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This packet will include:

* Intake Form
* Informed Consent & Practice Policies
* Telehealth Informed Consent
* Privacy Practices/HIPAA
* Good Faith Estimate
* Final Signature Page
* Minor Client Background Information
1. Please save a copy of this packet to keep for your own records.
2. You can choose to print and bring a signed paper copy to your first session or electronically fill it out and send it to your counselor’s HIPAA secure email.
3. If you choose to send the packet to your therapist via their HIPAA secure email you are confirming all typed signatures and initials represents your legal handwritten signature.

We look forward to meeting you and your child!

**MINOR CLIENT INTAKE**

(for clients under 18 years of age)

Date: Click or tap to enter a date.

Child’s Name: Click or tap here to enter text. Age: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date. Gender: [ ] M [ ] F

Name of person filling out this form: Click or tap here to enter text.

Relationship to child: Choose an item. Cell number: Click or tap here to enter text.

Email: Click or tap here to enter text.

Address (street, city, state, zip): Click or tap here to enter text.

 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**

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**Emergency Contact for Minor Child:**

Name: Click or tap here to enter text.

Relationship to child: Choose an item. Cell Number: Click or tap here to enter text.

Email: Click or tap here to enter text.

Address (street, city, state, zip): Click or tap here to enter text.

**RIGHT TO SEEK COUNSELING FOR A MINOR**

**If the minor child lives with both biological/adoptive parents check here and skip to the next page.**

[ ]  I am the child’s biological /adoptive/ parent with full rights to seek counseling for my child.

[ ]  I provided the name of the child’s other parent under Emergency Contacts.

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**If the minor child does not live with both biological/adoptive parents continue reading.**

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

[ ]  I will provide a copy of the most recent custody documents.

2. The legal advisors for ECA recommend that we notify the child’s other parent before we begin a counseling relationship. We are obligated to make a good faith effort to contact the other parent and document these attempts in our files.

* If you have any concerns or questions about the protocol above, please do not hesitate to discuss those concerns with the counselor at your parent intake.

[ ]  I will provide the most recent contact information for the minor child’s other legal parent or guardian.

**Other parent’s demographic information (if already listed as an Emergency Contact there is no need to list again).**

Other parent’s name: Click or tap here to enter text.

Cell number: Click or tap here to enter text.

Email: Click or tap here to enter text.

Address (street, city, state, zip): Click or tap here to enter text.

**INFORMED CONSENT AND PRACTICE POLICIES**

**Treatment**

I agree for my child to take part in treatment with an **Elledge Counseling Associates (ECA)** counselor. Treatment may include interpersonal, cognitive, cognitive-behavioral, psychodynamic, and affective methods to achieve my goals.

* I understand that making a treatment plan with the counselor and working toward those goals are in my child’s best interest.
* I understand that the counselor will give me and my child feedback and treatment options based on their education, training, and experience but I have the final say so in my treatment.
* I understand that no promises have been made to me as to the results of treatment.

I may stop treatment at any time; however, I agree to talk with my child’s counselor if I consider ending therapy before all the treatment goals are met.

**Confidentiality**

Confidentiality is the ethical right of all clients. However, there are certain exceptions when the therapist may be ethically bound, and legally required to share information with the proper authorities.

 Possible Exceptions to Confidentiality:

1. The therapist assesses that your child is a danger to themselves or others.

2. Your child reports past or present abuse/neglect/exploitation of any child, elderly person, or a person with a disability (physical or intellectual).

* This may include any abuse you disclose in the parent intake.
* Reports can be made keeping your name anonymous.

3. You or your child acknowledge committing present or past 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. You or your child disclose the use of pornography involving minors.

