Child

**New Client Packet Checklist:**

Welcome to Life in Balance Counseling & Wellness Center. Full completion of this packet will enable us

to provide you with the best possible service. This packet takes about 45 to 60 minutes to complete.

To enable us to provide you with the best care possible, please be sure to fill out all pages front and back and initial each page.

**Please bring the following to your child’s first appointment**. They are required for insurance and medical records compliance:

* Insurance card
* Guardian’s Driver’s License or Photo ID
* Any additional medical records or notes you may have from previous practitioners
* Copay or other payment required by your insurance company

**Please note the following:**

* All forms must be signed by the child’s legal guardian. If there is a custody agreement in place, a copy of the agreement must be provided to our offices prior to the first appointment. Written consent must be given by both custodians if required in the custody agreement in order for the child to receive services. If services are court ordered, a copy of this order must be provided prior to the first appointment.
* Client Registration (next page) must be filled out completely. The date of birth and social security number of the insurance policy holder is required to submit insurance claims. If you do not have this information, we cannot bill your insurance. You would then be held responsible for charges that your insurance would otherwise cover.
* Please complete this packet in its entirety. This will help your practitioner understand more about your child’s visit.
* The Authorized Release of Protected Information is the last page of the packet. Please fill in your child’s name and date of birth; the name of the Life in Balance practitioner with whom you will be working with on the line next to clinician’s name; and the name and demographic information of the person or entity with whom you wish to share your information. Please wait to sign and date this sheet until you check in with our receptionist, so they can witness your signature.
* Please review and check that each page has been signed and initialed.

Thank you for your cooperation and patience in filling out these forms to help

us better understand your needs and bill your insurance correctly.

*We appreciate the opportunity to serve you.*

**CLIENT REGISTRATION**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you the guardian of this child? Yes/No. If no, please do not complete this form.

Do we have authorization to send mail to the address listed above?  Yes  No

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
School Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade Level:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by (Required for Tricare Insurance): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a custody agreement in place? Yes/No. If yes, please explain and provide required documents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE: All items in this section must be completed to bill your insurance**

Policy Holder’s Full Name: DOB:

Policy Holder’s SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Client:

Home Address: \_\_\_\_\_\_\_Phone:

Employer and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Single  Married  Employed  Unemployed  Retired  Disabled

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Group#: Mental Health Phone #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group#: Mental Health Phone #:

Thank you for choosing Life in Balance Counseling & Wellness Center. Today’s initial appointment will take approximately 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of what to expect, our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. All of the clinicians in our practice have earned a graduate degree (Masters or Doctorate) from an accredited University. All Life in Balance Clinicians are licensed to practice in the state of Virginia or are resident clinicians who have completed a graduate degree and are pursuing licensure under direct supervision of a licensed clinician. The clinical supervisor’s name and credentials may be obtained upon request. Our clinicians only practice within their scope of training and experience. In the course of our training and previous employment, we have had experience in treating a wide variety of individuals including children, adolescents, adults, individuals, couples, families, and groups. Your counselor will have his/her own primary specialty areas of expertise. Treatment practices, philosophy, and plan limitations and risks will be discussed with you today.

**OUR PRACTICE CONSISTS OF THE FOLLOWING CLINICIANS:**

☼ Angela McGoldrick, LPC ☼ Dr. Alan Forrest, LPC, LMFT

☼ Andrew Burns, LPC ☼ Angela Cardenas, LPC

☼ Cindy Blevins, LPC ☼ Donna Wagner, LPC

☼ Erin Sullivan, LCSW ☼ Jess Talley-Haynes, LPC

☼ Lisa Kirkner, LPC ☼ Liz Kates, LPC

☼ Sarah Trenis, LPC ☼ Season Childress, LPC

☼ Tracy Willis, LPC

**RESIDENTS IN COUNSELING:**

 ☼ Jenny Cole, MS ☼ Shelly Fox, MA

 Under the supervision of Cynthia Blevins, LPC
 If you have questions or concerns,

 please contact Cindy at 540.381.6215 ext 307

**OFFICE HOURS**Our office hours are Monday – Thursday 9am-6pm and Fridays 9am-5pm. You may reach our office by phone at (540) 381-6215 to schedule an appointment. If we are unavailable, you may leave a message on our confidential voice mail box and someone will return your call as soon as possible during normal business hours. Most practitioners have confidential voice mail boxes. Do not leave messages if you have a psychiatric emergency; please call ACCESS at (540) 961-8300, dial 911, or go to the Emergency Room.

