Child Trauma Counseling Services, LLC

Child and Adolescent Intake Form

(effective July 13, 2020)

This information is considered confidential and will not be released without written permission of parent/s and/or guardian. Please complete the form and provide details where possible.

PART I: Identifying Information

Child's Name: ____ D.O.B.: _____________________

Address: ____________________________________City: ______________State: __________Zip:___

Gender: _______________ Grade: ____ School: ____

Special Ed: **Yes or No** If yes, is there a current IEP**: Yes or No** If yes, what is the IEP for:

____

When is IEP scheduled to be updated? ____

What grades does this child usually earn? ____

Mother's Name: ________________________Phone: H: ____________C: _______________________

Father's Name: _________________________Phone: H: ____________C: _______________________

Best email address: ____

Parents' marital status: **Married Divorced Separated Never Married Living Together**

Who is the major caretaker of this child? ____

If divorced, who has custody of this child? ____

Emergency Contact other than yourself: ______________________________Phone:________________

Private Insurance: ____________________________Group #: ___________ Policy#:________________

Responsible party's name: ____

Responsible party's date of birth: __________ Social Security Number: ____________________________

Relationship to child: ___________________ Employer: ____

Name of person completing form: ___________________________ Relationship to child: ______________

PART II: Reason for Referral

What is the main concern you have and why are you here today? ________________________________

____

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Does this issue/s present problems at home? _____ School: ______ Other: ________________________________

What makes things better? ____

What makes things worse? ____

Has this child been evaluated for the current problem/s before? **Yes or No** If yes, when and by whom:

____

Has the child seen a therapist or psychologist previously for any reason? **Yes or No** If yes, why and by whom:

____

May I contact that person for additional information? Circle: **Yes or No** If yes, list contact info:

____

____

Please sign here to give authorization to contact the person listed above who previously provided treatment to this child:

____

Therapist initials ROI given:_____

PART III: Social and Behavioral Questions:

Place a check to any behavior or problem that your child currently exhibits:

_____Difficulty with speech (articulation or producing sounds)
_____Difficulty with hearing
_____Difficulty with language
_____Poor bowel/bladder control
_____Difficulty with coordination
_____More clumsy than others
_____Sensitive to noises
_____Sensitive to touch
_____Picky eater
_____Wets bed
_____Is too active
_____Easily distracted/short attention span
_____Fearful: of what: ____________________________________
_____Frequent tantrums
_____Oppositional/defiant
_____Nightmares
_____Trouble sleeping: Can't fall asleep: ____________ Can't stay asleep :____________________
_____Loss of appetite
_____Memory problems
_____Attachment problems: Over attach: _____________ Under attach: _____________________
_____Boundary issues
_____Aggressive: With whom: ____
_____Angry
_____Impulsive
_____Anxious

______Decreased enjoyment in previously enjoyed activities
______Does not get along with peers
______Over exaggerated startle response
______Moody
______Sad
______Inappropriate sexual talk
______Sexual acting out
______Other:____

Please use this space to describe any behaviors or problems in detail:
____

____

Does this child have friends at school? **Yes or No**

Does this child keep friends for long periods of time? **Yes or No** Goes thru friends quickly? **Yes or No**

How does this child get along with others at school? ____

____

PART IV: **Family Information**
Please list those persons who are important in your child's life: ____________________________________

____

____

Who lives with this child? ____

____

What does your family do for fun? ____

____

How would you describe this child within your family unit… i.e. the smart one, the happy one, the troublemaker, the black sheep, the gifted one, the talented one, or something else?
____

____

How do you discipline the children in your family? What works best for this child?

____

How does this child get along with other family members?

____

Does his/her behavior cause difficulty within the family? **Yes or No** If yes, explain________________________

____

What are this child's strengths? What is he/she good at? ____

____

What are this child's best qualities? ____

If the child is adopted please fill out following information: If not, skip to Part V

Is the child adopted? **Yes or No**

How long has this child lived in your home? ____

When was this child initially placed outside the birth home? ___________

How many placements has this child had? ______________

Why was this child removed from his/her birth family? ____

____

What were you told about this child's history?

____

____

Do you think your concerns for this child are related to his/her adoption? **Yes or No**

PART V: Prenatal, Birth and Developmental History

During pregnancy, did the child's mother use any of the following?

