PROFESSIONAL COUNSELING ASSOCIATES, INC.

# CHILD INTAKE FORM

## GENERAL INFORMATION

**Please provide the following information and answer the questions. Information you provide here is protected as confidential information.**

Child's Name:_____ Today's Date:_____

Child's age:_____ Date of Birth (DOB):_____

Address:_____

_____

Parent's Name: _____ Parent's Name: _____

Home phone:_____ May I leave a message? Yes No

Cell phone:_____ May I leave a message? Yes No

Work phone:_____ May I leave a message? Yes No

Email: _____ May I email you? Yes No

(For appointment scheduling purposes only, as email not considered a confidential medium of communication).

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

_____

_____

_____

## HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? _____

_____

_____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

_____

_____

_____

Please list your child's current prescription medications with dosage (psychiatric and general health):

_____

_____

_____

## Your Child's Symptoms or Problems

How much are <u>each</u> of the following areas currently a problem for your child?

| | Not at all 1 | A little 2 | Somewhat 3 | Considerably 4 | Terribly 5 |
|---|---|---|---|---|---|
| Anxiety | 1 | 2 | 3 | 4 | 5 |
| Physical Problems | 1 | 2 | 3 | 4 | 5 |
| Sleep Problems | 1 | 2 | 3 | 4 | 5 |
| Depression | 1 | 2 | 3 | 4 | 5 |
| Alcohol or Substance Abuse | 1 | 2 | 3 | 4 | 5 |
| Parent-Child Conflicts | 1 | 2 | 3 | 4 | 5 |
| Sibling Conflicts | 1 | 2 | 3 | 4 | 5 |
| Social Relationships | 1 | 2 | 3 | 4 | 5 |
| School Problems | 1 | 2 | 3 | 4 | 5 |
| Sexual Problems | 1 | 2 | 3 | 4 | 5 |
| Spiritual/religious | 1 | 2 | 3 | 4 | 5 |
| Legal problems | 1 | 2 | 3 | 4 | 5 |
| Eating Disorder | 1 | 2 | 3 | 4 | 5 |
| Abuse (physical, emotional, sexual) | 1 | 2 | 3 | 4 | 5 |

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No
(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:_____

_____

_____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

_____

_____

_____

_____

Who is your child's primary care physician? _____

Who is your child's psychiatrist (if applicable)? _____

Any concerns about child's sleep? _____

Any concerns about child's eating habits? _____

_____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

## FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

| | Please circle | List Family Member(s) |
|---|---|---|
| Anxiety (general) | Yes No | |
| Obsessive Compulsive Behavior | Yes No | |
| Depression | Yes No | |
| Suicide Attempts | Yes No | |
| Bipolar/Manic Depressive | Yes No | |
| Alcoholism | Yes No | |
| Substance Abuse | Yes No | |
| Domestic Violence | Yes No | |
| Eating Disorders | Yes No | |
| Obesity | Yes No | |
| Schizophrenia | Yes No | |
| Counseling or Psychotherapy | Yes No | |
| Psychiatric Hospitalizations | Yes No | |

## YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

**School/Academics**

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____ Public or Private (circle one)?

Street Address: _____

School District/County? _____ Phone: ___(___)_____

Is your child in a regular classroom? Yes No Does your child have an IEP or 504 plan ? Yes No

_____

# PROFESSIONAL COUNSELING ASSOCIATES, INC.
# REGISTRATION FORM

| | | | | | |
|---|---|---|---|---|---|
| Today's Date: | | | PCP: | | |
| **PATIENT INFORMATION** | | | | | |
| Patient's last name: | First: | Middle: | Marital Status: | | |
| | | | Birth date: | Age: | Sex: ○ M ○ F |
| Address: | | | | | |
| Social Security no.: | Home phone no.: | | Cell phone no.: | | |
| Occupation: | Employer: | | Employer phone no.: | | |
| EMAIL ADDRESS:_____ | | | | | |
| Other family members seen here: [Other patients] | | | | | |
| **INSURANCE INFORMATION** (Please give your insurance card to the receptionist.) | | | | | |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: | | |
| Is this person a patient here? | ○ Yes ○ No | Is this patient covered by insurance? | ○ Yes ○ No | | |
| Occupation: | Employer: | Employer address: | Employer phone no.: | | |
| Please indicate primary insurance: | | | | | |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: |
| Patient's relationship to subscriber: | | | | | |
| Name of secondary insurance (if applicable): | | Subscriber's name: | Group no.: | Policy no.: | |
| Patient's relationship to subscriber: | | | | | |
| **IN CASE OF EMERGENCY** | | | | | |
| Name of Emergency Contact | | Relationship to patient: | Home phone no.: | Work phone no.: | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **PROFESSIONAL COUNSELING ASSOCIATES, INC.** or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

**ORDINATION OF TREAMENT:** *It is important that all health care providers work together. As such, we ould like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent, no information will be shared.*

**____You may inform my physician(s)  _ I decline to inform my physician**

**PHYSICIAN NAME:**_____

**CLINIC:** _____
**ADDRESS:** _____
**PHONE:** _____

***Signature(s)***_____ ***Date***_____

**CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:**

*I/We consent that* _____*maybe treated as a client by Professional Counseling Associates. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.*

***Signature(s)***_____ ***Date*** _____

***NOTES:***_____
_____
_____
_____
_____
_____
_____
_____
_____

# INFORMED CONSENT

Thank you for choosing Professional Counseling Associates, Inc. (PCA), 5840 Post Road, East Greenwich, RI. Today's appointment will take approximately 50-70 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS:** *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Rhode Island State Law, we are obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs us that you are in danger of harming yourself or others, e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary and we are unable to return a call within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. We, Professional Counseling Associates, Inc. will follow those emergency services with standard counseling and support to the client or the client's family.*

***Signature(s)**_____ **Date:**_____

**FINANCIAL/INSURANCE ISSUES:** *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, We request that you pay the balance due at that time. If your balance exceeds $300.00, we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to a collection agency, the client or responsible party will be held responsible for any collection fee charged to my office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Professional Counseling Associates.*

***I have received a copy of my fee schedule** **(Initial)**

- ***CANCELLATION POLICY**: Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.*

***Signature(s)**_____ **Date**_____

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** *I/We have read and received a copy of the Notice of Privacy Practices and Client Rights document.*

***Signature(s)**_____ **Date** _____

# CLIENT RIGHTS

**Right to request how I contact you**
It is our normal practice to communicate with you at your home address and daytime phone number you gave when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. May we contact you at home? (circle one) yes no? May I contact you at work?: yes no. May I contact you by cell phone? yes no Where may I contact you_____?

**Right to release your medical records**
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

**Right to inspect and copy your medical and billing records**
You have the right to inspect and obtain a copy of your information contained in my medical records. To request access to your billing or health information, contact me. Under limited circumstance I may deny your request to inspect and copy. If you ask for a copy of any information, I may charge a reasonable fee for the costs of copying, mailing and supplies.

**Right to add information or amend your medical records.**
If you feel that information contained in your medical record is incorrect or incomplete, you may ask me to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and my response will be added to your record. To request an amendment, you must contact us. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

**Right to an accounting of disclosures**
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release.

**Right to request restrictions on uses and disclosures of your health information**
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office. However, we are not required to agree to such a request.

**Right to complain**
If you believe your privacy rights have been violated, please contact us and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

**Right to receive changes in policy**
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from our office.