

Application Packet

A complete application package is provided to help expedite the collection of information and the assessment process. If you wish to pursue the assessment process, please return all the requested material to ABC of Ohio. Include any other materials that you have, i.e., social history, adoption information, psychological/psychiatric treatment summaries, etc. You may print the entire application packet and return the completed package with your fee of \$110.00.

Please note -- Application materials should only be sent by mail or alternate delivery service. We do not utilize the Internet or Faxing for application processing. All phone calls will be returned promptly.

It is very important that all requested written material be completed and returned with the initial application. Caregiver/Parent autobiographies are mandatory. In addition to the required application material, it will be necessary for you to read "ADOPTING THE HURT CHILD" and "PARENTING THE HURT CHILD". Copies of both books will be sent to you upon receipt of the completed application material and application fee. Materials submitted will be kept on file for 6 months. If treatment is not pursued at ABC of Ohio, application material will be destroyed unless other arrangements have been requested prior to the six month expiration.

Financial Information

The total application fee for this process is \$110.00. The fee, \$110.00 is due with the return of your application material. Your books will be shipped at no additional cost upon receipt of your application and fee. A receipt will be provided for your county should you apply for PASSS funding after the assessment is completed. Please make your check payable to ABC of Ohio.

If you have more than one child to be evaluated, the sibling application fee is \$55.00 (\$5.00 prepayment + \$50 balance) for each child. One set of books will be issued per family.

Please be aware that due to the time intensive nature of attachment and bonding therapy, Medicaid is not accepted.

Our Financial Agreement has been prepared to help you in researching and arranging for payment of treatment. Please be prepared to provide accurate billing information for county/agency contacts and billing personnel, or other funding sources at the assessment appointment. If payment is to be made by a County or agency, it is necessary for you to provide a letter of financial commitment prior to the beginning of treatment.

A 50% prepayment is required for intensive therapy sessions. The prepayment is due on or before the first date of scheduled treatment. If County/agency payment is expected, this term will be waived upon receipt of a letter of financial commitment from the County/agency.

Medicaid funding **is not accepted** for treatment at ABC of Ohio.

State of Ohio PASSS Funding

Clients who have applied for the fiscal year State of Ohio PASSS funding will be scheduled pending approval of this funding. A copy of the approval letter must be provided to this office for client billing to be transferred to your county. For services rendered before approval, payment will be due in full from the party contracting

services. A receipt will be provided for reimbursement from your county when funding is approved. Information regarding this source of funding can be obtained from your county of residence department of human services/children services board adoption department. Formal application is required to access this funding.

Provider credentialing forms are required with all PASSS applications. Please print a copy to enclose with your application form. Go to <http://www.abcofohio.net/credentials.htm> and choose your provider's form.

PASSS brochures can be found online at www.odjfs.state.oh.us/forms/pdf/08120.pdf

Contact Info:

Adoption Services Section

Ohio Department of Job & Family Services - Douglas E. Lumpkin, Director

255 E. Main Street, 3rd Floor

Columbus, Ohio 43215-5222

(614) 466-9274

If you are from Ohio and do not plan to access PASSS funds, and choose to attempt to get insurance reimbursement, we will process insurance submissions when your account is paid in full. It is unlikely that insurance will cover attachment therapy or any therapy requiring multiple units on one day. Most mental health coverage is limited to one unit on a given date. In the intensives, six units are billed daily; the biweekly format (90-minutes every two weeks) or the follow-up format (90-minutes every two weeks) also exceeds what most companies will pay. In the intensives, we always use two therapists; insurance companies will not cover two therapists for the same period of time. If your company is one with which we have a contract, you will not be able to access benefits for attachment therapy as we are only contracted to provide traditional therapy at an agreed-upon UCR.

If you are from another state or country, we will, also, process your insurance for your reimbursement when your balance is paid in full, subject to the above issues.

Treatment Plans

ASSESSMENT: \$375.00

Prior to the child's assessment, the therapist talks with the parent(s) to discuss the history of the problem, current status of the child being referred, and other family issues. Prior to the end of the assessment, the parent(s) and child are seen together. The quality of the family relationship is critical as we work with the child. Most children with attachment difficulties often have quite effectively created a split between the parents, and, as a result, some erosion of the family relationship may have occurred. It is helpful in the treatment of your child for us to thoroughly understand the nature and quality of your family's relationship.