**COMMUNICATION**

It is our normal practice to communicate with you about health matters, such as appointment reminders, using the home address and daytime phone number you provided when you scheduled your appointment. You have the right to request that our office communicate with you in a different way.

Please DO NOT provide phone numbers if you do not wish for us to leave messages. If a phone number is provided as a form of contact, the front office will leave a message at that number.

Please check all that apply. You may contact me and leave messages at:

 At home at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 At work at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  On my cell at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please contact me *only at the following number* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please do not leave a message

 Please DO NOT remind me of appointments

**FINANCIAL/INSURANCE**

As a courtesy, we will bill your insurance company. All payments and/or co-payments are due at the time of each appointment. If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If the balance is not paid after 45 days, it will be charged 1.5% interest/month (18% APR). If the account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for collection fees charged to our office to collect the debt owed. Our office accepts personal checks, cash, Discover, Visa, and MasterCard (not American Express). A returned check fee of $35.00 will be charged. If we receive more than one returned check from an individual we may refuse future payment by check.

**FEES FOR SERVICE**

Initial Assessment & Diagnosis (45-55 minutes) $135.00

Individual Therapy Session (55 minutes) $125.00

Individual Therapy Session (45 minutes) $100.00

Family Therapy $125.00

Phone Consults (30 minutes) may not be covered by insurance $ 57.50

Phone Consults (55 minutes) “ $105.00

Group Therapy Session (50 minutes) $ 50.00

Deposition or Appearance in Court $500 + $100/hour

Records and Document Review ($30 minimum) $ 95.00/hour

Written Correspondence (depending on type) $ 50.00/page

No Show/Late Cancellation Fee $ 50.00

**NO SHOW AND LATE CANCELLATION POLICY**

Please contact our office within 24 hours if you are not able to make your appointment. If you do not show for a scheduled appointment or cancel with less than 24 business hours’ notice, a *NO SHOW/LATE* *CANCELLATION FEE of $50.00* will be charged for the cost of the missed appointment if permitted by your insurance company. This cost is not covered by insurance and is your responsibility and must be paid in full before your next appointment. If a second appointment is missed without canceling with a 24-hour notice, your counselor will speak with you about future appointments. If a third appointment is missed your counselor may not be willing to reschedule with you depending on your situation.

**AUTHORIZATION**

I authorize treatment deemed necessary by Life in Balance Counseling & Wellness Center Practitioners. I authorize Life in Balance Counseling & Wellness to release to my health plan any and all information which she deems necessary regarding my care and treatment to insure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to Life in Balance Counseling & Wellness for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Life in Balance Counseling & Wellness Center for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicaid, or to other contractual provisions that may limit a patient’s responsibility to pay for medical costs and services. Payment shall be due at the time of the appointment or within thirty days of receipt of a statement.

Signature of client (or person acting for client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to ensure that the best care possible is provided to my child I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

parent or guardian (please circle one) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to comply with the following guidelines.

**Please initial each line to indicate that you have read, understand and accept each statement.**

 \_\_\_\_\_\_\_\_ I understand that all phone consultations MUST be scheduled by calling the front office. These consultations are not insurance billable and must be pre-paid at the time of scheduling. They can be scheduled in 30 minute and 55 minute appointments.

\_\_\_\_\_\_\_\_ I understand that unscheduled phone calls are not possible due to practitioner’s schedules and that emergencies will be directed to emergency services and followed up on by the practitioner as soon as possible.