____Tobacco ____Alcohol ____Medications ____ Street drugs

Weight at Birth: ______________________

Any problems during birth? **Yes or No** If yes, explain: ____

Full Term: **Yes or No**

If not, how many weeks' gestation? __________________

Did your child meet developmental milestones on time? Such as rolling over, sitting, crawling: **Yes or No**

PART VI: Medical History

Have there been any health problems? **Yes or No** If yes, explain:

____

____

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Has he/she ever been hospitalized? **Yes or No** If yes, explain:

____

Has he/she ever had surgery? **Yes or No** If yes, explain:

____

Does he/she have allergies? **Yes or No** If yes, please list:

____

Medications: Please list any medications this child currently takes?

Name ____

Frequency ____

Dosage ____

Physician name: _______________________________ Telephone number: ___________________________

May I contact the prescribing physician to coordinate care if necessary? **Yes or No** If yes, list contact info:

____

If yes, please sign giving authorization to contact physician for coordination of care:

____

Therapist initials ROI given:_________

PART VII: Employment History

Has this child ever been employed? **Yes or No** If yes, explain: _____________________________________

____

PART VIII: Legal History

Has this child ever had difficulty with the police? **Yes or No** If yes, explain: _________________________

____

Is there an open court case for this child in criminal court or family court? **Yes or No** If yes, explain:

____

____

Has this child participated in court ordered treatment in the past? **Yes or No** If yes, explain**:**

____

____

Has this child ever been on probation? **Yes or No** If yes, give dates, reason, and name of probation officer:

____

To your knowledge has the child ever used drugs or alcohol? **Yes or No** If yes, explain:

____

____

PART IX: Other Information

Please discuss anything else that is important to know about this child:

____

____

____

Does this child have a history of trauma, physical abuse, sexual abuse, neglect, victim of crime, witness to violence, death in the family or family disruption? **Yes or No** If yes, please explain:

____

____

Does this child want to come to therapy? **Yes or No**

How will you know if therapy has been successful? ____

____

I completed the intake information myself, and I have reported as accurately as possible.

____

Signature Date

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Child Trauma Counseling Services, LLC
Informed CONSENT for ASSESSMENT & TREATMENT & POLICIES
(effective July 13, 2020)

I, ____ *authorize therapeutic services for*
(parent/guardian)

____.
(Child's full name)

The therapy relationship is a very personal one. This document has been developed to ensure there are no misunderstandings about the various aspects of counseling services provided by Child Trauma Counseling Services, LLC. It is important that you read this document and discuss any questions with your therapist, Samantha White, LPC, RPT. When you sign this document, it represents an agreement between you and Child Trauma Counseling Services, LLC, with whom Samantha White, LPC, RPT provides counseling services. You may revoke this agreement at any time. By discussing private and often sensitive issues with a trusted professional in a confidential setting, people are often able to free themselves from difficulties that have inhibited their abilities for joy, happiness and success. The freedom to be open and honest about such difficulties is essential for therapeutic progress. However, talking about sensitive issues can be difficult and cause distress. It is imperative that you communicate any distress you may notice or become aware of related to your child to Samantha White, LPC, RPT. There are risks and benefits to mental health treatment. You are free to review your treatment plan at any time, and if you disagree with any aspect of it, you are free to discuss this with Samantha White, LPC, RPT who will try to offer an acceptable alternative treatment plan. Should you refuse the recommended treatment, Samantha White, LPC, RPT may elect to withdraw her services.

Treatment Plan:
A treatment plan will be made to help guide the therapeutic process. This plan will be reviewed periodically to ensure treatment is progressing. You make have a copy of the treatment plan or ask to review treatment goals at any time.

Appointments: You can schedule appointments by calling Samantha White, LPC, RPT cell phone at *623-521-9043*. Appointments will ordinarily be 50 minutes in duration, once per week at a time mutually agreed on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, Samantha White, LPC, RPT asks that you provide 24 hours' notice. If you need to change or cancel an appointment, please call Samantha White, LPC, RPT cell phone at *623-521-9043*. If you miss a session without canceling, or cancel with less than 24 hours' notice, you may be required to pay for the session at the rate itemized below [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the cancellation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. **Your child's appointment day and time are shared on a building wide calendar that others located within the building can see. Others within the building include law enforcement, medical staff, administrative staff, therapists and Department of Child Services personnel. Individuals from these organizations are able to see your child's name and the date/time of your child's "other therapy" appointment. If that is okay with you please initial.** __________________ ***(please initial)***

Fees: Payment is expected at the time of service unless other arrangements have been made. By signing this document, you agree to pay for the services rendered through the methods listed below.

