CHILD CLIENT INTAKE

Date: _____

Child's Name:_____ **Age**:_____ **Date of Birth**:_____
Gender: □M □F

Does child have a preferred name/nickname/pronoun? _____

Name of person filling out this form: _____

Relationship to child: _____ Your cell number: _____

Your email: _____

With whom does the child reside? _____

Address where child lives: _____

City/State/Zip: _____

May we contact you by phone? _____ **Yes** _____ **No**

May we contact you by text? _____ **Yes** _____ **No**

May we contact you by email? _____ **Yes** _____ **No**

I understand that voicemail, text or email cannot be guaranteed private communication. I accept the risks to confidentiality when using such methods of communication. _____ **Yes** _____ **No**

What is the relationship status of the child's parents? (please circle)
never married relationship married separated divorced widowed remarried

Mother's Name: _____ Cell number: _____

Mother's email: _____

Mother's address: _____ City/State/Zip: _____

Father's Name: _____ Cell number: _____

Father's email: _____

Father's address: _____ City/State/Zip: _____

If child's parents were not married or are separated/divorced, please provide the following:

Other Non- or joint custodial parent name: _____ Gender: □M □ F

What is the custody/visitation arrangement? _____

Family Make-Up

Please list the child's siblings:

1.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female
2.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female
3.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female
4.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female
5.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female

Of which siblings/step-siblings does the child primarily live with and have contact with?

_____
_____
_____

Does anyone else live in the home with the child or see the child on a very regular basis?

_____
_____
_____

Spiritual or Cultural Information

It is our desire to understand your child and/or family as much as possible to better serve you. If there is any information about your family or the child's religion or culture that would be important for us to know or understand please include that information here and please share with us during the intake session:

_____
_____
_____
_____

Confidentiality – At times your child may speak of concerns with the therapist they have not yet shared with you. **We will always inform you of immediate safety concerns.** But outside of immediate safety, our preferred approach is to note the child's concerns and begin to address those concerns in session and help your child **grow towards a place of sharing with you themselves.** You have the final say regarding what issues are shared immediately or which we are allowed time to address in session. Please mark and discuss with the counselor which issues you immediately want the counselor to notify you of if disclosed in session.

For example: ____ same sex attraction ____ substance use ____ bullying (victim or aggressor)

____ pornography use/exposure ____ sexual activity ____ non-suicidal self-harm

LIFE FUNCTIONING INVENTORY

Client Name _____DOB /Age_____

Please list the problem(s) with which you want help:_____
_____
_____
_____

How long has this issue been a problem? _____

What strategies have been used at home to address these problems?

verbal reprimands	avoiding the child	removal of privileges
time-out	yelling	giving in
physical punishment	rewards	communication

Over which of the following issues (if any) do you have regular conflict?

room cleaning	dating relationships	choice of friends
curfew	household chores	church attendance
music	clothes/appearance	other _____

Do you consider yourself (and/or your spouse) consistent in your disciplining?

most of the time some of the time none of the time

Do you (and/or your spouse) have any consistent differences in your approach to discipline or expectations of your child? □yes □ no □n/a If yes, please explain:

_____
_____
_____
_____

Family Information:

Please list any mental health history of any family members:

_____
_____
_____
_____

Briefly describe your child's relationship with other members of your household:

_____
_____
_____
_____
_____

Medical History:

Has your child had any of the following:

head injury what age? _____ loss of consciousness? □yes □ no

Surgery _____

broken bones _____

severe injury _____-_____

medications _____

Is your child having any difficulty with appetite or eating habits? □yes □ no

If yes, check where applicable:

□ eating less □ eating more □ binge eating □restricting calories □ significant weight change

Has your child had suicidal thoughts recently? □yes □no

If yes, how often? □daily □ weekly □monthly □rarely

Have they had them in the past? □yes □no If yes, when? _____

Has your child ever attempted suicide? □yes □no If yes, when/how? _____

Has your child ever intentionally inflicted harm upon themselves? □yes □no

If yes, please describe: _____

_____

_____

Has your child had previous counseling or other psychological treatment(s)? □yes □ no

If yes, where and when was this received? For what problems? Was this a good or bad experience?

