**Hillary Wishnick, Ph.D**
**Clinical Psychologist**
**6400 Thornberry Court, Suite 620**
**Mason, OH 45040**
**(513) 237-2747, fax (513) 229-8385**

Thank you for your interest in Adolescent DBT Skills.

Please be aware that it is **required** that your teen be in grade 8-12. They must have an individual therapist who is comfortable with this referral . Additionally your teen must display a minimal level of willingness to engage in the program.

In order to be considered for the program, I must have the following information which can be sent or faxed to my office. I do not recommend scanning and emailing unless you are using an encrypted email program.

1. Application forms completed by both you and your adolescent
2. Adolescent History Form
3. Patient Registration Form
4. Release of information to your adolescent's therapist and psychiatrist (if applicable)
5. Clinician Agreement

Please also review the **DBT Contract**. This does not have to be signed by you until your adolescent enrolls in the class, but does contain important information about the program.

Typically the demand for this program far exceeds my capacity. I will do my best to accommodate as many adolescents as possible during the course of this school year, but cannot guarantee admission. These are some examples of factors that be considered when making decisions about accepting new members:

1. Clinical appropriateness and need
2. Your adolescent's readiness/willingness to engage in this treatment.
3. Your adolescent's therapist's training/willingness to use DBT individual therapy protocol during the course of treatment.
4. The age of your adolescent. In this clinician's experience, high school students tend to benefit more than middle school age ones.

Partial applications will not be considered. I will notify you when I have received your application in full. If it appears that there may be an opening for your adolescent, I will contact you to talk about this further and to set up a consultation. Please do not hesitate to contact me with any questions about the application process.

# DBT Registration Form

Participant Name:________________________________________Today's Date:___________________

Address:___________________________________________City:_______________State:_______Zip:___

Birthdate:_______________________Age:___________________________

Home Phone #:______________________________Cell Phone #:_________________________

Referred by:________________________________________

School________________________________

**Responsible Party Information**

Name of Person responsible for this account:_________________________________________

Address:_____________________________________City:_______________State:_______Zip:_________

Home Phone #:_______________________ Date of Birth:____________

Work Number:__________________

E-mail Address:___________________________________________Cell phone#:_____________

Spouse/Significant Other__________________________________________________________________

Address:_____________________________________City:_______________State:_______Zip:_________

Home Phone #:_______________________ Date of Birth:____________

Work Number:__________________

E-Mail Address:___________________________________________Cell phone #:___________________

**ADOLESCENT BACKGROUND AND HISTORY QUESTIONNAIRE**

**(To be completed by parent/guardian)**

Child's Name__________________________ Date of Birth________________

Form Completed By____________________ Today's Date____________

Living situation (check all that apply):

____ Child lives with both biological parents

____ Child lives with biological mother

____ Child lives with biological father

____ Child lives with adoptive parents (Age at adoption______)

____ Other arrangement (please explain)_____________________________

Who lives in the home with your adolescent?

| Name | Relationship to child | Age |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |

Are there any siblings not living in the home?

| Name | Relationship to child | Age |
| --- | --- | --- |
| | | |
| | | |

If the parents are divorced or unmarried, what is the current legal custody arrangement?________________________________________________________________________

If parents are divorced or unmarried, what is the frequency of contact between your child/adolescent and the non-custodial parent?_________________________________________________________________

**Pregnancy and Delivery**

Did the child's birth mother smoke during pregnancy? YES NO
Did the child's birth mother drink alcohol during pregnancy? YES NO
Did the child's birth mother use drugs during pregnancy? YES NO
Did the child's birth mother receive prenatal care during pregnancy? YES NO
Please describe any complications with the pregnancy or delivery:

**Developmental Milestones**

Please indicate the approximate age at which your child/adolescent achieved each of the following developmental milestones:

| Developmental Task | Age |
| --- | --- |
| First words | ________ |
| Crawled | ________ |
| Walked without support | ________ |
| Toilet trained | ________ |

**Education**

Where does your adolescent currently attend school ?_______________________________________________

What grade is your adolescent in? __________________________________

Has your adolescent ever skipped a grade? YES NO

Has your adolescent ever repeated a grade? YES NO

Does your adolescent receive any special academic services (e.g. special education, tutoring, gifted program)? YES NO

If yes to above question, please describe:

______________________________________________________________________________

Please describe any academic or school-related concerns that you have with regard to your adolescent:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Parents' highest grade completed: Parent 1 ____________ Parent 2 ___________

**Medical History**

Name and address of child's pediatrician or primary care physician:

_______________________________________
_______________________________________
_______________________________________

Are your child's immunizations up to date? YES NO

Has your child been diagnosed with any of the following medical conditions?

