Child Intake

Patient name: ______________________________ Age: _____ Date of Birth: ____/____/______

Home address: ______________________________ Home Phone: ____________________

Parent(s) Email: ____________________ Contact Preference: Phone Email Text

Name of person completing form: ____

Relationship to Child: ______________________________ Today's Date: ____/____/______

School: ____ Grade: ___________

Race: ________________________ Ethnicity: ________________________ Birth Gender: M F

Parent: ____ Mother / Father / Guardian
(last name) (first name)

Parent: ____ Mother / Father / Guardian
(last name) (first name)

Parent relationship: ___ partners ___ married ___ separated ___ divorced ___ widowed

If separated or divorced, provide date of separation: ______________________

If widowed, date of death: ______________________

Sibling(s) (name/age): ____

Who suggested that you seek assessment and/or counseling for your child?

___ School teacher ___ School counselor ___ Myself as a caregiver ___ Other: ___________________

Describe the overall problem that led you to seek help for your child:

____

____

____

My child has difficulty with a relationship in our family (parent, sibling, parent's partner): Yes No

If yes, who: ______________________________

I have reason to suspect my child has been abused (emotionally, sexually, and/or physically): Yes No

If yes, please explain:____

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Describe your child's school experience:

____

____

Describe your child's interactions with his/her parents or guardians:

____

____

Describe your child's interactions with siblings:

____

____

Describe your child's ability to complete tasks and follow directions:

____

____

I would describe my child as: Independent Dependent

Explain: ____

____

My child appears to have high levels of stress: Yes No

If yes, explain: ____

____

Describe your child's sleep patterns:

____

____

Describe your child's eating patterns:

____

____

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Describe your child's physical activity level:

____

____

Medical History

Birth: Duration of labor: ________________

Type of delivery: ________________________________

Difficulties: ____________________________________

How soon did the mother see baby? ________________________

Birth weight: ______________

Infancy: Age of weaning: __________________________

Feeding problems? _____________________________________

Approximate age of walking: ________

Approximate age of talking: ________

Sleep problems? Yes No

If yes, please explain: ____

Any behavior such as head banging, rocking, etc.? Yes No

If yes, please explain: ____

Does your child have difficulty separating from his/her parents? Yes No

If yes, please explain: ____

Has your child had any severe, long-term illnesses or accidents? Yes No

If yes, please explain: ____

Is your child on any medication? Yes No

If yes, please explain: ____

Does your child have any digestive problems? Yes No

If yes, please explain: ____

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Does your child have any allergies? Yes No

If yes, please explain: ______________________________

Does your child have any physical pain? Yes No

If yes, please explain: ______________________________

Does your child ever appear disoriented or dizzy? Yes No

If yes, please explain: ______________________________

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate family member/relation affected.

Autism	Yes	No	______________
Attention Deficit	Yes	No	______________
Depression	Yes	No	______________
Anxiety Disorder	Yes	No	______________
Bipolar Disorder	Yes	No	______________
Panic Attacks	Yes	No	______________
Alcohol/Substance Abuse	Yes	No	______________
Eating Disorder	Yes	No	______________
Learning Disability	Yes	No	______________
Trauma History	Yes	No	______________
Domestic Violence	Yes	No	______________
Obesity	Yes	No	______________
Obsessive Compulsive Behavior	Yes	No	______________
Schizophrenia	Yes	No	______________
Other			______________

Any other information you would like to share?

____

____

____

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New Patient Information

NAME: ______________________________ **Date:**______________
Last First M.I.

Home Address: ______________________________
City State Zip

Home Phone (   )______________ Cell (   )______________

Birthdate:______________ Occupation: ______________

Employer/School:______________ Work Phone: (   ) ______________

Soc. Sec. #: ______________ **Marital Status**: Married Domestic Partner Sep Div Widow Single

Emergency Contact:______________ Relationship to client______________

Phone #: (   )______________ OR (   )______________
Permission to contact above person in emergency? Please Initial Yes or No: Yes______ No______

Primary Care Physician______________ Referral source______________

PRIMARY INSURANCE INFORMATION **SELF PARENT SPOUSE GUARDIAN**

Name______________ Insured's Employer______________
Last First M.I.

Home Address: ______________
(if different) City State Zip

Work phone of insured (   )______________ Insurance Co. ______________

Home Phone (   )______________ Plan Name ______________
(if different)

Birthdate of insured______________ Insured's ID #______________

Soc. Sec. # of insured______________ Policy Group #______________

RESPONSIBLE PARTY/SECONDARY INSURANCE **SELF PARENT SPOUSE GUARDIAN**

Name______________ Insured's Employer______________
Last First M.I.

