CLIENT INFORMATION

Welcome! Please provide the following information for my confidential records.

Name: _____

Date of Birth: _____

Name of parent/guardian: _____

Contact Info:

Address: _____

_____

Home Phone: _____ May I leave a message? ☐ Yes ☐ No

Cell Phone: _____ May I leave a message? ☐ Yes ☐ No
May I text you if necessary? ☐ Yes ☐ No

Email: _____ May I email you? ☐ Yes ☐ No

Emergency Contact:

Name: _____

Address: _____

Phone Number: _____

Relationship: _____

CLINICAL INFORMATION

Please have the child or a parent fill out the following information. If you feel uncomfortable answering any questions, feel free to skip over them.

Mental Health

Why are you seeking treatment at this time? _____

_____

_____

Have you ever been in therapy before? If yes, what was the result? _____

_____

_____

Do you have any previous mental health diagnoses? _____

_____

In what areas do you feel you need help?

- ☐ Depression
- ☐ Anxiety
- ☐ Grief/Death/Loss
- ☐ School
- ☐ Family
- ☐ Other significant relationships
- ☐ Trauma
- ☐ Substance use/abuse
- ☐ Anger Management
- ☐ Other

Have you experienced any of the following recently?

- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Self-injury
- ☐ Obsessive/intrusive thoughts
- ☐ Thoughts of harming others
- ☐ Violence
- ☐ Depression
- ☐ Anxiety or Panic Attack
- ☐ Death in the family
- ☐ Poor sleep patterns
- ☐ Change in weight
- ☐ Racing thoughts
- ☐ Agitation/irritability

Please list any persistent physical symptoms or health concerns: _____

_____

_____

Please list any current medications, reasons for taking medication, and dosage:

_____

_____

Educational

Which school do you attend? What grade are you in? _____

Check which behaviors are problematic (or have been problematic in the past):

- ☐ Tardy/Skipping class
- ☐ Disruptive/Defiant
- ☐ Social problems
- ☐ Excessive absences
- ☐ Dropped out
- ☐ Repeated grade
- ☐ Poor performance
- ☐ Suspended
- ☐ Expelled

Family History

List the people living in your household: _____

_____

_____

Describe your home environment: _____

_____

_____

Who is your primary emotional support? _____

_____

INFORMED CONSENT

The following is information regarding the practices, policies and procedures of this business, and is intended to clarify the terms of the professional therapeutic relationship between the Therapist and Client. Any questions or concerns regarding the contents of this document should be discussed with the Therapist prior to signing it.

1. Therapy sessions will run 50 minutes, what is considered to be one "clinical hour".

2. Risks and Benefits of Therapy
   - Participating in therapy may result in a number of personal and relational benefits to the Client. Such benefits may require substantial effort on the part of the Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. However, there is no guarantee that therapy will yield these benefits.
   - Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which the Therapist will challenge the Client's perceptions and assumptions, and offer different perspectives. The issues presented by the Client may result in unintended outcomes, including changes in personal relationships. The Client should be aware that any decision on the status of his/her personal relationships is the responsibility of the Client.
   - During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. The Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

3. Patient Financial Responsbility: The agreed upon fee is _____.
   - The fee should be paid at the end of each session, unless alternate arrangements have been made. ***Any sessions not paid by insurance due to lack of authorization will become your responsibility.***
   - As a courtesy, my office will verify and bill your insurance. ***This is not a guarantee of payment. You are ultimately responisble for payment of your services***.
   - Upon receiving payment from your insurance company, ***the percentage of services not covered will become your responsibility.***
   - If your insurance company is responsible for the payment of your claims and you have questions about how your claim was processed, ***please contact your insurance company directly.***
   - You are responsible to notify me of any changes to your insurance policy. If you do not notify me, you will be responsible for the charges.
   - The person signing this financial agreement is ultimatley responsible for the account. ***I acknowledge being informed and agree with the above Patient Financial Responsibility policy.***

     X_____

4. In the event you must cancel a session or reschedule a session, it is important that I be informed as soon as possible. ***If you provide less than 24 hours notice of cancellation, you will be charged.*** Please note that insurance companies will not pay for sessions that you do not attend.

5. Due to my work schedule, I am often not immediately avaliable by telephone. When I am unavaliable, you can leave a confidential voicemail on my private line, which I monitor frequently. I will make every effort to return your call on the same day you have contacted me, although occasionally it may take me up to 24 hours. ***In case of an emergency, you should contact your family physician or go to the nearest emergency room and ask for the psychologist/psychiatrist on call.*** If I will be unavaliable for an extended time, I will provide you with the number of a colleague to contact if necessary.

6. Confidentiality and privacy are essential components of the treatment relationship. However, I am required to make disclosures in some situations which include, but are not limited to, ***1) reasonable suspicion of abuse or neglect of a child, or a dependent or elder adult, 2) threat of harm to self or others, and 3) pursuant to legal proceedings.***

   When working with a minor, parents should be aware that I am not a conduit of information regarding the minor. Psychotherapy can only be effective if there is a trusting and confidential relationship between myself and the child. While parents can expect to be kept up to date on their child's general progress in treatment, they will typically not be privy to detailed discussions that occur during our therapy sessions. However, parents can expect to be informed in the event of any serious concerns I might have regarding the safety and well-being of the minor, including but not limited to suicidality.

I have received and read this information and discussed any concerns with the Therapist.

_____ _____.
Signature of Client(s) Date

_____ _____.
Signature of Parent(s)/Guardian(s) Date

A copy of the Health Insurance Portability and Accountability Act (HIPPA) is available for me to read and discuss with my therapist. I acknowledge that I have received and/or understand the information contained in HIPPA:

_____ _____.
Signature of Client(s) Date

_____ _____.
Signature of Parent(s)/Guardian(s) Date