_____ Asthma
_____ Allergies
_____ Cancer or blood disease
_____ Cystic Fibrosis
_____ Diabetes
_____ Headaches/Migraines
_____ Obesity
_____ Kidney disease
_____ Liver disease
_____ Gastro-intestinal condition
_____ Other (Please specify ________________________________________)

If yes to any of the above conditions, please describe the treatment regimen:

___________________________________________________________________________

___________________________________________________________________________

Does your child have any food or drug allergies? YES NO DON'T KNOW

If yes, specify___________________________________________________

Do you have any concerns with your child's dietary habits? YES NO

If yes, specify ___________________________________________________

Has your adolescent had a significant appetite change in the last month? YES NO

Comments:_____________________________________________________

Do you have any concerns with your child's sleeping patterns? YES NO

If yes, please specify ____________________________________________

Has your adolescent had a significant change in sleep patterns in the last month?

YES NO

Comments:_____________________________________________________

**Behavioral/Emotional Health History**

Please indicate any past or present behavioral or emotional concerns:

| | Past | Present |
|---|---|---|
| Inattention | ____ | ____ |
| Hyperactivity | ____ | ____ |
| Fears/Phobias | ____ | ____ |
| Sad/Depressed mood | ____ | ____ |
| Eating concerns – extreme pickiness | ____ | ____ |
| Eating concerns – strict dieting | ____ | ____ |
| Eating concerns – overeating | ____ | ____ |
| Eating concerns – binging and purging | ____ | ____ |
| Eating concerns – excessive exercise | ____ | ____ |
| Learning problems | ____ | ____ |
| Difficulty getting along with peers | ____ | ____ |
| Social skills problems | ____ | ____ |
| Victim of teasing or bullying | ____ | ____ |
| Bullying other children | ____ | ____ |
| Arguing with adults | ____ | ____ |
| Physically harming other people or animals | ____ | ____ |
| Threatening physical harm to anyone | ____ | ____ |
| Fire starting | ____ | ____ |
| Running away from home | ____ | ____ |
| Talking about or attempting suicide | ____ | ____ |
| Cutting or mutilating body | ____ | ____ |

Obsessive thoughts and/or actions ____ ____
Drug or alcohol use ____ ____
Motor tics ____ ____
Stuttering ____ ____
Other concerns (please specify) ________________________________________

Has your child had previous outpatient psychological treatment? YES NO

Name of therapist Dates of treatment Reason for treatment

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Has your child had previous inpatient psychological treatment? YES NO

Name of program/facility Dates of treatment Reason for treatment

________________________________________________________________________________
________________________________________________________________________________

Has your child ever had a psychological or psycho-educational evaluation?

YES NO

If yes, what were the results?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Has your adolescent taken any medication in the past to address emotional, behavioral or academic problems? If so please specify:

Medication Dosage Reason

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Is your adolescent currently taking any medication (prescription, over-the-counter, vitamins, herbs, or supplements) for emotional, behavioral, academic, or medical reasons?

Medication Dosage Reason

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**Sexuality**

To the best of your knowledge your adolescent is/has

| | | | |
|---|---|---|---|
| Sexually active | YES | NO | UNKNOWN |
| Using contraceptives | YES | NO | UNKNOWN |
| History of pregnancy | YES | NO | UNKNOWN |
| History of abortion | YES | NO | UNKNOWN |
| Fathered a child | YES | NO | UNKNOWN |

Do you have any concerns regarding your adolescent's sexual development or sexual orientation? If so please comment:

_______________________________________________________________________________

____________________________________________________________

**Alcohol and Drugs**

Please describe your adolescent's pattern of alcohol and/or drug usage and any concerns you may have:

____________________________________________________________

____________________________________________________________

____________________________________________________________

**Significant Events**

Please check any significant events your adolescent has experienced:

____ Change of school
____ Move to a new place
____ Loss of someone close to the adolescent
____ Serious illness or injury to a family member or friend
____ Death in the family
____ Frightening experience for the adolescent
____ Divorce or separation
____ Change in family structure (someone moved in/out of home, blending of families)
____ Victim of physical abuse
____ Victim of sexual abuse
____ Victim of rape/sexual assault
____ Witnessed domestic violence
____ Other significant trauma (please specify)________________________

**Family Health History**

Have any family members (siblings, parents, aunts, uncles, cousins or grandparents) been diagnosed or treated for a mental health or substance abuse problem?

YES NO DON'T KNOW

Please explain if yes to above question:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

What are your child's strengths?

______________________________________________________________________________
______________________________________________________________________________

Are there any cultural, racial, sexual orientation and/or religious issues that need to be considered when planning your adolescent's treatment?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Thank you for completing this questionnaire.

Parent/Guardian Application for Adolescent DBT Skills Training

Name of Adolescent:_________________________________

Date of Birth:______________________________________

Referral Source:____________________________________

Individual Therapist_________________________________

Psychiatrist (if applicable)______________________________

1. Why are you seeing Adolescent DBT Skills at this time?

2. What are you hoping DBT can accomplish for your adolescent?

3. Has your child been involved in any mental health oriented groups in the past (such as the ones offered on inpatient and partial hospitalization programs)? If so, how has he/she responded to them?

4. Is your child currently engaging in high risk behavior such as cutting, suicide attempts, and substance abuse? If so, which ones?

5. Has your child been hospitalized for mental health reasons? If so, how often and why?

Adolescent Application (to be completed by potential program member)

Name______________________________

1. Are there things you want to be different in your life at this time? If so, what would you like to be different?

2. What are your typical ways of coping with stress?

3. Tell me about your previous experience with therapy. Have you found it helpful or not? Please explain.

Hillary Wishnick, Ph.D Clinical Psychologist
6400 Thornberry Court, Suite 620
Mason, OH 45040
(513) 237-2747 Fax (513)229-8385

Client Name_______________________________

**Adolescent DBT Skills Clinician Agreement**

Thank you for considering my Adolescent DBT Skills Training program for your client. This is a psycho-educational program focused on teaching adolescents and families a more effective skill set for addressing strong emotions. Specific skills taught include mindfulness, emotional regulation, distress tolerance interpersonal effectiveness and walking the middle path for improved adolescent/parent interaction. This is not a psychotherapy or support group and we do not focus on social skills feedback.

In order for DBT to be most effective, individual therapists need to follow up with what is being discussed in class. Individual therapy is the mechanism by which the adolescents learn how to apply the new skills to their own life situation. The skills training class in isolation will not be as effective as integrating the information into individual sessions.

I will provide you with diary cards to use, general information about DBT individual therapy and skills training and weekly summaries by email of the topics discussed. I am also happy to consult with you as needed. I will ask your client to sign a release of information form so we can collaborate, as needed. I will also let you know if I notice any concerning behaviors so you can follow up individually.

The expectations of you as an individual therapist are to:

1. Maintain responsibility for crisis management
2. Review diary cards during every session
3. Do behavioral chains of self-destructive behaviors (ie cutting)
4. Be available for phone coaching for your client on how to apply DBT skills to his/her problems.
5. Notify the skills trainer if the adolescent discontinues treatment with you and assist in transitioning them to a new clinician if needed
6. Be aware of what is being taught in DBT skills by reading the weekly summary.

Have you had any formal training in DBT (ie online or workshops?) Yes No

If yes, please explain

To what extent do you typically incorporate DBT into your individual work with clients?

__Not at all __Somewhat __Some __Often __Extensively

Did you initiate this referral to Adolescent DBT Skills Training? YES NO

If no, how was this family referred to the program (if known)?

If no, do you agree that this is an appropriate referral for this family? YES NO

If no, please explain.

I agree to follow through on these expectations during the course of DBT Skills Training.

