longer than (6) six years and may not include dates before April 14, 2003. The first list requested within a (12) twelve month period will be free. For additional lists, you will be charged for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to request alternative means of communication

Transformations' staff may seek to communicate with you through general common practices such as your cell phone, text messages, email, voice mail, the U.S. Postal service, etc. It is our policy to take reasonable measures to secure electronic communications. You have the right to request communication of your/your child's health information by alternative means or alternative locations. For example, you could request Transformations only contact you at work or by mail. To request communications by alternative or restricted means, you must submit your request in writing. You will not be asked the reason for your request and your request will be accommodated. Your request must indicate how or where you want to be contacted.

Right of access to protected health information

You have the right to request, either verbally or in writing your/your child's health information with certain exceptions. Transformations will respond to you within (30) thirty days (or (60) sixty days if extra time is needed). If your request is denied you have the right to have the request reviewed by a reviewing official who did not participate in the original decision to deny access. In accordance with Kentucky State Law 422.317, Transformations will provide, without charge to the client, a copy of the client's medical record. There will be a charge for any additional copies after that based on cost.

**EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

*Transformations will use your/your child's health information for treatment. We will use and disclose your/your child's protected health information in providing treatment and services. We may disclose your/your child's protected health information to agency*



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and non-agency personnel who may be involved in your/your child's treatment. This will include any one you designate to be apart of the child's service team including a Targeted Case Manager, Therapist, Community Support Associate, Psychiatrist, or Physician providing care to your child. We may also disclose protected health information to individuals who will be involved in your/your child's treatment after you are no longer associated with Transformations. This will guarantee the continuity of care. Transformations will use and disclose you/your child's protected health information so that billing and payment for services for the treatment of you /your child can occur. For billing and payment purposes we will disclose information to Medicaid, Medicaid's billing agent, or an insurance or managed care company, the DMHMRS, or any other designated third party payer. This disclosure for billing will continue after services are ended in order to secure reimbursement for services. Transformations will also disclose your/your child's health information to a managed care company or peer review organization designated by Medicaid or your third party payer, in order to secure and maintain authorization for treatment. Transformations will use your/your child's health information for regular health care operations. Transformations may use data separated from identifiable information for researcher and program development purposes. These uses and disclosures are necessary to manage the agency and our quality of care.

#### **EXAMPLES OF USES AND DISCLOSURES FOR OTHER SPECIFIC PURPOSES**

As required by law we will disclose you/your child's protected health information.

- \*Disaster Relief-to an agency organizing disaster relief efforts
- \*Public Health Activities-such as: reporting to a public health or government authority for preventing or controlling disease, injury, or reporting child abuse or neglect
- \*Food and Drug Administration (FDA)-concerning adverse events or problems with products or medications for tracking purposes to enable product recalls or to comply with other FDA requirements
- \*to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition
- \*for certain purposes involving workplace illnesses or injuries
- \*Reporting victims of abuse, neglect or domestic violence-information will be disclosed as required by law
- \*Judicial and Administrative proceedings-information may be disclosed in response to a court or administrative order, subpoena, discovery requests, or other lawful process. Efforts will be made to notify you about the request or to obtain an order or agreement protecting the information
- \*Health oversight activities-information may be disclosed to a health oversight agency for activities authorized by law, such as, audits, inspections, investigations, licensure actions or other legal proceedings.
- \*Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations
- \*to avert a serious threat to health or safety-any disclosure would be made only to someone able to prevent the threat of safety to you/your child, the public or another person
- \*research-only under your/your child's specific disclosure
- \*Workers Compensation
- \*Law Enforcement-as required by law to comply with reporting requirements including, but not limited to: complying with court orders, warrants, subpoenas, summons, identifying or locating a fugitive, missing person or material witness, when information is requested about the victim of a crime if the individual agrees, to report information about a suspicious death, to provide information about criminal conduct occurring at the agency, or information about emergency circumstances about a crime. \*National Security and Intelligence Activities, Protective Services for the President and others.
- \*Only data that has been separated from my identifiable information may be used for research and program development purposes, pursuant to 45 CFR 46.101(b.2). Protected health information is may only be used for research only if authorized through written release of information.

#### **YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF PROTECTED HEALTH INFORMATION**

Transformations will use and disclose protected health information (other than described in this Notice or required by law) only with your written authorization. You may revoke your authorization to use or disclose protected health information in writing, at any time. If you revoke your authorization, we will no longer use or disclose your/your child's protected health information for the purposes covered by the authorization except where we have already relied on the authorization.