Home Address: ______________
(if different) City State Zip

Work phone of insured (   )______________ Insurance Co. ______________

Home Phone (   )______________ Plan Name ______________
(if different)

Birthdate of insured______________ Insured's ID #______________

Soc. Sec. # of insured______________ Policy Group #______________

Consent for treatment: I hereby voluntarily consent to services for______**SELF** ____**MINOR CHILD** which may include assessment, treatment, and/or referral recommendations deemed necessary and advisable in the judgment of my therapist.

Signature of authorized person______________________________ **Date**__________

Signature of Second Parent (if shared custody situation)______________________ **Date**__________

CLIENT RIGHTS

As a client, when you enter a therapist-client professional relationship, you have certain rights. I, __________________ (therapist name), will do my best to honor your rights and give you the best treatment possible.

You, as a client, have the following rights:

- To be an active participant in decisions regarding your treatment and the scope of treatment.
- To be informed of where to access emergency attention if the practice does not offer these services.
- To be informed of the practice's policy for financial responsibility.
- To have the opportunity to express grievances and concerns regarding treatment.
- To receive truthful care from your therapist.
- To be assured that your therapist is practicing within his/her scope of experience, license, and education.
- To receive services, including evaluations and treatments, within a reasonable time frame.
- To be treated and receive services in the absence of bias regarding age, race, religion, gender, national origin, or sexual preference.
- To be treated courteously by all professionals within the practice.
- To know that all professionals involved in your case maintain confidentiality.
- To have all professionals adhere to the ethical standards of the professional organizations to which they are licensed and affiliated.
- To be able to terminate treatment or request a change of service provider.

I, ____, understand my rights described above.
Client Printed Name

____
Client Signature

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the client's medical decisions relative to the treatment situation.

I, ______________________________________ (*client*), hereby acknowledge that

__Avenues for Change has either offered me or provided me with a copy of the **Notice of Privacy Practices** that describes how information about me may be used and disclosed, and how I can access this information. I understand if I have questions or complaints, I may contact:

__Kelley Johnson

I also understand that I am entitled to receive updates upon request if __Avenues for Change___ amends or changes the **Notice of Privacy Practices** in a material way.

______________________________________ ______________

Client Signature Date

____

Relationship to Client (*if signed by someone other than client*)

____

Printed Name

IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL, ACTION TAKEN TO OBTAIN LEGAL SIGNATURE:

- ☐ Given to above signee
- ☐ Sent via U.S. Mail
- ☐ Advised person that policy is available on our website at: ______________________

In either situation the parent/legal guardian must sign and return this form either in person or by mail to:

____

____

Attn: HIPAA

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THIS SECTION IS TO BE COMPLETED BY MENTAL HEALTH PROVIDER

I made a good faith effort to obtain a written acknowledgement of receipt of the **Notice of Privacy Practices** from the above-named client, but was unable to because:

- ☐ Client declined to sign this Written Acknowledgement.
- ☐ Other (specify): ____

____ ________________
Therapist Signature Date

____
Printed Name and Title

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Informed Consent Form for Outpatient Services

This contract is not a substitute for the HIPAA Notice of Privacy Practices or other required HIPAA documentation. Additionally, since regulations and laws governing institutions are somewhat different from private practitioners, this form may need modification.

Welcome to our practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

There are different methods I may use to deal with the problems you wish to address. In order for the therapy to be most successful, you will be expected to work on things discussed during our sessions while you are at home, including homework assignments. Because therapy often involves discussing unpleasant aspects of your life, you may experience feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy often leads to improved relationships, problem-solving, and significant reduction in distress.

Our first few sessions will involve an evaluation of your needs. I will be able to offer you some suggestions of what our work will include and a treatment plan, if you decide to continue with therapy. You should consider this information, along with your comfort level of working with me. If either of us feels that I am not the right therapist for you, I will provide referrals to other practitioners better suited to help you.

Therapy involves a commitment of time, money, and energy, so it is important to find the right fit. If you have questions about my therapeutic style, I encourage you to discuss them whenever they arise.

MEETINGS

I normally conduct an evaluation in person; however, telehealth is available as well, that will last from _1_ to _2_ sessions. During this time, we can decide together if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I usually schedule one [45/50-minute] session per week, at a time we will agree on together, although some sessions may be more frequent.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. An exception is if we both agree that you were unable to attend due to circumstances beyond your control, in which case I will find another time to reschedule the appointment.

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PROFESSIONAL FEES

My hourly fee is $170 - $110 depending on my licensure. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. (Other professional services may include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me).

If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $200 per hour for professional services that I am asked or required to perform related to your legal matter. I also charge a copying fee of $.50 per page for records requests or $30 whichever is less.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a client's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will complete forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

If you have questions about your insurance coverage for mental health services, call your plan administrator. Of course, I will be happy to help you understand the information you receive from your insurance company and, if necessary, I can contact the insurance company on your behalf to obtain clarification.

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Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services.

