

DEMOGRAPHIC/INSURANCE INFORMATION

Date _____ Child's Name: _____ DOB: _____ Age: _____

Child's Primary Residence: _____ City: _____ Zip: _____

Caregiver (s) at this address:

Second Residence _____ City: _____ Zip: _____

Caregiver (s) at this address:

Relationship Status of Child's Parents: Married * Divorced * Separated * Widowed *
If divorced, what is the custody agreement?

Mother: _____ Father: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Home phone: (____) _____ Home phone: (____) _____

Cell phone: (____) _____ Cell phone: (____) _____

Referred by: Insurance Co. Physician Friend Google Ad Website Other: _____

Financial Responsibility—If paying privately, please check here

Name of Insured: _____ Date of Birth: _____

Client's Relationship to Insured: Self Spouse Mother Father Child Guardian

Insurance Carrier: _____ Insurance Phone#: _____

Co-pay \$ _____ Member ID#: _____ Policy/Group#: _____

Employer: _____ Employer Phone#: _____

- Your signature below authorizes your insurance company to pay me directly for services provided.
- You are also authorizing the release of information about your child's care to your insurance company. The information often required by insurance

companies may include, but is not limited to, diagnosis codes, dates of service, treatment and progress.

- **If your insurance company should deny payment, you will be responsible for any outstanding financial debt associated with therapy services.**

Parent or Legal Guardian: _____

Date: _____

Office Policies and Consent for Treatment

Welcome to my therapy practice. This document contains important information about my professional services and business practices and will serve as a therapeutic contract. Please read it carefully and jot down any questions that you would like to discuss.

My Philosophy

An important part of child therapy includes regular meetings with parents or parents & children together. These meetings are an essential part of your child's growth in therapy.

About the Therapy Process

- It is important for you to know that child counseling has risks and benefits. Therapy has been shown through research to be very beneficial to children. Although there are no guarantees about the outcomes of therapy, children often demonstrate a reduction in concerning behaviors and an increase in emotional well-being.
- One of the risks is possible disagreement between parents or disagreement between parents and therapist regarding treatment. If this occurs, I will make every effort to listen and understand your concerns. If at some time you decide to end therapy, I ask that you schedule a few closing sessions so that I can end treatment appropriately for your child.
- Trust between client and therapist is vital to the therapy process, even for young children. Therefore, I will not share the specifics of what your child has disclosed to me without the child's consent, unless there is a risk of harm to self or others. I will share with you general themes and treatment progress and will encourage your child to share important information with you as well.

- Although my responsibility to your child may require my involvement in conflicts between parents, I request your agreement that my involvement will be strictly limited to that which will benefit your child. This means that you agree that you will not attempt to gain an advantage in any legal proceedings between you and the child's other parent (guardian) regarding my work with your child. You also agree that you will not ask me to testify in court, whether in person or by affidavit and that you will instruct your attorneys not to subpoena me or to refer in any court filing to anything that I have said or done.

Custody/Guardianship

- Consent for services can only be authorized by a current legal guardian.
- For divorced parents, consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. (A copy of the divorce decree must be included in the client file indicating the custodial arrangement).
- Permission from both parents, regardless of the custodial arrangement is the preferred practice of this office.

Payment and Fees:

- | |
|--|
| <ul style="list-style-type: none">• No shows/Late cancellations (<i>less than 24 hours notice</i>) incur a fee of \$75.00. This fee cannot be billed to your insurance and client will be billed directly. |
|--|

- Payment is due at the time services are rendered in the form of **cash, check or credit card**.
- Private Pay: My standard fee is \$150 for Clinical Intake/hour and \$135/hour each following session for Individual, Marriage and Family counseling. Sessions are generally for an hour and are prorated for longer sessions.
- A credit or debit card will be kept on file for non-payment (insurance or client).

Other fees not covered by insurance: Client will be billed directly for services below:

Phone calls (with parent/caregiver).....1st 15 minutes-free; then \$135/hour (pro-rated)

Telephone consultation with other professionals at client's request.... \$135/hour (pro-rated) (i.e. teachers, school psychologist, psychiatrist, doctor, etc.)

Other services (i.e. write letters, fill out forms, report writing).....\$135/hour (pro-rated)

Legal: attorney calls, reports..... \$150/hour

Preparation of Copies of Client Records.....\$30.00

Returned Check Fee.....\$35.00

Confidentiality - (please refer to the HIPPA notice for additional information):

- The law requires that I report suspicions or evidence of child abuse, or child's/parent's expressed intention to harm oneself or others.
- Individuals may choose to contact me via email, fax or phone. In doing so, they agree to the understanding that email, fax and phone communication are not guaranteed confidential methods of communication.

Therapist Availability/Emergencies:

- By phone, you can leave a confidential message at **(469) 219-3256**.
- If your child is having a crisis or clinical emergency, **please call 911**.
- If your child is seeing a Psychiatrist, I advise that you contact him/her in times of emergent need.

Consent to Treatment:

- Your signature below indicates that you have had the opportunity to read the information in this document and that your questions regarding your child's care have been satisfactorily answered.
- Furthermore, it indicates that you are a legal parent or guardian of _____ and that you **consent to treatment for your child**.
- It also indicates that you understand and give permission for your child's therapist to seek clinical supervision or consultation about client issues when necessary (while maintaining client anonymity).
- A copy of this document will be provided at your request.

Parent/Guardian signature _____ Date _____

Parent/Guardian signature _____ Date _____

INTAKE QUESTIONNAIRE

Child's Name: _____ DOB: _____ Age: _____

Person completing form: _____

Describe the main reason you are seeking help for your child:

When did you first become concerned about these problem(s)?

Please list **all those living in your home** besides the child. This includes spouse, siblings, partner, friends and relatives. *Please use the back of this form if needed.*

Name	Age	Gender	Relationship to Child
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

Separation/Divorce:

Are parents separated or divorced? Yes No If yes, for how long? _____

If parents are separated/divorced, does non-custodial parent share legal custody? Yes No

Are both parents aware that this child will be receiving counseling? Yes No

Does child have contact with both parents? Yes No How often? _____

Counseling History

Has your child previously received counseling? Yes No If yes, when and for what?

Do you think that it was a positive experience for your child? Yes No

Was it a positive experience for both parents? Yes No

Has your child received medication for behavior or moods? Yes No

If yes, what was the outcome? _____

Please complete the following questions:

How well does your child fall asleep, stay asleep and wake up from naps and in the morning?

How does your child respond to separation?

What is your child's favorite thing to do?

Please describe a typical day in the life of your child:

What is the most important thing that I can do for you today?

Medical History

Pediatric office: _____ Doctor: _____

Address: _____ Phone: _____

Does your child have any **current** or **past** medical or physical concerns? Yes No

If yes please describe:

Has your child had any of the following? If yes, please explain:

Head injuries? Yes No If yes, did child lose consciousness? Yes No

Hospitalizations? Yes No

Surgeries? Yes No

Medical procedures? Yes No

Seizures? Yes No

Serious illness Yes No

hearing difficulties eye/vision problems asthma

sensory problems (i.e. doesn't want to touch certain textures; bothered by bright lights)

fine motor problems (handwriting, cutting, using fingers)

gross motor problems (clumsy, poor balance, trouble running)

allergies (food, pet, etc) Yes No If yes, what?

Current Medications:

Name of Medication	Dose/frequency	Reason	How long prescribed	Prescribing Doctor

Prenatal/Birth History

Did mother receive prenatal care? Yes No
 Were there any complications during: Pregnancy Yes No
 Labor Yes No _____
 Delivery Yes No _____
 Was child born premature or full-term? _____ Vaginal or Caesarian? _____
 Child's Weight at birth _____
 Was there an extended hospital stay for mother or child after delivery? Yes No
 Did child spend any time in the NICU? Yes No
 Alcohol or drug use during pregnancy? Yes No
 Use of medication during pregnancy? Yes No
 Did mother have post-partum depression? Yes No

Please check any items below that your child experienced as an infant or toddler:

- | | |
|--|--|
| <input type="checkbox"/> Exposure to lead | <input type="checkbox"/> Repetitive movements |
| <input type="checkbox"/> Walking/gross motor delay | <input type="checkbox"/> Difficult to comfort |
| <input type="checkbox"/> Speech/Language delay | <input type="checkbox"/> Eating non-foods |
| <input type="checkbox"/> Hand coordination/fine motor delay | <input type="checkbox"/> Overly social/friendly |
| <input type="checkbox"/> Poor attachment to parents/caregivers | <input type="checkbox"/> Slow response when called by name |
| <input type="checkbox"/> Sleeping difficulties | <input type="checkbox"/> Avoidance of eye contact |
| <input type="checkbox"/> Problems eating | <input type="checkbox"/> Separation from parents |
| <input type="checkbox"/> Not wanting touch | <input type="checkbox"/> Loss of previous abilities |
| <input type="checkbox"/> Clingy | <input type="checkbox"/> Other _____ |

Developmental Milestones: Please list age that each milestone was achieved:

Sitting _____	First word _____
Crawling _____	Two-word sentences _____
Standing _____	Toilet trained _____

Walking _____ Imitates others _____

Childcare

Childcare: _____ Phone# _____
 center home daycare in your home before/after school friend/neighbor
#Days/week: _____ #hours/day: _____ # Children in facility: _____
Has child been asked to leave any childcare? no yes

Education

School: _____ Grade: _____ Teacher _____
Has your child attended other schools? No Yes : How many? _____
What prompted the change? _____
How is your child's academic progress? excellent good fair poor struggling
Does your child receive any special services?
 tutoring (in school/ private) occupational/speech/physical therapy 504 plan IEP Other _____
Have you ever been called to pick your child up at school due to misbehavior? No Yes

Has your child ever had detention, been suspended or asked to leave a school? No Yes

Does child ever report not liking school or teachers? No Yes

Child and Family History - Please indicate any that child has experienced:

___ Parent injury/ illness/hospitalization	___ Death in the family
___ Unemployment of family member	___ Parental Conflict
___ Alcohol or drug abuse by family member	___ Witness to drug abuse
___ Abuse (Sexual, emotional, verbal, physical)	___ Family Financial stress
___ Violence in the home	___ Exposure to a traumatic event
___ Violence in the community	___ Car accident
___ Family members that have been arrested	___ Home robbery/invasion
___ Family members that have been incarcerated	___ Natural/other Disaster
___ Police confrontation/arrest of parent/guardian	___ Frequent moves

Family Mental Health History

Please indicate below if anyone in the family has experienced the following.

Has anyone experienced:	Mother's Side	Father's Side
Anxiety		
Depression		
Bipolar disorder		
Learning disorders (ADHD, dyslexia...)		
Drug abuse		
Alcohol abuse		
Schizophrenia		
Suicide attempts		
Completed suicide		
Panic Attacks		
Collecting useless items		
Violent temper		
Abuse (Physical/ Emotional/ Verbal / Sexual)		
Hallucinations or Delusions		
Strange behavior or thinking		
Other:		
Other:		

BEHAVIOR CHECKLIST: Please check items that describe your child's behavior for the **past year:**

<input type="checkbox"/> Academic problems/homework difficulties	<input type="checkbox"/> Not interested in things
<input type="checkbox"/> Angry mood/Rages	<input type="checkbox"/> Paying attention; focusing difficulties
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Perfectionism
<input type="checkbox"/> Arguing	<input type="checkbox"/> Playing with fire

<input type="checkbox"/> Being bullied or bullying	<input type="checkbox"/> Repetitive habits
<input type="checkbox"/> Blames others	<input type="checkbox"/> Rigid routines
<input type="checkbox"/> Bossiness	<input type="checkbox"/> Unusual behavior
<input type="checkbox"/> Confused thinking	<input type="checkbox"/> Self injury
<input type="checkbox"/> Crying frequently	<input type="checkbox"/> Separation anxiety
<input type="checkbox"/> Defiant (to parents or other adults)	<input type="checkbox"/> Sexualized behavior (that seems inappropriate)
<input type="checkbox"/> Destroys things	<input type="checkbox"/> Shyness (excessive)
<input type="checkbox"/> Disorganized, loses things	<input type="checkbox"/> Sleeping, waking difficulties
<input type="checkbox"/> Doesn't want to try new things	<input type="checkbox"/> Somatic complaints (headaches/stomachaches)
<input type="checkbox"/> Eating issues (too much, too little)	<input type="checkbox"/> Stealing
<input type="checkbox"/> Easily frustrated	<input type="checkbox"/> Strong feelings of guilt or shame
<input type="checkbox"/> Emotional outbursts	<input type="checkbox"/> Suicide attempts
<input type="checkbox"/> Fears	<input type="checkbox"/> Suicidal thoughts (says wants to die)
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Talking back
<input type="checkbox"/> Frequent conflict	<input type="checkbox"/> Tantrums
<input type="checkbox"/> Grief/loss	<input type="checkbox"/> Threats or comments about hurting self
<input type="checkbox"/> Hair pulling	<input type="checkbox"/> Threats or comments about hurting others
<input type="checkbox"/> Hard to make/keep friends	<input type="checkbox"/> Too concerned with neatness
<input type="checkbox"/> Hears or sees things others do not	<input type="checkbox"/> Toileting
<input type="checkbox"/> Hits others	<input type="checkbox"/> Transitions are difficult
<input type="checkbox"/> Hurts animals	<input type="checkbox"/> Strong reactions to textures, light, sound
<input type="checkbox"/> Hyper; trouble sitting still	<input type="checkbox"/> Unhappy, sad or depressed
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Unusual thoughts
<input type="checkbox"/> Irritable	<input type="checkbox"/> Wetting/ soiling pants or bed
<input type="checkbox"/> Lack of confidence	<input type="checkbox"/> Withdrawn; not sociable
<input type="checkbox"/> Learning and remembering difficulties	<input type="checkbox"/> Worries a lot
<input type="checkbox"/> Mood quickly goes up and down	<input type="checkbox"/> Yelling
<input type="checkbox"/> Nightmares/Night terrors	<input type="checkbox"/> Won't speak outside the home

Credit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. You may pay by cash or check, but a card must still be kept on file.****

Name

Print Last

First

Middle Initial

Name on Card if different

I authorize Collin County Counseling to charge my credit/debit card for professional services as follows: *Initial*

_____ All visits for which payment was not made at time of visit (this includes fee for service, deductibles and co-pays).

_____ To charge my card for the balance of fees not paid by my insurance company within 90 days.

_____ To charge my card \$50.00 for each no-show or late cancellation (less than 24 hours notice).

Type of Card: Visa MasterCard Discover

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____
3-digit number on the **back** of the card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements:

Street

City

State

Zip

Card Holder Signature _____, Date ____ / ____ / ____