- Accepted forms of payment: Cash, debit, Mastercard, Visa, Discover and American Express.
- Blue Cross Blue Shield of AZ will be billed; you are responsible for co-payment/deductible at time of service.
- Cigna will be billed; you are responsible for co-payment/deductible at time of service.
- Aetna will be billed; you are responsible for co-payment/deductible at time of service.
- There is a $100 charge for copies requested from the file.
- Deductibles are paid down in increments of Samantha White, LPC, RPT contracted rates with each plan.
- Private Pay: See fee schedule below.
- **No-show / Late cancel:** $65.00 for no-shows and cancellations with less than 24 hours' notice. See fee schedule for signed document regarding payment for no-shows and late cancelations.

Insurance Matters: Check the mental health benefits of your insurance plan**.** While Samantha White, LPC, RPT provides assistance, ***it is the family's responsibility to verify eligibility, coverage, deductibles & co-payments.***

- **Authorization**: Some plans require policyholder to obtain an authorization number**.** If authorization was required but not obtained by the first visit then the policyholder is responsible for session fee(s).
- **Coverage**: If insurance coverage details are unclear at intake, full private pay will be charged. Any overpayment will be reimbursed to the family as soon as coverage is clarified.
- **Denials:** Policyholder is responsible for any fees the insurance company declines to reimburse.
- **Primary Insurance**: Samantha White, LPC, RPT will bill the primary insurance company only. If the policyholder wishes to bill a secondary insurance a superbill is available upon request.

Custody/Guardianship Issues

- Consent for services can only be authorized by a current legal guardian/s.
- If parents are separated, services are provided only with written consent of **both** parents. However, if custody is contested in anyway, your child's treatment will be stopped until all custody matters are finalized.
  - For divorced parents, consent may be given by the parent authorized to make medical decisions. If medical decisions are ordered to be made jointly, consent of **both** parents is required. Any and all communication between divorced parents will be handled via email with both parents attached to each email. **Copies of legal paperwork are required to document the above information.**

Confidentiality: Child Trauma Counseling Services, LLC will make every effort to keep your child's personal information private. Your child's emotional and physical wellbeing are of utmost importance to Samantha White, LPC, RPT. She is committed to your child's care and to the confidentiality of all personal information shared in our therapy sessions, except in circumstances governed by law. State and federal laws define the limitations of confidentiality as when there is a real or potential danger to your child or others, when the courts issue a subpoena or when child abuse or neglect is suspected. These are other limitations to *confidentiality* to which you need to be aware:

- Insurance companies request dates of service and diagnosis codes. To authorize additional sessions, they request some details about treatment and progress.
- Consultation**:** Samantha White, LPC, RPT consults regularly with other professionals regarding clients; however, client's identity remains completely anonymous, and confidentiality is maintained.
- E-Mails, Cell Phones, Computers: Individuals may choose to contact me via email or cell phone. In doing so, they agree to the understanding that email and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality. ________________ ***(please initial)***

- Disclosures required by Arizona Board of Behavioral Health Examiners when a lawsuit is filed.

Although Samantha White, LPC, RPT will do her best to always keep your confidentiality, please realize that certain methods of communication, such as email, phone and text can never be completely secure. Please try to utilize these methods of communication for scheduling purposes only. If you choose to communicate sensitive or therapeutic information via phone, text or email, it will be assumed that you realize the possibility for a breach in confidentiality and you knowingly accept this risk. All emails containing therapeutic information will become part of the therapeutic record.

Samantha White, LPC, RPT is required by law to report any suspected or reported child physical abuse, sexual abuse, emotional abuse and/or neglect. Samantha White, LPC, RPT is also required by law to notify others if a client is a danger to him/herself or others. Samantha White, LPC, RPT is not required to inform parents about reports made to law enforcement or Department of Child Safety. _____________***(please initial)***

Release of Information: If you wish to have information released about your child's therapeutic services, you will be required to sign a consent form before such information will be released. No information will be released without your written permission giving consent.

Record Keeping: Samantha White, LPC, RPT will keep records of counseling sessions and a treatment plan which include goals for counseling. These records are kept to ensure a direction of sessions and continuity in care. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality Section. There

is a fee for obtaining copies of records. See fee section. Records will be kept for at least seven years but may be kept longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet at CT Counseling Services, LLC.

Contacting Therapist: You may call Samantha White, LPC, RPT on her cell phone at *623-521-9043* if you need to speak with her or leave a message on her voicemail. However, Samantha White, LPC, RPT is often not immediately available by telephone. Samantha White, LPC, RPT does not answer her phone when other clients are in the office or Samantha White, LPC, RPT is otherwise unavailable. At these times, you may leave a message on her voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters.