These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Please note, some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

Once we have all of the information about your insurance coverage, we can discuss what we can expect to accomplish with the benefits that are available, and what will happen if your benefits run out before you feel ready to end our sessions.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I will not answer the phone when I am with a client. I do not have call-in hours. When I am unavailable, my telephone is answered by my answering service or secretary who knows where to reach me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays.

If you are difficult to reach because of your schedule, please inform me of times you will be available. **If you are unable to reach me and feel that it is an emergency, call 9-1-1 or go to the nearest emergency room.** If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence, if necessary.

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CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. A judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice that I am unable to provide, formal legal advice may be needed. The laws governing confidentiality are quite complex, and I am not an attorney. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature: ______________________________ Date: ________________

Client Printed Name: ______________________________

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Avenues For Change,
809 S Patton, PO Box 1223, Great Bend, KS 67530
620-796-2206

Authorization for Recurring Credit Card Charges

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. You will be charged the day of your therapy appointment unless other arrangements have been made. The charge will be made under the name Avenues For Change or rendering clinician. You agree that no prior notification is necessary unless the amount billed each time exceeds $170, in which case you will receive notification in advance.

Name of Client____

Account Type: ☐Visa ☐MasterCard ☐American Express,(AmEx) ☐Discover

Cardholder Name ____

Account Number ____________________________________

Expiration Date __________

CVV (3-digit number on back of Visa, MasterCard, or Discover; 4 digits on front of AmEx) _______

I authorize Avenues for Change, LLC to charge this credit card for professional services and associated charges as agreed below. These charges may include:

Co-pay and/or co-insurance for session: $_________

Self-pay for session or payment for session not covered due to deductible: $________

Charge for cancellation without 24 hours' notice: $__30_______

Other charges [specify]: ___________________________ $________

___________________________ $________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

Signature of Authorized Credit Card User:

___________________________________Date:______

HIPAA Compliance Privacy Notice

Your Information, Your Rights, Our Responsibilities

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.*

Name of Therapist/Practice: ____Avenues for Change________________________

Address: __809 S Patton, PO Box 1223, Great Bend, KS 67530__

Phone: __620.796.2206__ Email: __info@a4change.org_

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we have shared your information.
- Get a copy of this Privacy Notice.
- Choose someone to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way we use and share information, as we:

- Tell family and friends about your condition.
- Share information in a disaster relief situation.
- Share information for marketing, sales, or fundraising purposes.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety issues.
- Perform research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.

This information is discussed in further detail on the following pages.

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YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.
- You can ask to see or receive an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your medical record.
- You can ask us to correct your health information that you think is incorrect or incomplete. Ask us how to do this.
- We may deny your request, but we will tell you why in writing within 60 days.

Request confidential communications.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will agree to all reasonable requests.

Limit what we use or share.
- You can ask us not to use or share certain parts of your health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may deny it if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to your request, unless a law requires us to share that information.

Receive a list of those with whom we have shared information.
- You can ask for a list ("accounting") of the times we have shared your health information for six years prior to the date you ask, with whom we shared this information, and why.
- We will include all the disclosures except those about treatment, payment, and health care operations, and certain other disclosures (such as any you requested us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you request another within 12 months.

Get a copy of this privacy notice.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act on your behalf.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act on your behalf before we take any action.

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File a complaint if you feel your rights are violated.
• You can complain if you feel we have violated your rights by contacting us.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ .
• We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in your care.
• Share information in a disaster relief situation.

If you are not able to tell us your preference – for example, if you are unconscious – we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases, we never share your information unless you give us written permission:
• Marketing purposes.
• Sale of your information.
• Most sharing of psychotherapy notes.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

To treat you.
• We can use and share your health information with other professionals who are treating you.
To run our organization.
• We can use and share your health information to run our practice or improve your care, and contact you when necessary.
To bill for services.
• We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We have to meet many legal conditions before we can share your information for these purposes. For more information, visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html .

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To help with public health and safety issues.

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

To perform research.

- We can use or share your information for health research.

To comply with the law.

- We will share information about you if state or federal laws require it, including the Department of Health and Human Services, if it needs to confirm that we are complying with federal privacy law.

To respond to organ and tissue donation requests.

- We can share health information about you with organ procurement organizations.

To work with a medical examiner or funeral director.

- We can share health information with a coroner, medical examiner, or funeral director when a person dies.

To address workers' compensation, law enforcement, and other government requests.

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions, such as military, national security, and presidential protective services.

To respond to lawsuits and legal actions.

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Name of Person Responsible for HIPAA Notification: Kelley Johnson

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices detailed in this notice and give you a copy of it.
- We will not use or share your information other than as described here, unless you give us written permission. If you give us permission, you may change your mind at any time. Let us know in writing if you change your mind. For more information, visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html .

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CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective date: _1/1/2021

Privacy Officer information: ___Kelley Johnson, above address and phone

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