 \_\_\_\_\_\_\_\_ I understand that all written correspondence requires pre-payment and is not insurance billable.

\_\_\_\_\_\_\_\_ I understand that written correspondence must be requested 7 business days prior to the date it is needed by contacting the front office.

 \_\_\_\_\_\_\_\_ I understand that if I would like for my child’s practitioner to attend school meetings, court dates or any other out of office appointment I MUST contact the front office no less than 10 days prior to the date of that appointment to allow time to clear your practitioner’s schedule.

 \_\_\_\_\_\_\_\_ I understand that all out of office appointments require pre-payment and are not insurance billable.

By signing I agree to comply with the above guide lines in order for my child to receive the best care possible. I acknowledge that my failure to comply so will lead to the discontinuation of services at Life in Balance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**UNDERSTANDING PSYCHOTHERAPY AND INFORMED CONSENT**

It is important for you to understand what counseling is about and what you may expect during therapy. Please read this material carefully and ask the therapist to explain anything that is unclear to you.

**What are Counseling and Psychotherapy?**

“Counseling” and “Psychotherapy”, or simply “therapy”, are words for the same process which is: using proven methods to assist people in changing how they think, feel and behave. Legitimate therapy is practiced by professionals Licensed (or license eligible under supervision) by the state in the areas of Clinical Social Work, Professional Counseling, Psychology, or Psychiatry.

**The Risks of Counseling:**

Research has shown that competent therapy provided by trained and licensed professionals is helpful to most people. At the same time, therapy is not guaranteed to result in a successful outcome every time for everyone. It is important that you understand this before you invest time and money in counseling. The greatest risk of counseling is that it may not, by itself, resolve your problem or concern. Unexpected emotional strain, stress, and life changes may happen during therapy. Other people in your life may not respond how you might like them to with the changes you make during therapy.

**How does therapy work?**

Therapy at Life in Balance will involve several steps. Therapy sessions are usually 45 to50 minutes in length and are typically held one time per week to start.

First, your counselor will listen to the concerns that you brought to counseling. He/she will get to know you and how you view your life and yourself. You will probably understand your situation better as you and your counselor talk. After you and your counselor explore your concerns, you will choose specific goals and objectives for therapy. Next, you and your counselor will work together to develop a plan for meeting those goals.

You and your counselor will define and work toward accomplishing your goals using research-proven methods. These methods include, for example, accessing your inner strengths and resources, changing thoughts that affect how you feel and what you do, or homework assignments in which you try on new behaviors to see how they fit. You and your counselor may decide to involve other family members in your session. Please know that any work in the sessions will occur only with your permission. It is very important to your counselor to see that your limits are respected. Your specific needs and concerns will determine what is done.

Your counselor will frequently take time to examine your progress toward your goals to make sure you both are on the right track. You and your counselor will decide together when your therapeutic goals are met and when to move toward completing therapy. Your therapy may be terminated if you fail to maintain regular attendance or if your therapist feels you are not making progress. You will be notified in advance of any possible termination of services.

In the unlikely event that your clinician is unable to provide ongoing services, another clinician within the group practice can provide those services. Our office will maintain your records for a period of 7 years. Please contact the Executive Director, Angela McGoldrick, LPC, for any questions pertaining to this.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS**

Your verbal communication and clinical records are strictly confidential except for situations covered in the Notice of Privacy Practices. Please note that confidentiality cannot be guaranteed if you use electronic communications with practitioners or office staff. This includes e-mail, instant messaging, social media and text. In addition, we will protect your privacy in public. We will not communicate with you in public unless you

initiate contact nor disclose that you are a client. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact ACCESS services at (540) 961-8400, CONNECT at 1-800-284-8898, emergency services (911), or proceed to the nearest Emergency Room for assistance. Life in Balance Clinicians are not on-call outside of their office hours. Our Clinicians will follow up those emergency services with standard counseling and support to the client or the client's family.