Social Media and Communications Policy. Samantha White, LPC, RPT will not "friend" clients or collaterals or "follow" clients or collaterals on any social media platforms (ie – Facebook, Twitter, LinkedIn etc.). It is understood that Samantha White, LPC, RPT has an internet presence and understands that clients and collaterals have the right to review our therapeutic services in an online forum (ie – Yelp, Healthgrades etc.). It is encouraged that clients and collaterals consider how doing this would compromise the right to confidentiality. If a client or collateral chooses to do this, it will be assumed that the client or guardian is waiving the right to confidentiality.

EMERGENCY: If you feel you cannot wait for a return call or it is an emergency situation, go to your local emergency room, call 911 or call the Maricopa County Crisis Line at 602-222-9444.

Litigation Considerations: If you become involved in the legal system (divorce, custody or civil litigation) you can expect that Samantha White, LPC, RPT **will not** make recommendations, testify or get otherwise involved in your legal matters. If there is a custody matter, Samantha White, LPC, RPT **is not** an expert in custody issues and **will not** make recommendations for placement or evaluate for appropriate placement. It is an inherent conflict of interest for a treating professional to also offer evaluations or opinions in legal matters. If a parent has these expectations, it can affect disclosures of personal information vital to treatment.

Your signature below indicates that you have read this Agreement and agree to its terms and consent for treatment. ***I have read this form, discussed my questions with Samantha White, LPC, RPT and agree to its terms.***

Child's Name:___________________________________

____

Parent/Guardian ***signature*** */date* *Parent/Guardian* ***signature*** */date*

____

Therapist signature/date

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Child Trauma Counseling Services, LLC
SERVICES & FEE SCHEDULE
(effective July 13, 2020)

Service	***Fee***
Intake	$225.
Individual Session	$175 per hour
Family Session	$175 per hour
Telephone Consult: *with parents, doctors, school staff, parenting coordinators, case workers & other professionals*	$20 per quarter hour
School or Daycare Observation	$85 per hour
Attendance at IEP Meetings	$85 per hour
Travel Reimbursement	.50 cents per mile
Court Appearance (1 Hour Minimum)	$200 per hour
Court Report Writing	$100 per hour
Copy Fee	$100 per request
No Show or Late Cancellation	$65
Returned Check Fee	$35

Please sign to acknowledge receipt of this information.

____
Parent/guardian signature/date

____
Therapist signature/date

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Notice of Privacy Practices

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

Effective: January 1, 2017

Contact Information: Samantha White, LPC, RPT. Owner/Therapist, Child Trauma Counseling Services, LLC-- 623-521-9043.

Who Will Follow This Notice: Mental health therapists working at the Southwest Family Advocacy Center.

How We Safeguard Your Protected Health Information (PHI):

By law, we are required to ensure that your PHI is kept private. The PHI constitutes information created or noted by therapists that can be used to identify you. It contains data about your past, present, or future health or conditions, the provision of health care services to you, or the payment for such health care. We are required to provide you with this Notice of privacy procedures. This Notice explains when, why and how we use and/or disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within our organization. With some exceptions, we may not use or disclose more of your PHI than necessary to accomplish the purpose for which the use of disclosure is made; however, we are legally required to follow the privacy practices described in this Notice.

Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI already on file. A new copy of this Notice will immediately be posted in our office. You may also request a copy of this Notice from our therapists.

Uses and Disclosures for Treatment, Payment and Health Care Operations:

We may use or disclose your protected health information (PHI), for treatment, payment and health care operations purposes with your written consent. Sometimes we are required/allowed by law to use or share your PHI without your written consent.

Treatment: We may disclose your PHI to provide, manage and/or coordinate your health care and related services. Your PHI may be shared with your treating health professional, the mental health team, supervisors and directors.

For Payment: We may use your PHI to obtain payment for your healthcare services. This may include sharing information with your insurance company to include payment for service, to determine eligibility for coverage or to establish premiums.

For Health Care Operations: We may disclose your PHI to facilitate the efficient and correct operation of our mental health practice and the daily functions of the Center. These may include, but are not limited to, quality analysis, accreditation requirements, staff development, training, consultation and demographic purposes. Additionally, we may use your PHI with our accountants or attorneys for audits or litigation. Unless otherwise specified, you may be called by name in the lobby, we may leave voice messages on your telephone and we may send appointment reminders and other treatment-related literature via email.

Individuals Involved in Your Care: We may disclose PHI to a person that you identify that is involved in your mental health care. We may also give PHI to someone who helps pay for your care.