INTENSIVE THERAPY: \$600.00 per Day -- 10-Day Model (Maximum)

The intensive model is a maximum period of 10 days during which the parent(s) and child spend three hours daily in outpatient treatment. There are times when progress made is such that the intensive is shortened. This is a clinical determination that is made during the treatment process. Intensive therapy is scheduled Monday -- Friday.

FOLLOW-UP: \$250.00 -- 90-minute session

Follow-up to the intensive is required. Some families choose to use the Attachment and Bonding Center of Ohio; others choose to work with a therapist who may have referred them to ABC of Ohio. If people choose to work with a therapist outside the office, we strongly recommend that the therapist participate in the intensive treatment process in an effort to provide continuity of care.

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 ABC of Ohio
 12608 State Road, Suite 1
 Cleveland, Ohio 44133
 440-230-1960
www.abcofohio.net

BI-WEEKLY THERAPY MODEL: \$250.00 -- 90-minute session

Children who are not so severely disturbed benefit from our biweekly 90-minute sessions. This option may be recommended at the time of assessment.

Financial Agreement

Date _____

I, _____ (recipient) or _____ (parent, legal guardian, or custodian of minor) am aware that services provided for _____ in this office will not be billed to Medicaid, and I agree to be liable for the fee for service.

Signature _____

If other than parent:

Title _____

Agency _____

Child Registration Form

PLEASE PRINT

Name of Child _____ Birthdate _____

Parent's name

(Father) _____ DOB _____

(Mother) _____ DOB _____

Address _____

Telephone

(Daytime) _____ (Evening) _____

Level of Education

(Father) _____

(Mother) _____

(School of Child) _____ Grade _____

Others living at home:

Name	Sex	Birth date	Age	School/Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Father Employed by _____

Business Telephone _____

Soc. Sec. # _____

Mother Employed by _____

Business Telephone _____

Soc. Sec. # _____

Family Physician _____

Referred by _____

Telephone# _____

Chief Complaint & Problem _____

Is Child Adopted? _____

If So, At What Age? _____

Child's First Name Prior to Adoption _____

Complications of Birth & Delivery _____

Have there been any physical or emotional separations (i.e. death, hospitalizations, depression) between child and caretaking adult during the first 26 months of life? _____

If so, please elaborate in CHILD'S HISTORY report.

Is there, as far as you know, any possible history that could be considered abusive? If so, indicate type(s) and age of occurrence. _____

If it is hard to remember ages, please simply check the problem areas or areas you feel were/are advanced or slow in development.

Age he/she:

held head up _____

crawled _____

walked with help _____

Does he/she:

have blank spells _____

rock _____

shuns attention _____

Is he/she:

shy or timid _____

affectionate _____

well coordinated _____

used sentences _____	have temper tantrums _____	impulsive _____
fed self _____	have falling spells _____	stubborn _____
dressed alone _____	have unusual fears _____	right/left handed _____
turned over _____	bump head _____	clumsy _____
sat _____	hold breath _____	
walked alone _____	show dare devil behavior _____	
was weaned _____	have sleep problems _____	
said "no, no" to everything _____	have eating problems _____	
smiled at parents _____		
pull up at crib _____		
said 4-10 words _____		
helped with dressing _____		
dry during day _____		
dry during night _____		

PREVIOUS TESTING OR THERAPY:

Dates: _____

Place: _____

With whom: _____

Child History Report

Please write a summary description of your child **IN NARRATIVE STYLE**. Include:

1. History of problem behavior
2. Medical problems
3. Adoption history and process, if applicable

Please discuss how you made the decision to adopt

4. A summary which will help give us a clear understanding of your child's difficulties

Please contact us if you have any questions.

Physician's Statement

Prior to your child's participation in treatment in this office, I am requesting that he/she have a physical by your family physician or pediatrician. This physical should approximate one that is given for sports activities. A physician statement is required indicating that the child is free from any medical condition and/or communicable disease. If there is a specific condition, we would like to know what it is, and if there are any limitations to the child's participation in normal activities.

You may feel free to share this letter with your physician, and if there are any questions, please encourage your physician to contact me. The results of the physical and medical clearance statement must be received in this office prior to the scheduled assessment date.