_________________________________ ______________________
Clinician Signature Date

___________________________________ ______________________________________
Clinician printed name Client's Name

Address:_________________________________________________________________________________

Phone ____________________ Fax_______________________________________

Email address (for class summaries only )_________________________________________________________

Please feel free to contact me at (513) 237-2747 or drhillarywishnick@drillarywishnick.com with any questions about the program or this agreement.

**Hillary Wishnick Ph. D**
**Licensed Clinical Psychologist**

## DBT Contract

Thank you for your interest in my Dialectical Behavior Skills Training class. This document outlines my policies related to individuals who are participating in DBT skills training only, not individual therapy. When you sign this document, it will represent an agreement between us.

### THE DBT SKILLS TRAINING CLASSES

The initial step will be a family consultation with Dr. Wishnick to determine your adolescent's readiness and appropriateness for this type of treatment. This consultation will also orient you to the program and allow you to discuss any questions and concerns you may have.

The program consists of 18 sessions, divided into three units of six classes each. Each unit consists of the following

1. Four meetings for only the adolescents
2. One meeting for the parents only
3. One meeting for the parents and adolescents together.

New families can enter at the beginning of each unit, as space allows. Many adolescents benefit from repeating portions of or all of the curriculum. Once they finish the entire curriculum they can continue in the program, as long as they find it to be helpful and only need to commit to one unit at a time.

### FEES

The fee for the 18 week program is $975. This fee includes the initial consultation, the 18 class meetings, the materials for adolescents and their parents and time spent in consultation with other mental health professionals involved with the adolescent such as their therapist and psychiatrist. A $100 deposit is required to hold a space in Skills Training. This deposit is fully refundable if at least two weeks notice is given that the adolescent will not be participating. If less than two weeks notice is given, there will be no refund of the deposit.

Any other services such as document preparation will incur a separate charge, which will be discussed with you before these services are rendered.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. These fees must be received in advance of any document preparation or court appearances. This charge also applies to any documentation prepared for the court including letters and treatment summaries.

### BILLING AND PAYMENTS

Unfortunately many insurance plans do not reimburse me adequately to be able offer a quality, DBT Skills training program that will allow me to keep that class size small enough to allow your adolescent sufficient personal attention. Insurance does not compensate me for the cost of the materials and the extensive time spent in consultation with other professionals involved with your adolescent. Upon request, a detailed receipt will be given that may be submitted directly to your insurance company for potential reimbursement. It also may be possible to use HSA (health savings account) funds, depending on the policies of your plan. I will not be doing a diagnostic evaluation of your adolescent so I cannot give you a diagnostic code or a letter of medical necessity. This needs to come from their individual therapist or psychiatrist.

You can pay the entire balance up front and receive a 10% discount or choose to pay a third ($325) at the beginning of each session. In all cases payment is due a week before the session begins. If payment is not received the week before session, your place in the program may be forfeited. Once you commit to participating in one of the units, no refunds will be offered for classes missed or early withdrawal. In case of early withdrawal when you have paid the full balance ($975) a refund will be offered for the units not attended. Should your adolescent finish the 18 weeks and decide to continue, a 10% discount will be offered for each subsequent unit, provided that he/she does not require new materials.

Please note that a collection agency is used for any bills over 120 days past due. The collection agency fee is charged directly to the client's delinquent account. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided and the amount due.

**CONTACTING ME**
I am often not immediately available by telephone during the day because I do not interrupt client sessions to answer the phone. However, I do monitor my voicemail frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. You may also contact me via email which is drhillarywishnick@drhillarywishnick.com. Please remember that email is not a secure medium. I do use encrypted email when I send clinical information, but unless you also use an encrypted program, emails that originate from you is not secure. You can obtain a free encrypted email address from hushmail, which will ensure the privacy of our communication.

**EMERGENCIES**
If I am not your adolescent's individual therapist, all crisis calls should be directed to their individual therapist and/or psychiatrist.

**PROFESSIONAL RECORDS**
The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Clients will be charged an appropriate fee for any professional time spent in responding to information requests and for photocopying costs.

**TERMINATION FROM PROGRAM**
It is required that adolescents maintain a relationship with an individual therapist, with whom they are meeting regularly (at a bare minimum once per month) during the entire duration of the program. If there is a disruption in the relationship with the individual therapist, I would be happy to assist you in finding another qualified mental health professional. If your adolescent is not meeting with an individual therapist at least monthly, they will not be allowed to continue in DBT skills.