**Your Child’s Privacy**

Your child may share concerns with the therapist they have not shared with you. **We will always inform you of immediate safety concerns.** Outside of immediate safety, our preferred approach is to begin addressing those concerns in session and help your child **grow towards sharing their concerns with you themselves.** You have the final say regarding what issues are shared immediately with you and which concerns we are allowed time to address in session. Please mark below 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 [ ]  sexual activity [ ]  non-suicidal self-harm

[ ]  bullying (victim or aggressor) [ ] pornography use/exposure

**The Client/Counselor Relationship**

It’s important to remember that although the sessions with the 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 the scheduled sessions only.
	1. Texts or emails are for the purpose of appointment scheduling only.
	2. Texts or calls outside of session are for emergency purposes only.
2. Due to ethical guidelines, please do not to invite your child’s counselor to social gatherings, offer them expensive gifts, or ask the counselor to write references.
3. Please do not attempt to connect with the counselor through **social networking sites, i.e., Facebook, Instagram, LinkedIn, dating apps, etc.**).
4. Your child’s counselor is required to keep the identity of clients confidential. Therefore, the counselor cannot, and will not, acknowledge you or your child outside of counseling sessions unless you first acknowledge them.
5. When the counseling relationship ends, the limitations of contact with the counselor must remain the same. The Texas LPC Code has strict boundaries on these matters.

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>.

**Legal Requests/Court Proceedings**

If I, or my legal counsel, or an adversarial counsel subpoenas my child’s counselor or any counselor from ECA to appear in a deposition or any court proceeding, I agree to pay that counselor $1500.00 per day to appear; in person or online.

* If the counselor is required to travel outside the county of their primary office site, and/or stay overnight an additional full day rate will be charged.
* The counselor will require a subpoena to appear. An email subpoena is acceptable.
* The court appearance fee is due 72 hours in advance of 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.

* This is not a guarantee.
* The counselor’s legal fees, and time spent in court preparation is a billable expense.

If I or my legal counsel request 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.

* All payments must be processed before the documents are presented.
* Please allow two weeks to process requests for documents.

**Texas LPCs may not offer an expert opinion or recommendation relating to the conservatorship of, or possession of, or access to a child according to** Texas Administrative Code (Title 22, Part 30, Chapter 681), and ethics (Subchapter C).

**Client Files & Records Requests**

Copies of the client file may be requested at any time. I agree to pay all reasonable copying/scanning, and/or postage costs.

* All payments must be processed before the documents are presented.
* Please allow at least two weeks for requests to be fulfilled.
* Client files will be kept for a minimum of seven (7) years from the date of termination of

services with the client, or five (5) years after the client reaches the age of majority (18), whichever is greater.

* Each therapist has a plan in place for the security, storage, and disposal of your records. Please feel free to ask them about these procedures.

**Unaccompanied Minors Policy**

These requirements are for the protection of all minors and in agreement with our church partner sites. Please read each policy statement and check to acknowledge your agreement.

[ ] 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.

**Emergency Protocol**

ECA is not equipped to offer urgent-care availability in a mental health emergency. You may call or text your child’s therapist in the event of an emergency but they may not be able to respond to you immediately. Please allow at least 24 hours for them to respond during the week. On weekends your child’s therapist may not respond until Monday.

Our protocol involves working with clients and their parents to cope with difficult stressors, crisis situations, and to maintain safety. Each client’s individual needs will be considered.

Preparation might include:

* Increasing positive coping skills
* Building a support system
* Creating a personalized safety plan

**In the event of a life-threatening mental health emergency please follow this Safety Plan:**

* Call the North Texas Behavioral Mobile Response Team (to schedule an evaluation at your home w/in 24hours) 866-260-8000
* Call 911 (for immediate response)
* Go to the nearest Behavioral Health Hospital (google “Behavioral Health near me”)
* Call the National Suicide & Crisis line (800) 273-TALK
* Text the Suicide text line at 741-741

**NOTICE OF PRIVACY PRACTICES**

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. 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.
* **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 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.

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.

 **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, 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.
* 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:

1. 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***;

2. the information refers ***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

3. 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 the personal representative is reasonably likely to ***cause substantial harm to the individual or another person***.

* The right to inspect or copy your information. To do so, 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 by way of 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 next appointment or by e-mail.
* 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 you’re 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.
* 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 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. There will be no retaliation for your filing a complaint. 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 one is available, you may request a written copy of a revised notice from this office.

For more information about HIPAA or to file a complaint: (202) 619-0257 Toll Free: 1-877-696-6775

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

**TELEHEALTH INFORMED CONSENT\***

*\*Parents of in-person clients may choose to sign this form as a back-up in the event of unforeseen circumstances that may make it difficult to attend a scheduled in-office appointment.*

**Telehealth Counseling Options Offered:** I understand that my counselor may offer counseling via phone and visual telecommunication (online). Online sessions are only offered through a HIPAA compliant platform. There are no HIPAA compliant phone platforms.