#### **OUR RESPONSIBILITIES REGARDING YOUR/YOUR CHILD'S PROTECTED HEALTH INFORMATION**

Transformations is required by law to:

- \*maintain the privacy of your/your child's health information
- \*provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about your child
- \*abide by the terms of this notice
- \*notify you if we are unable to agree to a requested restriction
- \*accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to make changes to this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. Any changes made will affect the protected health information

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we maintain at that time. We will post a copy of the current Notice at our office site. We will provide a revised copy of the Notice to parents/legal guardians upon request on or after the effective date of revision.

**WE WILL NOT USE OR DISCLOSE YOUR/YOUR CHILD'S PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION, EXCEPT AS DESCRIBED IN THIS NOTICE.**

If you have questions, would like additional information, or feel your rights have been violated, you may contact the Privacy Officer: **Teresa Lloyd, 4010 Dupont Circle, Suite 582, Louisville, KY 40207. [tlloyd@transformationsllc.net](mailto:tlloyd@transformationsllc.net).**

If you have any other complaints or concerns you may also call the privacy officer and clinical director at **502-899-5411**.

If you are still dissatisfied you may file a complaint by sending a written statement to the above address

Teresa Lloyd  
4010 Dupont Circle Suite 582  
Louisville KY 40207

or to:  
Office of Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F  
HHH Building  
Washington, DC 20201

Transformations will not retaliate against you if you choose to file a privacy complaint or exercise your privacy rights.

### **Quality Assurance Program**

Transformations is committed to supporting its providers in learning new and better ways to help you. So your feedback on our services is important to help us know what we need to change. Transformations will be emailing you a few brief questionnaires. Please answer each survey as you receive it. The surveys will be sent through a secure website and email system. You may also contact us at any time at [office@transformationsllc.net](mailto:office@transformationsllc.net) or call me personally at 502-905-9494.

Thank you for choosing Transformations as your service provider.

Sincerely,

Teri Lloyd, LMFT

Clinical Director



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## AUTHORIZATION TO SHARE INFORMATION

1. I authorize Transformations & its representatives & Name Rubens Hegrid  
4010 Dupont Circle Suite 582 Contact information DCBS worker/Guardian  
Louisville KY 40207 908 W Broadway  
Phone & fax 502-899-5411 Louisville Ky 40203  
Secure email: office@transformationsllc.net 502-595-5651

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal.  
Other: \_\_\_\_\_

I understand that the purpose of sharing this information is for: \_\_\_\_\_  
Coordination of Care

2. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.
3. I understand that I may revoke this authorization, at any time, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization, or obtained my authorization for the purpose of receiving reimbursement from a third party.
4. This authorization will expire on 3/19/20, or immediately following the revoking of the authorization, or after the following event has occurred if this is a onetime release
5. I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.
6. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child's identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

Harry Potter 3/19/19  
Consumer/Guardian if Client is under 18 Date  
Self  
Relationship to Client

Minerva McGonagall, LPCA 3/19/19  
Witness Date

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### AUTHORIZATION TO SHARE INFORMATION

I authorize Transformations & its representatives & Name Dorothy Tomlinson, APRN  
4010 Dupont Circle Suite 582 Contact information Howards Pediatrics  
Louisville KY 40207 33177 Magic Lane Ste 102  
Phone & fax 502-899-5411 Louisville, KY 40207  
Secure email: office@transformationsllc.net 502-899-3322

To share with one another the following items from my Protected Health Information:  
Psychological, psychiatric, clinical, medical and educational evaluations, records, progress  
summaries, contact logs, treatment plans, and progress updates both written and verbal.  
Other: \_\_\_\_\_

I understand that the purpose of sharing this information is for: Coordination of Care

I understand that I may refuse to sign this authorization and that Transformations, LLC and its  
Contractors will not allow my refusal to interfere with the receipt or payment of behavioral  
health services.

I understand that I may revoke this authorization, at anytime, in writing to Transformations at the  
address indicated below, except if Transformations or its Contractor has taken any action based  
on prior authorization, or obtained my authorization for the purpose of receiving reimbursement  
from a third party.