**You have the right:**

* To be treated in a humane and dignified way.
* To be informed of your treatment options, risks, and benefits.
* To take an active role in treatment planning.
* To have questions answered fully.
* To have confidentiality and privacy within legal/ethical guidelines.
* To facilitated review of your clinical information.

**You have the responsibility:**

* To be honest in providing information.
* To keep your appointments, to be on time, and to give a 24-hour notice if you should need to cancel your appointment.
* To be free of alcohol/drugs during your therapy session.
* To respect the therapist and facility.
* To respect the privacy and rights of others.
* To know your insurance requirements, deductibles, and co-pays.
* To pay your co-pay, deductible, or full charge at the beginning of each appointment.

**COORDINATION OF TREAMENT**

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared, however we do need your physicians name and demographic information for insurance billing.

*\_\_\_\_*You may inform my physician(s) \_\_\_\_I decline to inform my physician

Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS**

I/We have reviewed and received a copy of the Notice of Privacy Practices, if requested. The Notice of Privacy Practices is available on our website at [www.lifeinbalancecenter.com](http://www.lifeinbalancecenter.com) or through the Front Office. Signing this acknowledgement does not mean you have agreed to any uses or disclosures of your protected health information outside the purposes outlined in the Notice of Privacy Practices.

**CHILD SUPERVISION**

Children’s Names & Ages

Life in Balance Counseling and Wellness Center strives to maintain a peaceful therapeutic environment to enhance well-being and healing. This includes keeping noise and activity levels to a minimum to avoid disrupting services. Many of our services such as meditation, massage, yoga, and hypnosis are best provided in a quiet environment.

We would prefer that children always be supervised by a responsible parent or other adult at all times while at Life in Balance. However, we do understand that sometimes it may be necessary to leave them in the waiting and/or play room. Please keep the following in mind:

1. Life in Balance will neither provide supervision nor assume liability for your children’s safety while they are unsupervised.
2. Children under the age of 5 should never be left unsupervised.
3. You must let front desk staff know you are leaving your children in the waiting and/or play room. Staff will need to know children’s names and ages as well as which practitioner you are seeing.
4. Please inform your children left waiting that they must play or sit quietly.
5. Rough play or disruption to other Life in Balance services, guests, or practitioners will not be tolerated.
6. Three step process for unruly children:
	1. If your children become disruptive, they will be asked once to curb disruptive behaviors by Life in Balance staff.
	2. If your children continue to be disruptive, staff will request you speak to your children to curb their disruptive behaviors.
	3. If your children continue being disruptive, they will not be permitted to be left unsupervised at Life in Balance again. You will need to make other arrangements for your children while receiving services.

**PRESENTING PROBLEM AND PAST TREATMENT**

Mother’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father’s Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please briefly describe why you are seeking counseling for you child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has your child had this problem? Did something happen before it started? \_\_\_\_\_

If your child has been diagnosed with a mental health disorder, please list here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child received mental health treatment before? \_\_\_\_ If so when? Where? \_\_\_\_\_

What was the reason for seeking treatment? \_\_\_\_\_

 \_\_\_\_\_

What was most helpful about your child’s mental health treatment? \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was least helpful about your child’s mental health treatment? \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had psychological testing before? \_\_\_\_\_\_\_ If so when? \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Where? \_\_\_\_\_

Is your child receiving other mental health services such as: Psychiatrist Substance Abuse Treatment Mental Health Supports Case Management \_ Crisis Services

If yes, Provider’s name: Phone: Agency:

Is your child receiving services with Dept of Rehabilitative Services or other Agencies?