For Public Health Activities: We may share PHI when we are required to collect information about disease or injury, or to report information to a public health authority.

For Health Oversight Activities: We may share PHI with an agency responsible for monitoring the health care system for activities authorized by law. The may include audits, investigations, inspections and licensure.

For Research Purposes: We may, in certain and specific circumstances, use your PHI to assist in medical or psychiatric research.

Threats to Health or Safety: We may provide your PHI If disclosure is compelled or permitted by the fact that you or your minor child is in such mental or emotional condition as to be dangerous to yourself or the person or property of others. To avoid harm, we may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public. If disclosure is compelled by the client or the client's representative pursuant to Arizona Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

Child Abuse: We are required to report PHI to the appropriate authorities when a disclosure is mandated by the Arizona Child Abuse and Neglect Reporting law. **Adult Abuse:** We are required to report PHI to appropriate authorities when a disclosure is mandated by the Arizona Elder/Dependent Adult Abuse Reporting law.

As Required by Law: We will disclose PHI when required to do so by federal, state, or local law, judicial, board, administrative proceedings, or by law enforcement (i.e. in response to court order, subpoena, warrant, summons; to identify or locate a suspect, fugitive, material witness or missing person; information about the victim of a crime; about a death that may be the result of criminal conduct; in emergency circumstances to report a crime, the location of the crime or victims).

Lawsuits and Legal Disputes: We may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discover request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request to obtain an order protecting the information requested.

For Workers' Compensation Purposes: We may provide PHI in order to comply with Workers' Compensation laws.

Appointment Reminders and Health-Related Services: We may use your PHI to provide appointment reminders or to provide information about alternative treatment options.

Your Rights Regarding Your Protected Health Information:

Right to Inspect and Copy Your PHI: You have the right to see your PHI or get copies of it, however, you must request to do so in writing. In some situations, we may deny your right to view and copy your PHI in its entirety. If your request is denied, you will receive written notice, which you may be able to appeal. If your request is approved, there may be a charge for coping and we may require 7-10 business days to complete the copying.

Right to Request Restrictions: You have the right to request limitations on how we use your PHI. We will consider your request, but do not have to agree to it. If we do agree to the restrictions, we will put the agreement in writing and follow it, except in emergency situations or as required by law. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

Right to Request Confidential Communication: You have the right to ask that we communicate with you in a specific manner and in a specific location.

Right to Request Amendments: You have the right to request an amendment of PHI, if you believe there is a mistake or missing information, for as long as the PHI is maintained in record. The request must be written and include reasons supporting the request. We may deny the request, if we determine that: 1) the PHI is complete

and correct or 2) was not created by us and is not part of our records or 3) is a type of information that we cannot disclose. You will be notified in writing if your request is denied and may appeal the decision.

Right to Tracking of Disclosures: You have the right to request a list of the disclosures we made of your PHI including the person receiving the information, the date and the purpose of the disclosure. This list will not include disclosures for treatment, payment or health care options or any release of information we made to you or to those you authorized, your family, or any release to national security, intelligence authorities, law enforcement, health authorities or disclosures made before April 15, 2003.

Right to Receive This Notice: Upon request, you have the right to receive this notice by email or to receive a paper copy of this notice.

Complaints: If you believe your privacy has been violated or you disagree with a decision we made regarding releasing or using your PHI, you may appeal in writing to Samantha White, LPC, RPT, Owner/Therapist, Child Trauma Counseling Services, LLC. You may also file a complaint in writing or via email to the Secretary of the U.S. Department of Health and Human Services at:

Office of Civil Rights
US Dept of Health & Human Services
50 United Nations Plaza, Room 322
San Francisco, California 94102

I, ____ (print name), hereby acknowledge

that I have received the Notice of Privacy Practices on _____________________ (date).

I am the (please check one): **___ Parent** **___ Legal Guardian**

____ ____________

Parent or Legal Guardian Signature **Date**

On behalf of: ____ _____________

Name of Child (Please Print) **Date of Birth**

Child Trauma Counseling Services, LLC

CONSENT TO USE and DISCLOSE PROTECTED HEALTH INFORMATION

(effective July 13, 2020)

This form is an agreement between "you" ___________________________________ and CT Counseling Services, LLC . When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here ___________________________________.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or other business or government functions.

By signing this form, you agree to let us use your information here and to send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Privacy Offices by calling 623-521-9043.

See Protecting Your Privacy handout for additional important information about your rights.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

1.____

Signature of parent/guardian/date

____

Printed name of parent/guardian state relationship to client

2.____

Witness signature/ date

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