This authorization will expire on 3/19/20, or immediately following the  
revoking of the authorization, or after the following event has occurred if this is a one time  
release

I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental  
health or Chemical Dependency-Authorization Disclosure, my Protected Health Information,  
used and /or shared under this authorization may not be shared by the recipient of the  
information beyond the purpose for which my authorization was given, without first obtaining  
my specific written consent to the re-disclosure.

I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my  
child's identifiable information may be used for research and program development purposes,  
unless written consent by signing this form is provided.

I have read and understand this authorization.

Rubens Haard 3/19/19  
Consumer/Guardian if Client is under 18 Date

DORS/Guardian  
Relationship to Client

Minerva McHonagall LP@A 3-19-19  
Witness/Title Date



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**AUTHORIZATION TO SHARE INFORMATION-EDUCATIONAL SYSTEM**

I authorize Transformations & its representatives & Name Hogwarts School  
4010 Dupont Circle Suite 582 Contact Information Albus Dumbledore  
Louisville KY 40207 3377 Magic Lane  
Phone & fax 502-899-5411 Louisville, Ky 40207  
Secure email: office@transformationsllc.net 502-899-3333

To share with one another the following items from my Protected Health Information:  
Psychological, psychiatric, clinical, medical and educational evaluations, records, progress  
summaries, contact logs, treatment plans, and progress updates both written and verbal.  
Other: Academic and behavior reports including but not limited to IEP reports

I understand that the purpose of sharing this information is for: the provider to work with and  
support the educational system, assess the child's behavioral needs, and provide  
recommendations and interventions in the academic setting.

I understand that I may refuse to sign this authorization and that Transformations, LLC and its  
Contractors will not allow my refusal to interfere with the receipt or payment of behavioral  
health services.

I understand that I may revoke this authorization, at anytime, in writing to Transformations at the  
address indicated below, except if Transformations or its Contractor has taken any action based  
on prior authorization, or obtained my authorization for the purpose of receiving reimbursement  
from a third party.

This authorization will expire on 3/19/20, or immediately following the  
revoking of the authorization, or after the following event has occurred if this is a one time  
release

I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental  
health or Chemical Dependency-Authorization Disclosure, my Protected Health Information,  
used and /or shared under this authorization may not be shared by the recipient of the  
information beyond the purpose for which my authorization was given, without first obtaining  
my specific written consent to the re-disclosure.

I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my  
child's identifiable information may be used for research and program development purposes,  
unless written consent by signing this form is provided.

I have read and understand this authorization.

Albus Dumbledore 3/19/19  
Consumer/Guardian if Client is under 18 Date  
Albus Dumbledore  
Relationship to Client  
Minerva McGonagall, LPCA 3-19-19  
Witness/Title Date

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## AUTHORIZATION TO SHARE INFORMATION

1. I authorize Transformations & its representatives & Name Potunia + Vernon Dursley  
4010 Dupont Circle Suite 582 Contact information Aunt + Uncle  
Louisville KY 40207 4 Privet Dr  
Phone & fax 502-899-5411 Louisville Ky 40299  
Secure email: office@transformationsllc.net 502-495-1696

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal.

Other: \_\_\_\_\_

I understand that the purpose of sharing this information is for: Coordination of Care

2. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.
3. I understand that I may revoke this authorization, at any time, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization or obtained my authorization for the purpose of receiving reimbursement from a third party.
4. This authorization will expire on 3/19/20, or immediately following the revoking of the authorization, or after the following event has occurred if this is a onetime release
5. I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.
6. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child's identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

Rubens Hagrid 3/19/19  
Consumer/Guardian if Client is under 18 Date  
Debs/Guardian  
Relationship to Client

Minerva McGonagall, LPCA 3-19-19  
Witness Date



Client Name Harry Potter Medicaid # 1234567891  
Birthdate 7/31/03 Insurance # 84356297

## AUTHORIZATION TO SHARE INFORMATION

1. I authorize Transformations & its representatives & Name Albus Dumbledore  
4010 Dupont Circle Suite 582 Contact information Emergency Contact  
Louisville KY 40207 Hogwarts School  
Phone & fax 502-899-5411 3377 Magic Lane Louisville KY 40207  
Secure email: office@transformationsllc.net 502-899-3333

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal.

Other: \_\_\_\_\_

I understand that the purpose of sharing this information is for: Coordination of Care

2. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.

3. I understand that I may revoke this authorization, at any time, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization or obtained my authorization for the purpose of receiving reimbursement from a third party.

