Healing Path Counseling Child Client Intake Form

Child's Last Name	Middle Name	First Name

Birth Date	Age	Sex	Email Address
/ /		❑ M ❑ F	

Street Address	City	State	ZIP Code	Social Security
				- -

P.O. Box	City	State	ZIP Code

Best Phone Number	Alternative Phone Number	Can we leave a message/voicemail?
( )	( )	❑ Yes ❑ No

Who can we thank for referring you? (Please check one box & list name)	❑ Dr.	❑ Counselor	❑ Website	❑ Family

❑ EMDRIA	❑ Friend	❑ Psychology Today	Name:_____

Occupation	Employer

Emergency Contact

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Client Consent

Patient/Therapist Relationship

- You and your therapist have a professional relationship existing exclusively for therapeutic treatment.
- In the following of ethical guidelines, social relationships between therapist and clients are prohibited. (this includes social media such as Facebook, Twitter, and Linked-In)

Risks and Benefits:

- Counseling is beneficial, but as with any treatment, there are inherent risks.
- During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions.
- The benefits of counseling can far outweigh any discomfort encountered during the process.
- It is our desire, however, to work with you to attain your personal goals for counseling.

Capacity or Death:

- In the event of my death or inability to provide therapy, your record will be transferred to another therapist.
- This information will be held by the Arkansas Board of Examiners in Counseling. They can be reached at (501)683-5800.

Confidentiality:

- Confidentiality is an ethical standard that protects clients from the disclosure of information without their consent.
- Healing Path Counseling follows all ethical standards prescribed by state and federal law.
- We are required by practice guidelines and standards of care to keep records of your counseling.
- These records are confidential with the exceptions noted in the Notice of Privacy Practices provided to you, and when I believe you are a danger to yourself or others

Consent To Treatment:

- By signing this client information and consent form as the client or the guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form.
- I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child, if said child is the client), and I understand that I may stop services at any time.
- **Note**: If you are consenting to treatment of a minor child, and a court order has been entered with respect to the guardianship of the child, or impacting your rights with respect to consent to the child's mental health care and treatment, Healing Path Counseling will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

Parent/Guardian Name- Please Print _____ Date

Signature-Parent/Guardian _____ Date

Therapist _____ Date

HEALING PATH COUNSELING FEES, CREDIT CARD AUTHORIZATION, AND OFFICE POLICIES

APPOINTMENTS

- Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long.
- More frequent sessions or an intensive outpatient schedule are available if determined appropriate by you and your therapist. For progress to be made in counseling, it is crucial that you attend appointments consistently.
- Please notify us within 24 hours of scheduled appointment, if you will be unable to attend (see fee schedule for late and reschedule fees)

OFFICE POLICIES

- Prior to entering counselor's office, please silence your cell phones, and please turn off all electronic devices.
- Please plan ahead for your appointment, and make appropriate arrangements for children, pets, and travel to and from the office.

FEES:

- Fees for first time clients will be taken in the form of two $50.00 payments. The first is due at the time the appointment is scheduled. For this reason, we ask that you supply a credit card and authorization to process the payment. The second payment will be due when you arrive to your scheduled visit.
- After the initial session, fees are expected at the beginning of each session. This will allow you to concentrate fully on your counseling session. We accept check, money order, cash, credit cards, and some health savings cards.

FEE SCHEDULE:

• Diagnostic & Evaluation Session (1st visit) ($50.00 to hold the appointment, $50.00 due at scheduled time	$100.00
• Regular Office Visits (45 minutes) (Individuals, Couples & Play Therapy)	$100.00
• Outside Office Work(inpatient visits, court, collaborative law services, academic, phone/video meetings)	$150.00/hr
• Court appearances-requires a 4 hour minimum retainer due the week of court (no refund will be given, if less than 48 hours notice of cancelling court)	$600.00
• Written Reports (insurance companies, supervisors, etc. pro-rated at	Minimum $25.00
• Returned check fee per check	$50.00
• Cancelled or Rescheduled Appointment without 24 hr. notice	$25.00
• 2nd Cancelled or Rescheduled Appointment without 24 hr. notice	
• No Show Appointment	$50.00
• 2nd No Show Appointment plus all no shows thereafter	$100.00
• Late Fee for Outstanding Balances (applied monthly)	10%of total bill
• A reasonable fee will be charged for copies of any records requested by the client	Minimum $25.00

INSURANCE/EMPLOYEE ASSISTANCE PROGRAMS (EAP) /WORKER'S COMPENSATION

- Clients are responsible for full payment at time of services.
- We do not bill insurance, but we will provide, at your request a 1500 form to submit to your insurance on a monthly basis.
- It is your responsibility to obtain the address for the MENTAL HEALTH DEPT of your insurance, and to follow-up regarding processing with your insurance.
- It is your responsibility to contact your human resource department to find out if you have an employee assistance program, and to inform them that you would like to take advantage of the program.
- We must be notified by the EAP that they are covering your sessions prior to your counseling session, or you will be responsible for payment for that session.
- If your appointments are being covered by an Employee Assistance Program, Worker's Compensation, or insurance they may require medical records in order to approve payment. In order for Healing Path Counseling to release those records, permission needs to be given on the HIPPA form.