If four consecutive DBT skills training class sessions are missed, your adolescent will be considered terminated from the program. Readmission is not guaranteed and will be at the discretion of the skills trainers.

**CONFIDENTIALITY**
In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

1. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my records and/or testimony if he/she determines that the issues demand it.

2. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. The situations are as following:
    A. If a client is (in my assessment) at risk for suicide, I am obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
    B. If I believe that a child, elderly, or disabled person is being abused, by Ohio law I must file a report with the appropriate state agency.
    C. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police and/or seeking hospitalization for the client.
3. Parents have a right to know about treatment of minor children.
4. Personal information about you will be sent to a collection agency in the unlikely event that your bills are not paid within 120 days.

If one of these situations occur, I will make every effort to fully discuss it with you before taking any action.

**NON-AFFILIATION** Although Dr. Wishnick shares space with other providers including, but not limited to, Adult, Child and Family Counseling of Mason, she is an independent provider and maintains responsibility for only her own practice.

**CONTRACT**: I HEREBY AUTHORIZE Hillary Wishnick, Ph.D, to render treatment and/or assessment to me, my dependent, or person for whom I serve as legal guardian. I have read the preceding policies and information sheet. I understand the right of confidentiality is not absolute. I assume personal financial responsibility for all treatment and assessments conducted by Hillary Wishnick, Ph.D per the terms of this contract. Such responsibility is not transferable to any other person even in the case of custody or child support disputes and/or related court decrees.

_______________________________________ _______________________________

Signature of client, parent or legal guardian Date

Hillary Wishnick, Ph.D, Clinical Psychologist
6400 Thornberry Court, Suite 620
Mason, OH 45040
513-237-2747, fax (513) 229-8385

# AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, authorize Hillary Wishnick, Ph.D to release the following information from my (or give relationship ___________) medical/clinical or financial record. This authorization includes release of information concerning drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions and/or HIV status and related conditions and/or AIDS or AIDS-related conditions. Review of the records is also authorized.

**Patient Information (Please Print)**

Name: ______________________ Date of Birth: ____________ SS#___________________

**The following information may be released or reviewed:**

θ Academic Records θ Assessment Registration θ Case Summary θ Closing Summary θ Diagnosis θ Doctor Orders θ Psychological Tests θTreatment Plan θ Lab/Medical Results θPsychological/Consultation Reports θ Other
____________________________________________________________ θ**All Information Listed Above**

The above information is to be forwarded either by mail, fax, electronic transmission, picked up or reviewed to:

Name of Person: ______________________________________________________

Agency/Organization: ______________________________________________________

Street Address: ____________________________________________________________

City, State, Zip Code: _______________________________________________________

The above information is requested to be released for the following purposes only: __________________________________

_____________________________________________________________________________________________.

**PROHIBITION OF REDISCLOSURE:** This information is being disclosed from records where confidentiality is protected by Federal Law including CFR42. Federal regulations prohibit you from making further disclosure of this information except with specific written consent or the person to whom it pertains. A general authorization for the release of clinical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. The information used or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information, and thus is no longer protected by the state/federal privacy regulations, including the HIPAA Privacy Rule.

The statement must be signed and dated, and may be revoked at any time to the extent action has been taken prior to revocation of this authorization. In order to revoke the authorization the individual/parent/legal guardian who authorized the initial release must do so in writing. **This consent will expire ninety (90) days after the date below, or sooner by my choice, in which case this consent will expire on ____________.**

I understand that a standardized fee has been established for copies of medical/clinical records. Please inquire regarding these fees prior to requesting copies. A faxed or xeroxed copy of this release may replace the original copy.

**I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.**

______________________________________________________ ____________________________

**Signature of Client or Parent if Minor** **Date Signed**

Hillary Wishnick, Ph.D, Clinical Psychologist
6400 Thornberry Court, Suite 620
Mason, OH 45040
513-237-2747, fax (513) 229-8385

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**Patient Information (Please Print)**

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City, State, Zip Code: _______________________________________________________

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______________________________________________________ ____________________________

**Signature of Client or Parent if Minor** **Date Signed**