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For the Parents/Caregivers

Caregiver's/Parent's Autobiography Outline

MENTAL HEALTH OF PARENTS

It is always helpful for us to have as much information about family history, style, and overall functioning as possible before beginning the intensive treatment program. To get this information, we have found that autobiographical statements of the caregivers/parents have proven invaluable. Therefore, it would be helpful if each caregiver/parent would prepare a narrative statement that addresses the issues solicited by the following questions. **PLEASE DO NOT GO THROUGH THIS LIST OF QUESTIONS AND ANSWER THEM. WRITE A SUMMARY OF YOUR LIFE EXPERIENCES IN NARRATIVE STYLE.** Include in the summary discussion of the issues that the questions are addressing. If there are other areas that are important, also include them. Contact us if you have any questions.

- Did either of your parents often complain of physical problems that were not medically confirmed?
- Was either of your parents often depressed, noticeably unhappy or irritable?
- Did either of your parents have problems with alcohol?
- Did your parents often argue?
- Was there ever physical violence between your parents?
- Were there other significant difficulties of your parents particularly during your early childhood?
- Please describe the good and bad characteristics of your parents.

DIVORCE AND STEPPARENTS

- Did your parents divorce? If so, please answer the following:
- At what age were you when your parents separated?
- With whom did you live?
- Was there a stepparent in the home?
- How old were you when the stepparent entered your life?
- How did the stepparent handle control issues with you?

AFFECTION

-Please describe affectionate behavior of your parents or caretakers, or lack of it. Please give frequency and your reactions. Would you be more or less affectionate with your child? Why?

ROLE IN FAMILY

-What role did you have in your family of origin and how do you see that influencing your relationship to a child?

DISCIPLINE

- How did your parents discipline you?
- Do you agree with their behavior? Why?
- In what ways have you changed?

ABUSE

- Do you feel that either of your parents, or caretakers was ever abusive? If so, in what way?
- How have you dealt with your feelings about this issue?

NEGLECT

- Were there any issues of loss or abandonment in your childhood? -If so, do you see that issue causing some problems in your relationship with a child?

COMMUNICATION

- How did verbal communication differ from each of your parents toward you?
- Did either of your parents understand your feelings? Please explain.
- How did communication progress during the teenage years?
- Did either parent use: (please indicate which parent and to what excess)
- Disapproval?
- Withdrawal?
- Threats of physical punishment?
- Threats of abandonment?
- Hitting or spanking?
- Verbal criticism?
- Did actions (good or bad) show your feelings to your parents better than words? Please describe.
- In what ways, if any, has your communication process changed from that of your parents? If change has occurred, what caused this change?

Permission to Treat

I/We understand that a variety of techniques will be used in our child's treatment. They may include: use of music, use of animals, nurturing holding by parents and therapists as needed, psychodrama, role play, psychoeducation, cognitive behavioral therapy, traditional therapy, use of pre-adoptive historical information, and family centered therapy. Parents are always included in treatment as the parent-child relationships are critical to the process of treating attachment difficulties.

I/We consent to participate in the therapy described above.

PARENT/GUARDIAN

DATE

CLIENT

DATE

Attachment Symptom Checklist for Children Under 5

Note: These checklists are screening devices and are only one component of a professional diagnostic assessment. They should not be used as stand-alone measurements.

CHILD'S NAME: _____

DATE OF BIRTH: _____

Symptoms	None	Moderate	Severe
1. Cries; miserable all the time, chronically fussy	_____	_____	_____
2. Resists comforting or nurturance	_____	_____	_____
3. Resists or dislikes being held	_____	_____	_____
4. Poor eye contact or avoids eye contact	_____	_____	_____
5. Flat, lifeless affect (too quiet)	_____	_____	_____
6. Likes playpen or crib more than being held	_____	_____	_____
7. Rarely cries (overly good baby)	_____	_____	_____
8. Angry or rageful when cries	_____	_____	_____
9. Exceedingly demanding	_____	_____	_____
10. Looks sad or empty-eyed	_____	_____	_____
11. Delayed milestones (creeping, crawling, etc.)	_____	_____	_____
12. Stiffens or becomes rigid when held	_____	_____	_____
13. Likes to be in control	_____	_____	_____
14. Does not hold on when held (no reciprocal holding)	_____	_____	_____
15. When held chest to chest, faces away	_____	_____	_____
16. Doesn't like head touched (combed, washed)	_____	_____	_____
17. Generally unresponsive to parent	_____	_____	_____
18. Cries or rages when held beyond his wishes	_____	_____	_____
19. Overly independent play or makes no demands	_____	_____	_____
20. Reaches for others to hold him rather than parent	_____	_____	_____
21. Little or reduced verbal responsiveness	_____	_____	_____
22. Does not return smiles	_____	_____	_____
23. Shows very little imitative behavior	_____	_____	_____
24. Prefers Dad to Mom	_____	_____	_____
25. Gets in and out of parents lap frequently	_____	_____	_____

- 26. Physically restless when sleeping _____
- 27. Does not react to pain (high pain tolerance) _____
- 28. Overly affectionate to strangers _____
- 29. Feeding problems _____
- 30. Speech development delayed _____

Completed by: _____ Relationship to _____

Address: _____ Phone:(day)_____

Date completed:_____ Phone:(evening)_____

Note: This checklist is a screening device, and is only one component of a professional diagnostic assessment. It should not be used as a stand-alone measurement.