4. This authorization will expire on 3/19/20, or immediately following the revoking of the authorization, or after the following event has occurred if this is a onetime release

5. I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

6. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child's identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

Rubeus Hagrid 3/19/19  
Consumer/Guardian if Client is under 18 Date

DOSS/Guardian  
Relationship to Client

Minerva McGonagall, LPCA 3-19-19  
Witness Date

Client Name Harry Potter Medicaid # 1234567891  
Birthdate 7/31/03 Insurance # 84356297

### Authorization for Emergency Medical Treatment

I give consent for Transformations staff and its representatives to seek out and sign for the emergency medical care of the above named client.

Parent / Legal Guardian Name (if other than client) Rubeus Hagrid JCS Guardian  
Address 908 W Broadway Louisville Ky 40203  
Home phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Emergency phone # \_\_\_\_\_ Work Phone # 502-595-5651

I give consent for the following person to be contacted in the event of an emergency:

Emergency Contact Person Albus Dumbledore of Hogwarts  
Address 3377 Magichane Lou. Ky 40207 Relationship to client School Administrator  
Phone Numbers 502-899-3333

I understand that reasonable effort will be made to contact the guardian and then the emergency contact person at the above phone numbers. If the client is considered to be in immediate danger and requiring medical care, I give consent for emergency medical care. I do not hold Transformations LLC or its representatives liable for any injury or expense incurred in providing and securing medical care.

### Health Information

Allergies none

Medical Problems  
none

Medications/Doseage none

Does the Client have a Living Will? ☐ yes ☒ no. If yes, Transformations requests a copy of the will be kept on file. If no, Transformations will assist you in obtaining information on setting up a living will at your request.

Rubeus Hagrid 3/19/19 Minerva McGonagall 3-19-19  
Signature of parent/guardian/ or client date Witness Signature date



Client Name Harry Potter Medicaid # 1234567891  
Birthdate 7/31/03 Insurance # 84356297

### Transportation Form

Client Name Harry Potter  
Address 4 Privet Dr Louisville Ky 40299

I hereby authorize Minerva McGonagall to transport the following persons:

Harry Potter  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rubeus Hagrid  
parent/ guardian

Minerva McGonagall LPCA  
witness

3/19/19  
Date

**This authorization remains valid until the case is terminated or by the guardian's written request.**

Client Name Harry Potter Medicaid # 1234567891  
Birthdate 7/31/03 Insurance # 84356297

**CONSENT FOR OBSERVATION  
and/or  
AUDIO/VIDEO TAPING**

I give permission for Transformations staff and contractors to observe and/or tape record or video tape any and all contacts involving:

Harry Potter  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the observation session(s) will be conducted and/or tapes will be used exclusively for purposes of internal consultation designed to promote and improve the quality of treatment rendered by Transformations and the Contractor. I understand that audio/video tapes for such purposes are not a part of the medical record of my treatment.

I further understand that in consenting to internal use of the tape by Transformations and Contractor, I do not waive the confidentiality of any information that may be contained in the tape. Unless this consent is revoked by me in writing, Transformations and Contractor, as the owners of the tape, may use and retain the tape as long as it is deemed useful for the purposes authorized herein.

This permission may be revoked at any time, for any reason, in writing by the undersigned.

Rubeus Hagrid  
Client or Parent/Guardian

3/19/19  
Date

Minerva McGonagall LPCA  
Witness

3-19-19  
Date



Client Name Harry Potter Medicaid # 1234567891  
Birthdate 7/31/03 Insurance # 84356297

## Screening and Mental Status Exam for Children and Teens

Identify the client's symptoms, the frequency (i.e. 3 x per day), and severity of problems by scoring on a scale from 1 to 10 with 10 as the most severe.