_____

_____

_____

_____

Has your child ever been hospitalized for psychiatric reasons? □yes □no

If yes, reason for hospitalization: _____

Hospital location: _____

Dates of hospitalization: _____

Academic History:

School currently attending: _____ Grade: _____
Grades (check all that apply):

Most recent report card:	___A's	___B's	___C's	___D's	___F's
Typical grade performance:	___A's	___B's	___C's	___D's	___F's

Has your child ever had an individual, educational assessment? □yes no
If yes, where, when, and what were the results?

_____
_____

Has your child ever been held back a grade? □yes □no If yes, what grade? _____
Reason:

_____
_____

Circle any of the following learning problems that have been identified:

ADD/ADHD	Dyslexia	Reading Disorder
Math Disorder	Written Expression Disorder	Other: _____

How easily does he/she make friends? (Please circle one)
better than average average worse than average

On average, how long does your child keep friendships? (Please circle one)
less than six months one year more than a year

Major Changes:
Please list any major changes in your child's life over the past five years:

_____
_____
_____

Positive Qualities:
Please list a few positive traits or strengths of your child:

_____
_____

Anything Else:
Please share anything else you want me to know about your child:

_____
_____
_____

Thank you for completing this paperwork. I look forward to meeting you and your child.

FEE ACCOUNTABILITY AND FINANCIAL CONSENT STATEMENT

A scheduled appointment must be cancelled with at least 24 notice to avoid financial responsibility for that session. It is my responsibility to call or text my counselor (day/night/weekend) to cancel my appointment.

If I fail to cancel an appointment with at least 24 hours' notice, a one-time charge or debit to my credit/debit card in the amount of my regular session fee will be made. Elledge Counseling Associates is not required to notify me of this charge.

Payment is due at the beginning of each session. All checks should be made out to **ECA**. If paying by cash, bring the exact amount. Counselors are unable to make change and excess cash will be applied to the next session. I understand that if I choose to pay ahead for sessions, no refunds will be made for unused sessions.

If my check is returned for insufficient funds I agree to a one-time credit/debit charge to my card/account plus the NSF fee and a service charge. Elledge Counseling Associates is not required to notify me of this charge.

If I do not return books/CD/DVD material(s) to my ECA counselor, I agree to the one-time charge or debit to my credit card/account in the amount of the replacement cost of the material(s) and credit card service fee. Elledge Counseling Associates is not required to notify me of this charge.

If I request diagnosis information, treatment summaries, or session attendance documentation, for insurance reimbursement, I agree to pay my counselor's regular session fee per hour to copy, complete, or mail the requested materials. All payments must be processed before the documents are presented. There is *no charge* for providing you with a standard receipt of sessions attended for tax purposes.

I understand that my counselor is unable to make further appointments with me until any balance on my account is paid in full.

Credit /Debit Card Information:

Name as it appears on the card _____

Credit/Debit Card #_____

Expiration Date_____ Security Code _____ Zip Code _____

_____ _____

Cardholder Printed Name & Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice, and of your individual rights and the practice's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which "students, trainees, or practitioners in mental health" learn under supervision to practice or improve their skills in group, joint, family, or individual counseling. <u>This also means, that unless you request otherwise, ECA counselors may consult with one another to coordinate care; in your case alone or in the case that a family member is also working with an ECA therapist.</u>

- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third-party payer, credit card or collection agency. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed in an attempt to collect payment.

- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you. We may at times communicate with you by text or email; both of which may not always be a secure form of communication. You may refuse this kind of communication by checking the appropriate box on your intake form.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. For example - a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with. Or we may contact your designated Emergency Contact in case of an emergency.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

(continued on next page)

NOTICE OF PRIVACY PRACTICES CON'T

Your Health Information Rights:

Although your records are the physical property of **Elledge Counseling Associates**, the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to our office manager.

You have:

- The right to request restrictions on certain uses and disclosures of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you. (i.e.- "This is **Elledge Counseling Associates** calling")
- The right to inspect and copy the information that we maintain about you. However, we ***may deny an individual access***, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
    - a health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to ***endanger the life or physical safety of the individual or another person***;
    - the information makes ***reference to another person*** (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
    - The request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to ***cause substantial harm to the individual or another person***.
    - If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example – at your regularly scheduled appointment at a church satellite office, or by e-mail or fax.
- The right to amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request with in sixty (60) days. In rare cases your request may be denied. For a complete description of Rights of Amendment, please contact our office manager.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request (you will always have access on our website)
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to our office manager, or Executive Director, or directly to the Secretary of Health and Human Services

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Brenda Elledge, Director, **Elledge Counseling Associates 328 Pebblebrook**, Red Oak, TX 75154. You should know there will be no retaliation for your filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free: 1-877-696-6775

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.