Has your child ever been hospitalized for psychiatric reasons? If so when? \_\_\_\_\_

Where? Briefly describe the reason:

Has your child ever had suicidal thoughts? Yes/No Has your child ever attempted suicide? Yes/No
If so when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was going on that lead to these feelings/thoughts?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YMPTOMS:** Please check any problems that your child currently has or had in the past:

Now Past

  Change in appetite (more or less)

  Feeling sad

  Crying spells

  Too little sleep (falling or staying asleep)

  Sleep more than usual

  Fatigue

  Loss of interest &/or pleasure

  Avoiding friends or family

  Expect failure

  Decreased concentration

  Thoughts of death

  Cutting or burning oneself

  Suicide plan or attempt

  Depression

  Often sick

  Loneliness

  Slow moving

  Hopelessness

  Confusion

  Worthlessness

  Friendly

  Lack of confidence/Low self-esteem

  Guilt

  Reckless or dangerous behavior

  Racing thoughts

  Pressured speech

  Inflated self-esteem

  Obsessive thoughts

  Compulsive or repetitive behavior

  Marital/family problems

  Sexual problems

  Relationship problems

  Long term memory problems

  Short term memory problems

  Wound up or tense more days than not

  Panic attacks

  Irritable

  Anxiety

  Easy going

  Muscle tension

  Irrational fear of something or someone

  Talking/acting w/out thinking

  Fidgety, restless, overactive

  Difficulty paying attention

  Frequent day dreams

  Bored easily

  Learning difficulties

  Often lose things

  Excessive dieting/exercise

  Obsessed with losing weight

  Use of laxatives

  Engage in self-induced vomiting

  Eating things that are not food

  Vandalism

  Fire-setting

  Lack of remorse for wrong-doing

  Selfish

  Bullies/gets in fights

  Lying

  Truancy

  Theft

  Argumentative/sudden anger

  Defiant of authority

  Temper tantrums

  Stubborn

  Avoid adults

  Afraid to leave a loved one

  Easily embarrassed

  Upset by minor changes

  Feeling detached from one’s body

  Feelings of unreality

  See or hear things others don’t

  Believe things others tell you aren’t true

  Fear of strangers

  Difficulty trusting

  Believe others are out to get you

  Intrusive thoughts

  Avoid things related to traumatic event

  Startle easily

  Flashbacks

  Nightmares

Other symptoms not mentioned above

How do these symptoms affect your child’s life?

Have you ever been told that your child may suffer from any of the following?

* ADD  ADHD  Anxiety  Depression  Other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel your child understands directions and situations as well as other children their age? Yes/No

If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your child’s intelligence:  Below average  Average  Above Average

Does your child play primarily with children:  Their age  Older  Younger

Describe any problems your child has interacting with other children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any problems your child has interacting with adults: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE USE HISTORY (Please complete if child is 12 or older)**

SUBSTANCE History of Use? Date of first Use: Date of Last Use:

 Yes No

Alcohol   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marijuana   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Barbiturates   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Klonopin, Ativan, Xanax,

Valium   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cocaine/Crack   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heroin/Opiates   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP, LSD, Mescaline   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Inhalants   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amphetamines, Speed,

Uppers, Crystal Meth   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designer Drugs, Ecstasy   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the Counter drugs   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nicotine   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child is currently using any substances, please describe when and where they typically use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe how your child’s use affects family and friends, including how they perceive your child’s use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you perceive your child’s use? \_\_\_\_\_

 \_\_\_\_\_

Has your child ever received substance abuse treatment? \_\_\_\_ If yes, when/where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had the following due to substance use? Blackouts Hallucinations Seizures Tremors Legal Charges DUI

**MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Physician’s Name | Specialty | What are they treating your child for? | Dates of treatment |
|  | **Primary Care Physician** |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Date of last physical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental exam:

 Please list all prescription, non-prescription medications, and supplements below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Medication | Prescribed by | Dosage/Frequency | Helpful? | Side effects/comments | Taken as Prescribed?  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |
|  |  |  | ☐ Y ☐ N |  |  |

Please mark X if your child has ever experienced any of these conditions:

Hypertension PMS/painful menstruation  Seizures

Heart disease Easy bruising  Head injury

Arteriosclerosis Skin rash  Headaches

Arthritis Allergies  Back pain

Kidney disease Asthma  Chronic pain

Varicose veins Skin sensitivity  Fibromyalgia

Phlebitis Environmental sensitivity  Chronic fatigue

Blood disorder Numbness/Stabbing Pain  Digestive disorder

Cancer/Malignancy Sensitive to touch/pressure  Operations

Diabetes Abscess or open sore  Infectious Diseases

Accident \_  Thyroid  Hypo (low)  Hyper (high)  Other

How does your child’s medical condition affect your life or theirs? \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on a special diet? If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your child’s activity level? Chores only **OR** min moderate exercise:\_\_\_\_\_\_times/week

What is your child’s highest weight? Current ?

How many hours does your child sleep at night? Does your child have trouble: falling asleep? \_\_\_

staying asleep? \_\_\_

Has your child ever had a neurological exam or EEG?  Yes  No

Does your child have problems with:  Hearing  Sight  Speaking

If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your child’s immunizations up-to-date:  Yes  No

**DEVELOPMENTAL HISTORY**

Pregnancy  planned  unplanned

Did the mother use drugs or alcohol while pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the mother have problems during pregnancy?  Yes  No If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s birth weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was child premature?  Yes  No

Check one:  Breast fed  Bottle fed At what age was this type of feeding discontinued? \_\_\_\_\_\_\_\_\_

Was your child:  Colicky  Active Was there any problem with weight gain?  Yes  No

At what age did your child walk \_\_\_\_\_\_\_\_\_\_ Were there any difficulties? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age was the child toilet trained? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were there problems with wetting or soiling afterwards? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What forms of discipline do you use when correcting your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Is your child adopted or a foster child?  Yes  No If adopted, what age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a foster child, how long as the child been in your care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are the child’s parents living together?  Yes  No If no, when did they separate? \_\_\_\_\_\_\_\_\_\_\_\_\_

What are the living/custody arrangements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe visitation arrangements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Living  Deceased

Cause and age of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Living  Deceased

Cause and age of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all members of household, ages, and relationship to child:

1. 5.

2. 6.

3. 7.

4. 8.

Has any blood relative of your child (parent, sibling, grandparent, aunt, uncle, etc.) ever had issues or been diagnosed with any of the following:

 Mental Illness Suicide Alcoholism Drug Problems Seizure Disorder

 Mental Retardation Chronic Illness ADD ADHD Bipolar Disorder

Has your child ever been emotionally/mentally, sexually or physically abused? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever: been in a war zone or civil unrest? Experienced a natural disaster? Been a victim of a crime? Had other traumatic experiences?

**SCHOOL**

Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have an Individualized Education Plan or 504 Plan? Yes No

Has your child ever had to repeat a grade? Yes No

Does your child’s teacher report any problems at school? Yes No

If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional comments or concerns you would like your child’s therapist to be aware of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPIRITUAL**

Is your child or family spiritual or religious in any way? Please explain activities:

Has your child had any loss or death in your life that is currently causing him/her distress? If so, please describe:

How do you cope with loss and/or death?

**CULTURAL**

What language(s) are spoken in your household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your child ethnically or culturally?

Does your child have any physical disabilities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL HISTORY**

What are your family’s sources of income?

Does your family receive any kind of assistance with food, housing, or other necessities?

Does your family struggle with your bills? \_\_\_\_\_Does your child have transportation?

**HOUSING**

Has your family been facing being homeless? Do you have issues where you live now (unsafe housing or neighborhood, poor relationship with neighbors or landlord)?

**LEGAL HISTORY**

**□** No legal history

 History of involvement in legal system (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Served detention time \_\_\_\_\_\_\_\_\_\_\_\_ For what crime(s)? \_\_\_\_\_

 Current legal charges (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Involvement with Child or Adult Protective Services (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for the time and effort you invested in completing this paperwork. This will help me to understand your child more fully and be better able to assist you on our journey together.**

Reviewed all the above content with client:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature (if applicable) Date

**Authorization to Release Protected Health Information (PHI)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/guardian of (child’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(date of child’s birth)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission to Life in Balance Counseling and Wellness Center and (clinician’s name) to send and/or discuss confidential case records and/or test results, to send treatment summaries and diagnosis information to and to receive confidential information from my primary care physician, psychiatrist, or other person/entity:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand my service record is protected under Federal and State regulations and that information to be released by my signature may contain information pertaining to medical, psychiatric, substance abuse treatment and/or confidential HIV/AIDS related information.