### Activity

- ☐ ( ) Hyperactivity
- ☐ ( ) restless such as squirming in seat
- ☐ ( ) impulsive: acts without thinking
- ☐ ( ) fidgets such as hands always busy
- ☐ ( ) ticks or unusual activities
- ☐ ( ) jokes inappropriately
- ☐ ( ) recent increase in activities: work, sex, social
- ☐ ( ) loss of energy or fatigue
- ☒ ( ) loss of motivation: no interest in activities
- ☐ ( ) bored and uninterested

### Relational

- ☐ ( ) drop in grades
- ☐ ( ) lost a job
- ☐ ( ) legal problems
- ☐ ( ) theft (in or out of home)
- ☐ ( ) dishonesty or lying
- ☐ ( ) dangerous or risk taking behavior
- ☐ ( ) missing or cutting school
- ☐ ( ) physically abusive to others
- ☐ ( ) conflict with parents or teachers
- ☒ ( ) destructive: hits or breaks things
- ☒ ( ) threatens to harm or kill others
- ☒ ( ) cruel to animals or other children
- ☐ ( ) suspensions from school
- ☐ ( ) fights with peers or siblings
- ☐ ( ) self-injurious: cuts, burns, tattoos, etc.
- ☐ ( ) threats to kill self
- ☐ ( ) suicide attempt
- ☒ ( ) blames others for own behavior
- ☒ ( ) lonely or difficulty attaching to others
- ☒ ( ) poor social skills: difficulty making and keeping friends
- ☒ ( ) defies authority
- ☒ ( ) withdrawn from family or friends
- ☒ ( ) ridiculed by peers

### Anxiety/Phobia

- ☐ ( ) nervous or anxious
- ☐ ( ) afraid of a lot of things
- ☐ ( ) afraid of a specific thing: \_\_\_\_\_
- ☐ ( ) worries often about: \_\_\_\_\_
- ☐ ( ) panic attacks
- ☐ ( ) feels disliked or criticized
- ☒ ( ) obsessive behaviors: counting, touching, exercising, etc.

### Mood

- ☐ ( ) angry
- ☐ ( ) grouchy or irritable
- ☐ ( ) depressed mood
- ☐ ( ) strong guilt feelings
- ☐ ( ) feels as if she/he is bad
- ☐ ( ) mood swings
- ☐ ( ) tearfulness
- ☐ ( ) hopeless or helpless
- ☐ ( ) dislikes self
- ☐ ( ) feels unloved or un-liked
- ☐ ( ) overestimates own abilities
- ☐ ( ) elevated mood

### Sleep

- ☐ ( ) marked change in sleeping habits
- ☐ ( ) difficulty falling asleep
- ☐ ( ) wakes up early & can't fall back asleep
- ☐ ( ) sleeps too much: \_\_\_\_\_ hrs per night
- ☐ ( ) sleeps too little: \_\_\_\_\_ hrs per night
- ☐ ( ) bad dreams or night terrors

### Appetite

- ☐ ( ) binge eating
- ☐ ( ) self-induced vomiting
- ☐ ( ) loss of appetite
- ☐ ( ) increase in appetite
- ☐ ( ) weight gain: \_\_\_\_\_ lbs.
- ☐ ( ) weight loss: \_\_\_\_\_ lbs.
- ☐ ( ) dislikes own appearance or body size

### MIND/SPEECH/THOUGHTS

- ☐ ( ) poor concentration/ easily distracted
- ☐ ( ) difficulty focusing on school work
- ☐ ( ) poor problem solving skills
- ☐ ( ) difficulty making decisions
- ☐ ( ) makes poor decisions
- ☐ ( ) accident prone
- ☐ ( ) forgets easily
- ☐ ( ) memory loss of significant events
- ☐ ( ) does not acknowledge own problems
- ☐ ( ) racing thoughts
- ☐ ( ) talks excessively

### Thought Content/Perceptions

- ☐ ( ) grandiosity
- ☒ ( ) strange or unusual ideas
- ☒ ( ) delusions or false beliefs
- ☐ ( ) thoughts of suicide
- ☒ ( ) avoids eye contact /direct conversation
- ☒ ( ) hallucinations: sees, hears, smells, feels
- ☐ ( ) reoccurring thoughts or play of distressing events
- ☒ ( ) paranoia: thinks others will injure self

### Physical

- ☒ ( ) physical complaints: stomach, head, etc.
- ☐ ( ) aches and pains
- ☐ ( ) sweaty palms
- ☐ ( ) auto or other accidents
- ☐ ( ) smells of paint/other chemicals
- ☐ ( ) health problems: \_\_\_\_\_
- ☒ ( ) doesn't give adequate care to hygiene
- ☒ ( ) onset of puberty: normal age range
- ☐ ( ) developmental delays or growth spurts
- ☐ ( ) difficult pregnancy
- ☐ ( ) prenatal drug use ( by mother)
- ☐ ( ) child is sexually active or acting out
- ☐ ( ) soiling or bed wetting
- ☒ ( ) reoccurring respiratory problems
- ☒ ( ) suspect drug or alcohol use
- ☐ ( ) cigarette use: amt. \_\_\_\_\_
- ☐ ( ) OTHER \_\_\_\_\_

Provider name, credentials, and date Minerva McHonnagall, LPCA 3-19-19

Client Name Harry Potter Medicaid # 1234567891  
Birthdate 7/31/03 Insurance # 84356297

## Screening and Mental Status Exam for Adults

**Symptoms Check List:** Please indicate what symptoms you are experiencing and the severity by making it with a number between 1 and 10 with 10 being the most severe.