**Client Privacy/Client Safety:** There is always a potential, albeit small, risk of compromise to confidentiality by using phone or visual communication

* For privacy purposes, I agree to hold sessions in a secure environment, with minimal distractions, and no one else in the room.
* For safety purposes, I will not try to hold sessions in the car while driving.
* For safety purposes, my counselor will confirm my identity and location at the beginning of each telehealth session.

**Technology Failure:** I understand that in the event of a technology failure during a phone or online session, immediate steps will be taken **by the therapist** to reconnect. Contact via the same method used before disconnection will be tried first, followed by text messaging. If calls or texts fail, email is the next backup step to failed phone and online reconnection. **The therapist** will repeatedly attempt to use these methods to contact me through the remaining session time. If reconnection is unable to be made within 10 minutes, depending on the time contact was lost, the compromised appointment will be terminated and may be billed at the full rate.

**Ethics/Laws:** Elledge Counseling Associates follows the laws and professional regulations in the State of Texas and ECA counselors are only authorized to offer telehealth sessions to clients in Texas.

**Please confirm your choice below.**

[ ] I reside in the State of Texas and I consent to telehealth counseling usinga HIPAA secure online platform only.

[ ]  I reside in the State of Texas and I consent to telehealth counseling usinga HIPAA secure online platform and/or a non-HIPAA secure phone call.

[ ]  I decline all telehealth services. I will only attend sessions in person.

**Good Faith Estimate Disclaimer**

You are entitled to receive a *Good Faith Estimate* of the expected charges for your services at Elledge Counseling Associates. On Dec. 27, 2020, the No Surprises Act (NSA) was signed into law as part of the Consolidated Appropriations Act of 2021. These provisions were intended to address unexpected gaps in insurance coverage that result in “surprise medical bills” when patients unknowingly obtain medical services from physicians and other providers outside their health insurance network.

Elledge Counseling Associates takes payment at the time services are rendered so there will never be “surprise medical bills” from ECA. However, in compliance with the No Surprises Act (NSA), we are providing you with an estimate of possible charges.

*This Good Faith Estimate* shows the costs of items and services that may occur in pursuit of your health care needs. The estimate is based on information known at the time the estimate was created; prior to the first session with your chosen counselor.

*The Good Faith Estimate* does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more, and get a form to start the process, go to [www.cms.gov/nosurprises/consumers or call 1-800-985-3059](http://www.cms.gov/nosurprises/consumers%20or%20call%201-800-985-3059).

**Good Faith Estimate for Mental Health Care Services**

**Therapist Name:** Click or tap here to enter text.

Elledge Counseling Associates National Provider Identifier # 1356881668

Taxpayer Identification # 20-0920005

**Details of Services:**Services Requested/Scheduled – 45-minute counseling sessions

Patient Diagnosis (if known): Click or tap here to enter text.
Date of initial appointment: Click or tap to enter a date.

**Expected Charges:**

Session fee $ Click or tap here to enter text.

**Other possible charges:**

Late Cancellation/No Show fee: (same as session fee) Click or tap here to enter text.

Court/Deposition Appearance - $1,500.00

Completing Legal Documents or Insurance Forms: $session fee/per hour

***Your actual total cost* will depend on the number of sessions you attend**.

*The Good Faith estimated costs are valid for 12 months from the date of the Good Faith Estimate.*

Estimated Total Cost $: Click or tap here to enter text. (Calculate this based on a weekly appt for 12 months).

Date of Good Faith Estimate: Click or tap to enter a date.

The Good Faith Estimate is NOT a contract. It is for your information purposes only.

**Fees & Financial Agreements**

I have agreed to the cost of sessions. Sessions last 45 minutes.

I am aware that payment is due at the beginning of each session.

* Payment may be made by cash, check, credit card or HSA card.
* Checks should be made out to **ECA**.
* If paying by cash, please bring the exact amount. Counselors are unable to make change and any excess 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.