This consent shall be in effect from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ until\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(No longer than one year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature of Patient/Guardian) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Witness) (Date)

**Credit Card on File Agreement**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to allow Life In Balance to keep my credit

card information on file. It is required by my insurance company for my co-pay to be paid prior

to my appointment. Therefore, I agree and permit Life in Balance to charge my credit card for

mine or my minor child’s co-pay in the event that prior to the appointment I am not able to be

reached or should the front office be unavailable to take my payment. I understand that no one

will contact me prior to making this charge as it is understood that if I owed a co-pay for an

 appointment that I have completed the co-pay charge will be charged to my credit card. I also

agree to allow my card to be charged for a no-show appointment or missed appointment without

a 24 hour prior notice to the office if I have missed an appointment more than 2 times.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**TeleMentalHealth Consent Form**

This form is to be completed in addition to Life In Balance Center standard Consent and Services Agreement. It does not replace Life In Balance Center standard Consent and Services Agreement.

I hereby consent to engaging in telehealth with a Life In Balance provider as part of my clinical treatment. I understand that “telehealth” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/behavioral health information, both orally and visually, to health care practitioners located and licensed in the Commonwealth of Virginia.

**I understand that I have the following rights with respect to telehealth:**

-I have the right to withhold or withdraw consent at any time without aﬀecting my right to future care or treatment nor risking the loss or withdrawal of any program beneﬁts to which I would otherwise be entitled.

-The laws that protect the conﬁdentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally conﬁdential. However, there are both mandatory and permissive expectations to conﬁdentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my behavioral or emotional state an issue in a legal proceeding.

-I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable eﬀorts on the part of my psychotherapist, that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

-In addition, I understand that telehealth based services and care may not be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and beneﬁts associated with any form of psychotherapy, and that despite my eﬀorts and the eﬀorts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.

-I understand that I may beneﬁt from telehealth, but that results cannot be guaranteed or assured.

-I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia law.

**Insurance reimbursement:**

I understand that my insurance may not cover telehealth with my Life In Balance Provider. I understand it is my responsibility to contact my insurance company to find out if my policy covers telehealth with my specific Life In Balance provider. I also understand that Life In Balance will bill my insurance, but this does not guarantee that my insurance will pay for telehealth mental services with my Life In Balance provider. If my insurance does not pay, I accept full responsibility for any payment due for services rendered by my provider. If my insurance does not cover telehealth for my Life In Balance Provider I understand that I can request face to face services or ask for a referral to a provider that my insurance covers.

Signature of Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Addendum to Informed Consent**

**Covid-19**

This form is to be completed in addition to Life In Balance Center’s standard Consent and Services Agreement. It does not replace Life In Balance Center’s standard Consent and Services Agreement.

To be in compliance with Executive Order 63 by the Governor of the State of Virginia we require masks to be worn inside of our office building. However, there are exceptions to this order and therefore we cannot mandate that everyone wear a mask. If you choose to enter our office site you do so at your own risk and agree that you will not hold Life In Balance Counseling and Wellness Center nor any of its employees or practitioners responsible or liable for the risk you take by entering into our office site should you contract Covid-19.

You have the right to reschedule your appointment at such a time that would reduce your risk.

You have the right to request a Telehealth appointment that may or may not be covered by your insurance carrier.

You have the right to ask for a referral to another practitioner in another office that may have less risks.

You have a right to discontinue services.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand my risks and rights of entering the building at Life In Balance for services and agree to the above statements.

Signature of Client or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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