Child/Adolescent Intake Form for Charlottesville Counseling Services

1111 Rose Hill Drive Suite 1, Charlottesville Virginia 22903

Please note: the information you provide here is protected, confidential information

Name: _____DOB:_____

Address:_____City:_____St:_____Zip:_____

Home ph: _____*Ok to leave message*? □Yes □No Child/teen's mobile:_____

Mother/Guardian:_____Phone:_____ *Ok to leave message*? □Yes □No

Email:_____*Ok to email*? □Yes □No **Note email is not considered to be confidential*

Father/Guardian:_____Phone:_____ *Ok to leave message*? □Yes □No

Email:_____*Ok to email*? □Yes □No **Note email is not considered to be confidential*

Are parents married? □Yes □No If not, what is the legal custody arrangement?_____

How did you find me? _____

Do you want me to submit insurance claims? □ No □ Yes If yes, complete the following and sign below:

Insurance policy holder: Name_____DOB_____

Address:_____City:_____St:_____Zip:_____

Relationship to child:_____Policy holder's employer:_____

Employer address:_____

Insurance:_____Ins phone:_____Copay:_____Deductible:_____

Insurance policy #:_____Group #:_____

I authorize the release of confidential protected health information to my child's insurance company for the purpose of submitting claims. I authorize insurance payments to be made directly to my provider. Clients of Wendy Summer authorize Clinical Billing Services to process their child's claims and billing.

SIGNATURE OF PARENT/GUARDIAN_____DATE:_____

For All Clients: Person responsible for payments:_____

If different from parent(s), relationship to child:_____phone:_____

Billing Address:_____

I acknowledge responsibility for payment of all fees regardless of insurance that this child may have to assist in this responsibility. If for any reason the account should become delinquent, I am responsible to pay for all collection, legal and late fees on behalf of this child.

SIGNATURE OF RESPONSIBLE PARTY:_____DATE:_____

Please list the reasons you are seeking counseling for your child:_____

_____

Is your child taking any psychiatric medication? □ No □ Yes If yes, please list (include dosage): _____

_____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services)?

□ No □ Yes, previous type of service and practitioner:_____

Has your child ever been hospitalized for psychiatric reasons? □ No □ Yes If yes, please describe: _____

_____

Has your child ever been given a mental health diagnosis? □ No □ Yes If yes, please list:_____

_____

Rate your child's physical health □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any health problems your child is experiencing:_____

Rate your child's sleeping habits: □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any sleep problems your child is experiencing:_____

Please list any difficulties with eating patterns_____

_____

Is your child currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

Has your child had or is your child having any self-harming thoughts/behaviors? □ No □ Yes, please describe:

_____

Has your child ever attempted suicide? □ No □ Yes If yes, please describe and give age(s): _____

_____

Is your child currently experiencing anxiety, panic attacks or phobias? □ No □ Yes If yes, please describe:____

_____

For adolescents, have there been any issues with smoking, drinking or drug use? □ No □ Yes, please describe:

_____

Do you consider your child or family to be spiritual or religious? □ No □ Yes If yes, please describe:_____

_____

Has your child ever had a psychological/educational assessment? □ No □ Yes If yes, please list age of child at time and reason for assessment:_____

Note: please consider providing us with a copy of your child's assessment to help in our work with your child.

In the section below identify if there is a family history of any of the following:

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Bipolar Disorder	yes/no	_____
Suicide Attempts	yes/no	_____

Charlottesville Counseling Services: Informed Consent

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- *Duty to Warn and Protect* When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
- *Abuse/Neglect of Children and Vulnerable Adults* If the counselor becomes aware during the course of treatment of any abuse/neglect or danger of abuse/neglect to a child (or vulnerable adult), then the counselor is required to report this information to the appropriate social service and/or legal authorities.
- *Minors/Guardianship* Parents/legal guardians of non-emancipated minors have the right to access records.
- *Insurance Providers* (when applicable)Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Signature of parent/guardian:_____Print:_____Date:_____

Cancellation Policy

If you need to cancel an appointment, you must give 48-business-hours (two business days) notice in order to avoid a missed appointment fee. A fee ($75) is charged for appointments that are cancelled with less than two business days' notice**.** *Please sign to indicate that you understand and agree to this policy:*

Signature of parent/guardian:_____Print:_____Date:_____

General Communications and Emergency Plan

In general, you may contact me by (1) phone, leaving a voicemail is confidential; sending a text message is not. Please do not send protected health information via text message. (2) Secure email. I subscribe to secure email service that requires you to log in to receive my email. The confidentiality of emails sent outside of this service cannot be guaranteed and should not be used for communication of protected health information.

If you or your child is ever experiencing an emergency, including a mental health crisis, please call 911 or contact Region Ten Emergency Services at (434) 972-1800. You may also contact me by phone, however do not wait to hear back from me during a mental health emergency; instead call 911 or Region Ten.

Signature of parent/guardian:_____Print:_____Date:_____

Consent to Treat

Please sign below to indicate that you have read ALL the above policies and that you understand and agree to comply with them. Your signature indicates that you have had a chance to ask your counselor any questions you might have about these policies and that your questions have been satisfactorily answered. You agree that you are personally responsible for all financial obligations incurred. You also consent to receive treatment by a Charlottesville Counseling Services counselor.

Signature of parent/guardian:_____Print:_____Date:_____