This list was adapted from Walter Buenning, Ph.D.; "Toddler adoption: The Weaver's Craft" by Mary Hopkins-Best; and "What You Should Know Before You Adopt a Child" by Institute for Attachment and Child Development. It is utilized by the Attachment and Bonding Center of Ohio as part of the pre-service application process.

Attachment Symptoms for Children Over 5

CHILD'S NAME: _____

DATE OF BIRTH: _____

Symptoms	None	Moderate	Severe
1. Superficially engaging and "charming"	_____	_____	_____
2. Lack of eye contact on parental terms	_____	_____	_____
3. Indiscriminately affectionate with strangers	_____	_____	_____
4. Not affectionate on parents' terms (not cuddly)	_____	_____	_____
5. Destructive to self, others, and material things (accident prone)	_____	_____	_____
6. Cruel to animals	_____	_____	_____
7. Stealing	_____	_____	_____
8. Lying about the obvious (crazy lying)	_____	_____	_____
9. No impulse controls (frequently acts hyperactive)	_____	_____	_____
10. Learning lags	_____	_____	_____
11. Lack of cause and effect thinking	_____	_____	_____
12. Lack of conscience	_____	_____	_____
13. Abnormal eating patterns	_____	_____	_____
14. Poor peer relationships	_____	_____	_____
15. Preoccupation with fire	_____	_____	_____
16. Persistent nonsense questions and incessant chatter	_____	_____	_____
17. Inappropriately demanding and clingy	_____	_____	_____
18. Abnormal speech patterns	_____	_____	_____

Completed by: _____

Relationship to child: _____

Address: _____

Phone:(day) _____

Date completed:_____

Phone:(evening)_____

Note: This checklist is a screening device, and is only one component of a professional diagnostic assessment. It should not be used as a stand-alone measurement.

This list was adapted from Walter Buening, Ph.D.; "Toddler adoption: The Weaver's Craft" by Mary Hopkins-Best; and "What You Should Know Before You Adopt a Child" by Institute for Attachment and Child Development. It is utilized by the Attachment and Bonding Center of Ohio as part of the pre-service application process.

attachment and bonding center of ohio

gregory c. keck phd

NOTICE OF PRIVACY PRACTICES

Our commitment to your privacy.

Our practice is dedicated to maintaining the privacy of your personal information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is a shorter version of the full, legally required Notice of Privacy Practices (NPP), posted in our waiting room that you can refer to for more information. However, we cannot cover all possible situations, so please talk to our Privacy Officer (see the end of this notice) about any questions or problems.

We will use the information about your health that we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. **If you do not consent and sign this form, we cannot treat you.**

If we, or you, want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you, and ask you to sign an Authorization Form to allow this.

Of course, we will keep your health information private, but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety, or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement or official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are other situations similar to these that don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information:

1. You can ask us to communicate with you about your health and related issues in a particular way, or at a certain place, that is more private for you. For example you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care, or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

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3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing, and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area, and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide you in any way.

If you have any questions regarding this notice, or our health information privacy policies, please contact our Privacy Officer who is Gregory C. Keck, Ph.D., and can be reached by phone at 440-230-1960, voicemail #2.

The effective date of this notice is April 14, 2003.

attachment and bonding center of ohio

gregory c. keck phd

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and the Attachment and Bonding Center of Ohio. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you, and to provide any treatment to you. We may also share this information with others who provide treatment to you, or need it to arrange payment for your treatment, or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change the NPP, you can obtain a copy from our Privacy Officer.

If you are concerned about some of your information you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer, telling us you no longer consent), and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

Signature of client or parent/legal guardian if minor

Date

Printed name of client or parent/legal guardian if minor

Relationship to client

Signature of authorized representative of this practice

DATE OF NPP _____ Policy given to client/parent/legal guardian

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