LEGAL REQUESTS/COURT PROCEEDINGS

If I, my legal counsel, or an adversarial counsel subpoenas any counselor from ECA to appear on my behalf, in a deposition or any court proceeding, I agree to pay that counselor $1500.00 per day to appear in court cases within the same county of the counselor's primary office location. If the counselor is required to travel outside their county or stay overnight, an additional full day rate will be charged. A half-day rate may be possible in the event of a pre-scheduled online court appearance.

I also understand that the counselor will require a subpoena to appear. An email subpoena is acceptable.

I also understand that the court appearance fee is due 72 hours in advance of my appearance, and if that fee is not paid as required, the counselor will seek legal representation to file a motion to quash the subpoena.

If the court appearance is canceled with a minimum of 48 hours advance notice, $1000.00 may be refunded to you. This is not a guarantee. Despite cancellation, payment processing fees, the counselor's legal fees, and the counselor's time spent in court preparation is an expense.

If I or my legal counsel requests a copy of the client file, session notes, treatment summaries or session attendance documentation on my behalf, I agree to pay all reasonable copying and or postage costs. Clients may pick up the documents or pay to have the documents mailed to them. All payments must be processed before the documents are presented.

ECA counselors are not expert witnesses nor custody evaluators. We cannot give legal advice so we strongly urge clients to discuss with their lawyers the perceived need for a counselor's documentation or court testimony, and the subsequent financial burden it may cause the client.

By signing below, you are stating that you have read and understood this policy statement and have had any questions about this document answered to your satisfaction.

Client Printed Name _____ Date _____

Parent/Guardian Signature _____

INFORMED CONSENT AND ECA POLICIES

I consent to my child taking part in treatment with an **Elledge Counseling Associates (ECA)** counselor. I understand that the counselor will develop a treatment plan consisting of goals I have for my child, goals my child may have, and those the counselor determines are in the best interest of my child.

I understand that no promises have been made to me as to the results of treatment.

I am aware that I may stop treatment at any time, however, I agree to talk with the counselor if I feel like ending therapy before all the treatment goals for my child are met.

Sessions last for 45 minutes. I also understand that if I or my child is late to an appointment the counselor will not run over into another client's appointment time and I will be billed for the entire session.

In the case of an emergency I may call my child's counselor. If the counselor is unavailable and it is a life-threatening emergency, I will call 911 or take my child to the nearest emergency room.

Confidentiality is the ethical right of all clients. However, there are certain exceptions, which surpass the confidentiality of the client-therapist relationship and the therapist may be ethically bound and legally required to inform the proper authorities.

Exceptions to Confidentiality:

1. The therapist makes an assessment that the client is a danger to self or others.
2. A client reports past or present abuse/neglect/exploitation of a child, elderly person, or a person with a disability (physical or intellectual).
3. A client acknowledges committing past or present abuse/neglect/exploitation of a child, elderly person, or a person with a disability (physical or intellectual).
4. When counseling records are subpoenaed by a court of law.
5. The client shares with the counselor their use of pornography involving minors.

By signing, you affirm you have read and understood the Informed Consent/ECA Policies.

_____ _____

Client Printed Name Date

_____

Parent/Guardian Signature

LIMITS OF THE COUNSELING RELATIONSHIP

It's important to remember that although the sessions with a counselor may feel very intimate emotionally or psychologically, the counseling relationship is a professional one and not a social one.

The counseling relationship is governed by certain laws (Texas Administrative Code, Title 22, Part 30, Chapter 681) and ethics (Subchapter C) that are set in place **for the protection of the client**.

For example:

1. Contact must be limited to scheduled sessions only.

2. Due to ethical guidelines, please do not to invite the counselor to social gatherings, offer gifts, ask the counselor to write references, or relate to them in any way other than the professional context of the counseling sessions (**this includes any interaction involving social networking sites, i.e., Facebook, Instagram, LinkedIn, dating apps, etc.**).

3. Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot and will not acknowledge you outside of counseling sessions unless you first acknowledge them.

