

Redman Counseling, LLC

678-447-5063

CHILD AND ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor. This information will help your therapist understand your child. It, as all communications with your therapist, is kept confidential to the full extent of Georgia law.

BACKGROUND INFORMATION

Child's Name _____ Date of Birth ____/____/____ Age _____

Child lives with (check one): ____ both biological parents ____ mother ____ father ____ other _____

If parents are divorced, describe custody arrangements: _____

Child's Home Phone _____ - _____ - _____

Child's Address/City/St/Zip _____

Emergency Contact (other than parent) _____ Phone _____

Custodial parent's contact information

Cell _____ Home _____ Work _____ ext. _____

Email _____

What is the best way to contact you for appointment reminders? Home Work E-mail Cell Don't contact
May we leave a message? Yes No

INFORMATION ABOUT CHILD'S MOTHER

Mother's Name _____ Age _____

Race _____ Employer _____

Occupation _____ Hrs/wk _____ Can you be contacted at work by phone? ____ Yes ____ No

(Circle the best way to contact you). Work _____ ext. _____

Cell _____ Home _____ Email _____

Church _____ Denomination _____ Active? ____ Yes ____ No

Describe any physical problems you have that require medication or physical care _____

Are you currently receiving medical treatment? ____ Yes ____ No Physician _____

Medication(s) currently using _____

Previous Counseling / Therapy? ____ Yes ____ No If yes, when _____

With whom and for how long? _____

INFORMATION ABOUT CHILD'S FATHER

Father's Name _____ Age _____

Race _____ Employer _____

Occupation _____ Hrs/wk _____ Can you be contacted at work by phone? ___ Yes ___ No

(Circle the best way to contact you). Work _____ ext. _____

Cell _____ Home _____ Email _____

Church _____ Denomination _____ Active? ___ Yes ___ No

Describe any physical problems you have that require medication or physical care _____

Are you currently receiving medical treatment? ___ Yes ___ No Physician _____

Medication(s) currently using _____

Previous Counseling / Therapy? ___ Yes ___ No If yes, when _____

With whom and for how long? _____

FAMILY MEMBERS Please list all family members:

Name	Relationship to Child	Age	School Grade Completed	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DESCRIBE THE ISSUE the child is having. If possible, list questions for which answers are sought:

Problem Areas: In the following list, please prioritize each item which identifies an area of concern to you by numbering them. For example, the number 1 would be placed by the item which concerns you the **most** today.

- | | |
|---|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thoughts of Suicide |
| <input type="checkbox"/> Education | <input type="checkbox"/> Trouble making decisions |
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Unhappy most of the time |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Use of Alcohol |
| <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Use of Drugs |
| <input type="checkbox"/> Physical Problems | <input type="checkbox"/> Work |
| <input type="checkbox"/> Problems with Social Relationships | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Problems with Children | <input type="checkbox"/> Religious/Spiritual Concerns |
| <input type="checkbox"/> Other _____ | |

CHILD'S MEDICAL HISTORY

Child's sicknesses, operations, and injuries; Medications, Doctors, Therapists; Existing Diagnosis;

Have there been any previous psychological, psychiatric, neurological, or EEG evaluations? ___ Yes ___ No

If so. Please list names and dates of contact. _____

Describe previous speech or hearing therapy, if any _____

What is the date of your child's last physical examination? _____ Physician's Name _____

ACADEMIC/SCHOOL INFORMATION

School Name _____ Grade _____ Teacher _____

How many previous schools attended, with dates:

Has child ever repeated a grade? Yes No If so, when? _____

How does your child get along with peers and authorities at school? _____

Describe difficulties in learning at school: _____

*****Please provide copies of all special testing (s)he has had for Educational or Psychological purposes.*****

Have other family members had learning difficulties? Yes No What? _____

Describe what your child likes to do for fun, special interests, hobbies, etc. _____

Describe your child's religious background (denomination, church membership, attendance, spiritual training, Bible reading, prayer, etc.) _____

I learned about Redman Counseling, LLC from: (Name, Address, phone if known)

May we send a thank you note to this person? ___ Yes ___ No

Your Signature _____ Date ____/____/____

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INFORMED CONSENT AND OFFICE POLICY STATEMENT

I. Welcome!

Thank you for choosing Redman Counseling, LLC. The following information will acquaint you with information relevant to treatment, confidentiality, and policies. Please inform the therapist of any questions you have regarding any of these policies.

II. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments.

III. Appointments:

Appointments are usually scheduled for 50-55 minutes. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency the therapist may be reached at (678) 447-5063. In the case of life threatening emergency and you are unable to contact your therapist call 911 or go to your local emergency room. You may also call the 24/7 GA Crisis Line at 1-800-715-4225.

IV. Confidentiality:

Counseling issues discussed between the therapist and identified client are important and are generally legally protected as both confidential and "privileged." Communications between the therapist and identified client will not be revealed unless required by law such as in situations as (1.) Suspected abuse or neglect of a child, elderly person or a disabled person (2.) When your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself (3.) Subpoena for court ordered release of information. Additionally confidentiality limits could be effected by: (a.) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc...; (b.) In natural disasters whereby protected records may become exposed; or (c.) When someone other than the therapist is present during the counseling session.

V. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section. Medical records are locked and kept on site.

VI. Fees:

Fee for the initial visit is \$150.00
 Each 55 minute session thereafter is \$125.00

VII. Payments:

Payment is due at the time of the session unless other arrangements have been made. You can request a professional statement of charges. If a child\minor is a client the adult bringing the child to the appointment is responsible for the bill regardless of divorce decrees. However, the client is responsible for deductibles, co-insurance amounts and/or co-payments. Any unpaid balances will be billed. Our method of payments include Cash, Check, Money Order, Visa, MasterCard, Discover, and American Express.

VIII. Cancellations and Missed Appointments:

If you must cancel your appointment please notify your therapist (messages may be left via voicemail) at least 24 hours in advance of your scheduled appointment at 678-447-5063. A charge may be incurred (i.e. amount equivalent to the co-pay when using insurance; the session rate if "self-pay;" or loss of a visit if utilizing EAP services) when cancellations are received less than 24 hours in advance or the client does not show for the session, except in cases of illness or emergency. The client is responsible for this charge since insurance companies do not reimburse for missed appointments.

IX. Returned Check Fee:

There will be a \$25.00 fee for any checks returned from your bank.

X. Termination of Services

If at any point you choose not to continue therapy please notify therapist of decision immediately so the chart can be closed. If you fail to reschedule an appointment within twelve weeks of your last session, therapy will officially be ended and your case will be deemed closed.

XI. Children

We cannot accept responsibility for the supervision of unattended children in the waiting room. If you are bringing your child to see a therapist, please bring another adult with you to supervise your child while you meet with the therapist. It is the responsibility of the person bringing the child to appointments to inform the custodial parent or the person who is the insured that insurance benefits are being utilized.

XII. Insurance

We will be glad to work with you by verifying your coverage and filing claims for you. However, it is ultimately your responsibility to see that authorizations or referrals are obtained and that the bill is paid. Utilization of your insurance benefits is likely to necessitate disclosure of clinical information to your insurance company.

XIII. Consent for Treatment

By signing below you: state that you have read and understood the Informed Consent Statement and Confidentiality Policy; have had your questions answered to your satisfaction; accept, understand, and agree to abide by the contents and terms of this agreement. I give my consent to enter a psychological counseling program and consent to participate in evaluation and/or treatment. I understand that signing this form does not commit me to a binding contract, but merely indicates my consent to begin therapy. I understand that I may withdraw from treatment at any time.

Signature _____ Date _____

****The signature of the custodial parent or legal guardian is required for clients under 18 years of age.**

 Spouse's Signature (if doing marital counseling)

 Date

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CLIENT INSURANCE INFORMATION

SECTION I: CLIENT INFORMATION

CLIENT'S NAME: _____

CLIENT'S DATE OF BIRTH ____/____/____

CLIENT'S ADDRESS: _____

CITY/STATE/ZIP _____

CLIENT'S TELEPHONE: HOME _____ WORK _____ CELL _____

PATIENT'S RELATIONSHIP TO INSURED (circle one) SELF SPOUSE CHILD OTHER

SECTION II: PRIMARY INSURANCE INFORMATION

INSURED'S NAME: _____

INSURED'S DATE OF BIRTH ____/____/____

INSURED'S SOCIAL SECURITY # _____

INSURED'S ADDRESS _____

INSURED'S TELEPHONE: HOME _____ WORK _____ CELL _____

INSURED'S INSURANCE PLAN NAME _____

POLICY OR GROUP NUMBER _____

INSURED'S EMPLOYER _____

IS THERE ANOTHER HEALTH INSURANCE PLAN?

SECTION III: SECONDARY INSURANCE INFORMATION

INSURED'S NAME: _____

INSURED'S DATE OF BIRTH ____/____/____

INSURED'S SOCIAL SECURITY # _____

INSURED'S ADDRESS _____

INSURED'S TELEPHONE: HOME _____ WORK _____ CELL _____

INSURED'S INSURANCE PLAN NAME _____

POLICY OR GROUP NUMBER _____

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Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers. As you might expect, the HIPAA laws and regulations are extremely detailed and difficult to grasp if you do not have formal legal training.

This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. It is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we make every effort to do what we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Redman Counseling, LLC is required to secure your signature indicating you have been given access to a copy of the Patient Notification of Privacy Rights document.

Patient Name (print) _____

I have read or will read a copy of the Redman Counseling, LLC Patient Notification of Privacy Rights document that provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document before signing this "acknowledgment form", and that I may at any time, now or later, ask any questions about, or seek clarification of, the matters discussed in this document.

Signing below indicates only that I have read or will read a copy.

(a) _____
Patient Signature

Date

(b) _____
Parent Signature (if patient is a Minor)

Date

(c) _____
Guardian Signature (if patient is Legal Charge)

Date

(d) _____
Witness

Date