### Activity:

- ☐ Decrease in energy or fatigue
- ☐ Hyperactivity
- ☐ Impulsive
- ☐ Restless
- ☐ Physically slowed
- ☐ Physically agitated
- ☐ Excessive social, work, or playful activities

### Behaviors:

- ☐ Work difficulties
- ☐ Aggressive
- ☐ Violent
- ☐ Compulsions
- ☐ Dishonesty or theft
- ☐ Destructive
- ☐ Disorganized
- ☐ Oppositional or defiant
- ☐ Reckless
- ☐ Self-injurious
- ☐ Violation of the rules or rights of others
- ☐ Legal problems

### Anxiety

- ☐ Anxiousness
- ☐ Fear of separation
- ☐ Jitteriness
- ☐ Panic attacks
- ☐ Phobias
- ☐ Worry about \_\_\_\_\_

### Mood

- ☐ Mood swings
- ☐ Angry
- ☐ Tearfulness
- ☐ Depressed mood
- ☐ Excessive guilty
- ☐ Elevated mood
- ☐ Feeling worthless
- ☐ Helpless
- ☐ Hopeless
- ☐ Irritability
- ☐ Hostility
- ☐ Loss of interests
- ☐ Loss of pleasure or apathy
- ☐ Low self-esteem

### Sleep Disturbance

- ☐ Early morning waking
- ☐ Hyper-somnia
- ☐ Insomnia

### Memory/ Attention

- ☐ Easily Distracted
- ☐ Difficulty Concentrating
- ☐ Indecisive
- ☐ Poor judgment
- ☐ Memory loss

### Thought and Speech

- ☐ More talkative than usual
- ☐ Urge to keep talking
- ☐ Racing thoughts
- ☐ Confused thinking
- ☐ Slurred speech

### Perceptions and Thought Content

- ☐ Delusions
- ☐ Hallucinations (visual, sounds, touch, smells, etc.)
- ☐ Bizarre or unusual thoughts
- ☐ Obsessive thoughts
- ☐ Paranoid thoughts
- ☐ Not feeling real/ depersonalization
- ☐ Grandiose thoughts
- ☐ Thoughts of suicide or death
- ☐ Thoughts of a distressing event or flashbacks

### Eating Disturbances

- ☐ Binge eating
- ☐ Loss of appetite
- ☐ Increase in appetite
- ☐ Inability to maintain a stable body weight
- ☐ self-induced vomiting

### Substance Use

- Type \_\_\_\_\_
- ☐ Work or family conflict over use
- ☐ Inability to decrease use
- ☐ Persistent desire for substance
- ☐ An increase in tolerance
- ☐ Withdrawal symptoms
- ☐ Excessive time to obtain, use, or recover
- ☐ Legal problems \_\_\_\_\_

*Client is  
a teen*

Provider name, credentials, and date \_\_\_\_\_



Client Name Harry Potter Medicaid # 1234567891  
Birthdate 7/31/03 Insurance # 84356297

## PHQ-9 Patient Questionnaire

In an effort to provide the highest standard of care and meet the requirements of your insurance company, we ask that you fill out the form below. This form is used as both a screening tool and a diagnostic tool for depression. Your provider will discuss the form with you during your visit. Thank you for your cooperation and the opportunity to care for you.

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all=0	Several days=1	More than half the days = 2	Nearly every day=3
1. Little interest or pleasure in doing things			1	
2. Feeling down, depressed, or hopeless.			1	
3. Trouble falling/staying asleep, sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.			3	
Add columns <u>1 + 1 + 3 = 5</u> Total score				

10. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all      Somewhat difficult      Very difficult      Extremely difficult

Total Score and Depression Severity: 1-4 minimal 5-9 mild 10-14 moderate 15-19 moderately severe 20-27 severe