# Cedars Counseling

## Child Intake Form

*Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.*

### Demographics

Legal Name: _____ Nickname: _____

Age: _____ DOB: _____

Child's Primary Address: _____

City: _____ State: _____ Zip: _____ County: _____

School: _____ Grade: _____ Teacher: _____

With whom does the child presently reside? _____ Relationship to Child _____

Primary Number: _____ May we leave a message? _____ Yes _____ No

E-mail: _____ May we leave a message? _____ Yes _____ No

*Please print your e-mail address clearly.

Where should we send an appointment reminder? _____ E-mail or _____ Text message

### Insurance Information ***This MUST be completed even though we have a copy of your card. You may e-mail the copy of your card to: info@cedarscounseling.com.**

**EAP** _____ Yes _____ No If yes, through whom _____

****EAP must be set up prior to your session**

EAP telephone number _____ Authorization Number _____

**Primary Insurance** _____ **Contract/ID#** _____

**Subscriber Name** _____ **Subscriber S.S.#** _____

**SubscriberAddress** _____

**Subscriber Date of Birth** _____ **Client's relationship to Subscriber** _____

**Secondary Insurance** _____**Contract/ID#** _____**Group #** _____

**Subscriber Name** _____ **Subscriber S.S.#** _____

**SubscriberAddress** _____

**Subscriber Date of Birth** _____ **Client's relationship to Subscriber** _____

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## Family Information

Father's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____

Email: _____ _____

Employer: _____ Occupation: _____

Marital Status: _____ Single _____ Married (_____ years married) _____ Divorced _____ Widowed

Spouse/Significant Other: _____

Has the child's father been previously married? _____ Yes _____ No

Mother's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____

Employer: _____ Occupation: _____

Marital Status: _____ Single _____ Married (_____ years married) _____ Divorced _____ Widowed

Spouse/Significant Other: _____

Has the child's mother been previously married? _____ Yes _____ No

## **Custody Arrangements** (if applicable)

Primary Residential Parent: _____

Visitation Schedule: _____

According to your Parenting Plan, who is authorized to make health care related decisions?

_____ Father _____ Mother _____ Joint _____Other (specify) _____

- **Please provide Cedars Counseling with a copy of your parenting plan.**

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## Household Members

Name _____ Relationship _____ Age _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

What kind of relationship does the child have with his/her siblings? _____ Good _____ Fair _____ Poor

What kind of relationship does the mother have with the child? _____ Good _____ Fair _____ Poor

What kind of relationship does the father have with the child? _____ Good _____ Fair _____ Poor

What kind of relationship does the child have with extended family?

Paternal: _____ Good _____ Fair _____ Poor Maternal: _____ Good _____ Fair _____ Poor

What are the primary methods of discipline used with your child, and how effective have they been? _____

_____

_____

Has your child ever experienced any type of abuse? (Physical/Sexual/Verbal) _____ Yes _____ No

If yes, please describe: _____

_____

## Medical/Mental Health Information

Were there any problems during the pregnancy of this child? _____ Yes _____ No

Is your child currently on any medications? _____ Yes _____ No

If yes, please list all of the medications which your child is currently taking: _____

_____

Medical conditions or illnesses: _____

Accidents or injuries: _____

Hospitalizations: _____

Child's current pediatrician: _____

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When was your child's last medical check-up? _____

How would you rate your child's overall health on a scale of 1-10? _____

Good 10 9 8 7 6 5 4 3 2 1 Poor

Briefly describe significant family events which your child has been exposed to: (i.e. divorce, remarriage, death, domestic violence)

_____

_____

If yes, please describe: _____

## Child's Academic History

Does your child enjoy school? _____ Yes _____ No

Does your child have any learning challenges? _____ Yes _____ No

If yes, please describe: _____

Has your child had any special testing or evaluation: _____ Yes _____ No

If yes, please describe: _____

List any special services that your child is currently receiving: (tutoring, speech therapy, etc.) _____

_____

What grades does your child typically receive in school? _____ Above Average _____ Average _____ Below Average

Has your child ever repeated a grade? If yes, which grade: _____

Has your child experienced any of the following problems at school? (Mark all that apply)

_____ Incomplete homework _____ Behavior problems _____Fighting _____ Detention

_____ Suspension _____ Poor attendance _____ Gang Influence _____ Exposure to drugs/alcohol

## Child's Present Psychological Status

How would you describe the personality of your child? _____

Does your child have any hobbies or other interests? _____

Is there anything currently bothering your child, causing them to worry or be stressed? _____ Yes _____ No

If yes, please explain: _____

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Has your child ever experienced any serious personal emotional losses? _____ Yes _____ No
If yes, please explain: _____

How would you rate your child's temper? _____ Short _____ Medium _____ Long

Has your child ever made statements of wanting to hurt themselves or someone else? _____ Yes_____ No

If yes, please explain: _____

## Presenting Issues

Why are you currently seeking counseling for your child? _____

_____

_____

_____

## Additional Information

Has your child previously been in counseling? _____ Yes _____ No

Name of therapist: _____ Date of counseling _____

Child's response to treatment: _____

**Print Name: _____** **Date: _____**

**Signature: _____** **Signed by: ___ client ___ guardian ___ personal representative**

**Print Name: _____** **Date: _____**

**Signature: _____** **Signed by: ___ client ___ guardian ___ personal representative**

_____ _____
Therapist Date

# Cedars Counseling

## Payment Contract for Services

The following are fees associated with services that may be provided at your request.

| Description of Service | Self-Pay Rates Therapist |
|---|---|
| Initial Intake | $135.00/Hr |
| Psychotherapy | $125.00/Session |
| Late Cancellations (Less than 24 hours notice) | $65.00 Each |

| Other Services | Amount |
|---|---|
| Court Appearance* | $150.00/Hr with $750.00 Minimum |
| Court Depositions* | $150.00/Hr |
| Court Documentation/Reports* | $150.00/Report |
| Phone Consultation/Paperwork/Chart Request | $25.00 - $50.00 |
| Psychological Evaluations | Varies |

**Please note**, if you utilize insurance, the fee will be adjusted according to the contracted rate.
*Required prepayment of services. Insurance **will not** cover these costs.

***I understand that should my insurance fail to reimburse for my services, I will be responsible for the full amount due. I understand that there will be a 2% interest charge on all outstanding balances over 60 days. In the event that my account goes into court for collection, I understand that there will be an additional charge to cover any attorney or legal fees and post-judgment interest at the rate of 2% per month.***

_____ _____

Signature of Client/Legal Guardian Date

_____ _____

Therapist Date

# Cedars Counseling

## Informed Consent to Treatment

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment or give my consent for the minor or person under my legal guardianship mentioned above, at Cedars Counseling, Inc. hereby referred as the Provider. Further, I consent to have treatment by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. Cedars Counseling encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

**Client's Rights and Responsibilities:** I certify that I have received the Client's Rights Information and certify that I have read and understood the content.

**Expectations:** Counseling is based on the relationship you develop with your counselor. Every case is unique, but generally you can expect the following:

- Education: You can expect some information and education about what you are facing.
- Assignments: Homework is a vital part of making the most of your counseling process.
- Client Centered: You can expect to have topics that revolve around you and your concerns.
- Sharing: You will be asked questions, and there is an expectation that you will openly share your thoughts and feelings.
- Discovery: Expect to examine yourself through looking at your thoughts, feelings, and behaviors.
- Length of Treatment: Sessions last 45-50 minutes.
- Frequency of Appointments: One session per week is typical but can be adjusted to meet individual needs.
- Interruptions: It is in your best interest to have uninterrupted care. Time between sessions can substantially lessen the desired effects of treatment.

**Non-Voluntary Discharge from Treatment:** A client may be terminated from the Provider non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts on the premises of Cedars Counseling, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter.

**Client Notice of Confidentiality:** The confidentiality of patient records maintained by the Provider is protected by Federal and//or State law and regulations. Please refer to the Privacy of Information Policy which will address all matters of confidentiality.

**Risks:** Therapy is very safe, but there are some risks. The biggest risk is the result of change. Change can have an undetermined impact on your life and in significant relationships. Another risk is emotional pain or anxiety but should be alleviated with continued treatment.

**Benefits:** Change is also the most significant benefit of therapy. You will learn new ways of interacting, thinking, and behaving. Often changes will result in the reduction of problems and reported symptoms prior to therapy.

**About your Counselor:** As you review this form with your counselor, he/she should explain his/her individual counseling style. This should include qualifications, approach to therapy, school of thought, and other information. If you have any questions now or later, feel free to ask your counselor.

**I have received a copy of the Client's Bill of Rights Notification and the HIPAA Notice of Privacy Practices, and I consent to treatment and agree to abide by the above stated policies and agreements with Cedars Counseling, Inc.**

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Therapist Date

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# Cedars Counseling

## Client's Bill of Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a client. The information contained in this document explains your rights and the process of complaining if you believe your rights have been violated.

**Your rights as a patient:**

- **Complaints:** We will investigate your complaints.
- **Suggestions:** You are invited to suggest changes in any aspect of the services we provide.
- **Civil Rights:** Your civil rights are protected by federal and state laws.
- **Cultural/Gender Issues:** You may request services from someone with training or experiences from a specific cultural or gender orientation. If these services are not available, we will help you in the referral process.
- **Treatment:** You have the right to take part in formulating your treatment plan.
- **Denial of Services:** You may refuse services offered to you and be informed of any potential consequences.
- **Record Restrictions:** You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
- **Availability of records:** You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records in which case we will discuss this decision with you.
- **Amendment of records:** You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in your records.
- **Medical/Legal Advice:** You may discuss your treatment with your doctor or attorney.
- **Disclosures:** You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

**Your rights to receive information:**

- **Costs of services:** We will inform you of how much you will pay.
- **Termination of services:** You will be informed as to what behaviors or violations could lead to termination of services at our facility.
- **Confidentiality:** You will be informed of the limits of confidentiality and how your protected health information will be used.
- **Policy Changes:** You will be notified in advance of any policy changes.

**Our ethical obligations:**

- We dedicate ourselves to serving the best interest of each client.
- We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
- We maintain an objective and professional relationship with each client.
- We respect the rights and views of other mental health professionals.
- We will appropriately end services or refer clients to other programs when appropriate.
- We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
- We hold respect for various institutional and managerial policies, but will help improve such policies if the best interest of the client is served.

**Client's responsibilities:**

- You are responsible for your financial obligations to the facility as outlined in the Payment Contract for Services.
- You are responsible for following the policies of the facility.
- You are responsible to treat staff and fellow clients in a respectful, cordial manner in which their rights are not violated.
- You are responsible to provide accurate information about yourself.
- Therapy is an individual process for which you will need to assume responsibility for making changes.
- In order to receive the greatest benefit, you need to be actively involved in the treatment process. Goal setting, assignments, and talking are all important and critical to treatment success.
- Treatment is voluntary, and you may end counseling at any time without fear of penalty.
- You can expect to be treated with respect.

**What to do if you believe your rights have been violated:**

- If you believe that your client rights have been violated, contact Elysse Beasley, Srpe, LPC

# Cedars Counseling

## HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAFREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health or condition and related care services.

**I. Uses and Disclosures of Protected Health Information Requiring Authorization**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

**II. Treatment**

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**III. Payment**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. If claims are denied, you are responsible for all costs of the services provided. There is a 2% interest charge on all outstanding balances over 60 days. In the event that your account goes into court for collection, there will be an additional charge to cover any attorney or legal fees and post-judgment interest at the rate of 2% per month.

**IV. Health Care Operations**

We may use or disclose, as needed, your protected information in order to support the business activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to a medical school student that sees patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law. Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object unless required by law.

You may revoke this authorization at any time in writing except to the extent that your physician or the physician's practice has taken an action previously on the use or disclosure indicated in the authorization.

**YOUR RIGHTS:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you request. If the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

**You have the right to request to receive confidential communication from us by alternative means or an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to this notice alternatively (i.e. electronically).

**You may have the right ot have your provider amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**V. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

**VI. Effective Date**

This notice shall go into effect April 14, 2003 and will remain so unless new notice provisions effective for all protected health information are enacted accordingly. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objects to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.