**Cancelation Policies**

* I understand that if I or my child is late to an appointment the counselor will not run over into another client’s appointment and I will be charged the regular session fee.
* If I need to cancel my child’s appointment I agree to call or text the counselor 24 hours before the scheduled appointment to avoid a no-show or late cancellation charge.
* I agree to the one-time charge in the amount of the regular session fee if I fail to cancel an appointment with less than 24 hours’ notice. Elledge Counseling Associates is not required to notify me of this charge.
* I understand that I will not be able to resume sessions until all no-show/late cancellation fees are paid.

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.

**Insurance Forms or Receipts for Tax Documentation**

There is no charge for a standard receipt or documentation of sessions attended. If I request a “Superbill” or HCFA 1500 form which includes a diagnosis, and session dates for out-of-pocket insurance reimbursement I agree to pay my counselor’s regular session fee per hour to prepare, scan, and/or mail the requested materials.

* Payment must be processed before the documents are presented.
* Please allow two weeks for processing.

**Credit Card Information**

A current credit card is required on file to book future appointments. Your card information is kept secure. If you decline to place a card on file, you may pay ahead for several sessions at your first appointment to hold future appointments. Please discuss any questions with your counselor. Reminder – prepaid, unused sessions will not be refunded.

Name as it appears on the card Click or tap here to enter text.

Credit/Debit Card # Click or tap here to enter text.

Expiration Date Click or tap to enter a date.

Security Code Click or tap here to enter text.

Cardholder’s Zip Code Click or tap here to enter text.

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**By signing or typing my signature below, I confirm I am the cardholder or have permission from the cardholder to provide ECA with this information and give consent to charge.**

**By signing or typing my signature below, I confirm I have read, understood, and agreed to all the Practice Policies provided to me in this packet and give consent for my child to begin sessions with an ECA counselor.**

Minor Client’s Name Click or tap here to enter text.

Parent/Guardian Name Click or tap here to enter text.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Click or tap to enter a date.

**Minor Client Background Information**

Section 1 – Family Make Up

*If the child splits time between your household and another home, please only answer the questions below for your household.*

With whom does the child primarily reside? Click or tap here to enter text.

Please list all the family members who live inside the family home. Click or tap here to enter text.

Do any non-biologically related adults live in the home? This may include a step-parent, fiancé/fiancée, boyfriend/girlfriend. Click or tap here to enter text.

If the child is named in a custodial document, please describe the visitation arrangement? Click or tap here to enter text.

Section 2 – Current Concerns

Please list the problem(s) that led you to seek counseling: Click or tap here to enter text.

How long has this issue been a problem? Click or tap here to enter text.

What strategies have been used to address these problems? Click or tap here to enter text.

Please list any major changes in your child’s life over the past five years: Click or tap here to enter text.

Please list three positive traits or strengths of your child: Click or tap here to enter text.

Section 3 - Family Health Information

Please list any mental health or substance abuse issues (past or present) experienced by any of the child’s family members: Click or tap here to enter text.

Has your child had any previous counseling? [ ] yes [ ] no

If yes, when, where, and why? Click or tap here to enter text.

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

If yes, when, where, and why? Click or tap here to enter text.

Section 4 - Spiritual or Cultural Information

It is our desire to understand your child and 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 feel free to address with the counselor during the intake session. Click or tap here to enter text.

**PARENT / GUARDIAN PARTICIPATION**

Parents, grandparents, and other family are the most important people in a child’s life. We as counselors are here to support you and your child in a therapeutic role. Having realistic expectations about our roles will help alleviate disappointment and set you and your child up for success.

Our role:

1. Provide a supportive place for your child to process difficult emotions, thoughts, and experiences.
2. Teach coping tools and tips as appropriate.
3. Facilitate healthy family communication as appropriate.
4. Offer education and tips to parents to encourage the improvement you and/or your child desire.

Your role:

1. Regular and punctual attendance at appointments (weekly is best whenever possible).
2. Participation and follow-through with any homework that your child’s counselor offers 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. Attendance at scheduled parent meetings to discuss progress, setbacks, and treatment goals.

[ ]  I understand that participation in my child’s therapy process is vital to the best outcome.

[ ]  I am willing to follow the participation guidelines outlined above.

*Thank you for your time and efforts with our paperwork; we know it can feel like a lot.*

*We look forward to meeting you at the parent intake.*