4. When the counseling relationship ends, the limitations of contact with the counselor must remain the same.

If you feel that your therapist has failed to adhere to the laws or ethics governing Texas LPCs please address this with your counselor or the Executive Director of ECA. Or you may file a complaint by writing or calling the Texas Behavioral Health Executive Council at 333 Guadalupe St., Ste. 3-900 Austin, Texas 78701, (512) 305-7700. Or you may download a complaint form from the website at https://www.bhec.texas.gov/wp-content/uploads/2020/07/BHEC-Complaint-Form.pdf.

My signature below affirms that I have read, understood, and agree to the limits of the counseling relationship.

_____ _____

Client Printed Name Date

_____

Parent/Guardian Signature

PARENT / GUARDIAN PARTICIPATION AGREEMENT

Parents, grandparents, and caregivers are the most important people in a child's life. We as counselors are here to support your child by providing a safe environment for him/her to process difficult emotions, thoughts and experiences. We will educate him/her on certain topics or provide coping tools and tips as appropriate. At times we will also be advocates for your child and ask you to work with us to see the improvement you and/or your child desire.

Some adult's mistakenly think that they will bring their child in for a 45-minute session every week or every other week and the counselor will work a miracle and solve all the problems their child has in two months. Unfortunately, that is unrealistic and allowing you or the child to believe that sets you both up for disappointment.

So, in order to set you both up for success, here's what we ask of you:

1. Regular, consistent and punctual attendance at appointments (weekly is best whenever possible)
2. Participation in educational and encouraging resources (fancy words for the homework that your child's counselor will assign you – articles, videos, activities, books, podcasts)
3. Patience (your child's problems probably didn't develop in a few weeks/months so solving them in a few weeks/months probably won't happen, either)
4. Attend regular parent meetings with your child's counselor to discuss progress, setbacks, and treatment goals
   - Parent sessions/updates are open to both parents unless deemed otherwise by a judge.
   - Stepparents or grandparents are welcomed into sessions if invited by the child's parent/guardian.

_____ I understand that participation in my child's therapy is essential to the best outcome.

_____ I am willing to follow the participation guidelines outlined above.

_____ _____

Client Printed Name Date

_____

Signature of Parent/Guardian

RIGHT TO SEEK COUNSELING FOR A MINOR

If the minor child <u>lives with both</u> biological/adoptive parents check here and sign below.

_____ I am the child's biological /adoptive/ parent with full rights to seek counseling for my child.

If the minor child <u>does not live with both</u> biological/adoptive parents continue reading and sign below.

1. Texas law and LPC ethics requires that ECA maintain a copy in our file (digital or paper) of the most recent custody papers, i.e. divorce decree, modified decree, SAPCR, etc., in the case of any minor client named in a custody agreement or court order (copy must be obtained PRIOR to sessions with the child).

2. Texas law and LPC ethics requires that if a minor client does not live with both biological/adoptive parents, then the adult seeking counseling will provide ECA with the most current phone number and/or address for the other parent in order to facilitate notification.

We are obligated to make a good faith effort to contact the other parent and document this in our files.

We are committed to therapeutically appropriate contact and feedback to all involved adults for the child client's well-being

If you have any concerns or questions about the information above please do not hesitate to discuss them with the counselor.

If legal documentation is required:

_____ I have provided a copy of the <u>most recent</u> custodial court documents.

_____ If applicable, I will provide the <u>most recent</u> contact information for the minor child's other legal parent or guardian.

_____ _____

Client Printed Name Date

_____ _____

Adult Printed Name/Relationship to Child Signature

UNACCOMPANIED MINORS POLICY

For the protection of all children and in agreement with our partner sites:

Please initial each policy and sign at the bottom acknowledging your understanding of this policy.

_____ Unaccompanied minors are not allowed in the office buildings for any reason.

_____ Unaccompanied minors are not allowed to wait unsupervised while their parent(s) are in session.

_____ A parent or guardian must remain in the building during a minor client's session. Parents/guardians who leave the premises during their child's appointment may no longer be able to schedule appointments.

_____ Adolescent clients who drive themselves to session may remain unaccompanied while waiting on their counselor.

My signature below affirms my understanding of, and agreement to adhere to these policies.

_____

Client Printed Name

_____ _____

Parent/Guardian Signature Date