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered. I understand that if I chose to end services, I am still responsible for any outstanding balance.

Signature-Client/Parent Date

Signature-Parent/Guardian Date

By signing below, you hereby authorize Healing Path Counseling to maintain your credit card on file in the event that there is a later charge to your account. You will be notified via email/telephone prior to any subsequent charges.

HIPPA AUTHORIZATION FORM

I, _____, whose date of birth is _____, authorize **HEALING PATH COUNSELING** to disclose to and/or obtain from _____ the following information:

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed.)

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Testing Information
- ☐ Educational Information
- ☐ Presence/Participation in Treatment
- ☐ Continuing Care Plan
- ☐ Progress in Treatment
- ☐ Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:-

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **HEALING PATH COUNSELING**. .

Expiration

Unless revoked in writing, this authorization form is valid until _____. If no date is indicated, the release is valid for one year from the date signed.

Conditions

I further understand that **HEALING PATH COUNSELING** will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

Storage of Records

Healing Path Counseling utilizes a third-party electronic medical record system to store your records. The third-party system is HIPAA compliant, and all employees of the third-party company must sign a confidentiality agreement prior to working for the company. Your signature below confirms your agreement to having your medical records stored electronically.

Upon request, I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Client Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual.

_____

_____ Check here if client refuses to sign authorization.

_____

Signature of Staff Witness Date

HEALING PATH COUNSELING
CHILD INFORMATION FORM

Child's Name_____ Date _____

Please list your therapy goals for your child

_____

_____

_____

MEDICAL HISTORY

Name of Primary Care Physician: _____ Physician's Phone: _____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken: (Please the next page to list additional medications)

1)_____ Dosage/Freq_____ 2)_____ Dosage/Freq _____

Prescribed by: _____

Has your child ever been hospitalized for medical or psychiatric reasons? ☐ YES ☐ NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems experienced by your child or any other family members:

_____

_____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

_____

SCHOOL HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? ☐ YES ☐ NO

If yes, please explain:_____

_____

What school is your child attending? _____ Is your child home-schooled? ☐ Yes ☐ No

What grade is your child in? _____

Please check all information which applies to your child's biological parents:

MOTHER	☐ living	☐ divorced	FATHER	☐ living	☐ divorce
	☐ deceased	☐ remarried		☐ deceased	☐ remarried
	☐ married	____# of times		☐ married	___# of times

With whom does your child live: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Guardian ☐ Grandparent

What custody and/or visitation orders are in place? :_____

*** Please copy orders to be placed in client's file.**

Does your child consider anyone else to be a "parent" in his/her life? ☐ YES ☐ NO If so, whom?_ _____

Check the box next to the word that best describes your relationship with the following:

	Poor	Fair	Good	Excellent
Your Mother	☐	☐	☐	☐
Your Stepmother	☐	☐	☐	☐
Your Father	☐	☐	☐	☐
Your Stepfather	☐	☐	☐	☐
Other (such as grandmother, guardian, etc)	☐	☐	☐	☐

List first names and ages of people living in the same home with your child.

Name	Age	Relationship (biological, step, half, etc.)	Grade/occupation

Are there any problems that have occurred in your family relating to:

☐ Alcohol abuse ☐ Drug abuse ☐ Sexual abuse ☐ Physical abuse ☐ Emotional abuse ☐ Traumatic event (ie. Tornado, car accident, fire, death of loved one

Please explain:

MENTAL STATUS

Please check any of the following that describe how your child has been feeling lately:

☐ sad ☐ anxious ☐ depressed ☐ frightened ☐ guilty ☐ angry ☐ ashamed ☐ aggressive ☐ resentful
☐ worthless ☐ tearful ☐ irritable ☐ confused ☐ jealous ☐ hopeless ☐ helpless ☐ extreme ups/downs

Describe any behaviors your child has demonstrated that cause concern:

Please check yes or no to the questions below, and explain any yes answers below.

		YES	NO
1.	Has your child had any changes in eating or sleep patterns?	☐	☐
2.	Has your child ever considered suicide in connection to your current problem?	☐	☐
3.	Has your child ever considered suicide in the past?	☐	☐
4.	Has your child ever attempted suicide recently or in the past?	☐	☐
5.	Has your child ever tried to hurt others or animals recently or in the past?	☐	☐

Please explain any yes answers in the space below.

LEVEL OF FUNCTIONING

Please describe what activities your child participates in:

Who is in your child's support network?

Please indicate how much time your child spends doing the following: (check the one that applies)

Activity	Time Spent				
	0 hours	1+hours	1-3 hours	3-5 hours	5 + hours
Engaging in physical Activity	☐	☐	☐	☐	☐
Playing on the computer	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐
Playing video games	☐	☐	☐	☐	☐

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses.