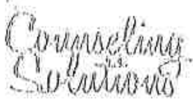

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MINOR CLIENT PERSONAL DATA

Please provide the following information for my records. All information you provide here is held to the same standards of confidentiality as our therapy. Please fill out this form prior to our first session.

Date: ____________ Referred By: ____________________________

Client Name ____ ☐ Male ☐ Female

Address ____
City State Zip Code

Age ________ Birthdate ___/___/______

School Attending ______________________________ Grade Level ______________

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other ____________

Parent/Guardian Name(s) ____

Home Phone(____) ____________ Cell Phone(____) ____________ Minor's Cell Phone(_____)____________

May I leave a message at home? ☐ Yes ☐ No Cell? ☐ Yes ☐ No

Emergency Contact: ______________________________ Phone Number ________________

Minor: In your own words, please state the nature of the main problem: ____________________
____
____

Parent: In your own words, please state the nature of the main problem: ____________________
____
____

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5
Mildly Upsetting Extremely Serious

What would you like to accomplish through counseling? ________________________________
____
____
____

FAMILY STATUS

Parents

Father: Name ______________________ Age______ Occupation ______________________

Mother: Name ______________________ Age______ Occupation ______________________

Marital Status of Parents: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Living Together ☐ Other ________

Briefly describe minor's relationship with Father ______________________________________

With minor's mother ____

If divorced, please specify minor's age at divorce and circumstances surrounding divorce: ________
____

Custody Arrangement ____

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Following information for parent primarily responsible for payment:
Name: ______
Employer: ______
Employer's Address: ______ Phone: ______

Following information for additional parent:
Name: ______
Employer: ______
Employer's Address: ______ Phone: ______

Siblings
Brothers' first names and ages ______
Sisters' first names and ages ______

Other
Please explain if any member of the family (immediate or extended) has ever suffered from anything that could be described as an "emotional" or "psychological" problem:
______

Please mention any history of domestic violence, child abuse or sexual abuse in the family: ______

Please comment on any history of alcohol or drug use in the family: ______

MINOR'S DEVELOPMENTAL HISTORY (If yes, please describe)

Pregnancy Planned: ☐ Yes ☐ No - Parents' Attitudes Toward Having Children ______
Complications with Pregnancy: ☐ Yes ☐ No ______
Premature Birth: ☐ Yes ☐ No ______
Age When: Crawled ______ Walked ______ Spoke First Word ______ Spoke First Sentence ______
Developmental Delays ☐ Yes ☐ No ______

MINOR'S EDUCATIONAL HISTORY (If yes, please describe)

School Grade ______ Name of current school: ______
Type of Class: ☐ Regular ☐ RSP ☐ SDC ☐ Gifted
School Problems? ______
Skipped a grade? ☐ Yes ☐ No ______
Held back a grade? ☐ Yes ☐ No ______

MINOR'S CURRENT FUNCTIONING (If yes, please describe)

Behavioral Problems ☐ Yes ☐ No ______
Problems with Parents ☐ Yes ☐ No ______
Problems with Siblings ☐ Yes ☐ No ______
Problems with Peer Relationships ☐ Yes ☐ No ______
Substance Abuse ☐ Yes ☐ No ______
Sexually Active ☐ Yes ☐ No ______
Any Cultural Considerations ☐ Yes ☐ No ______

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MINOR'S MEDICAL CONDITIONS

Please check all that apply:

	Never	Seldom	Sometimes	Often	Comments
Insomnia	☐	☐	☐	☐	
Loss of Appetite	☐	☐	☐	☐	
Back Pain	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Headaches	☐	☐	☐	☐	
Phobias (Fears)	☐	☐	☐	☐	
Nausea	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	
Nervousness	☐	☐	☐	☐	
Loss of temper	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	
Depressed mood	☐	☐	☐	☐	
High blood pressure	☐	☐	☐	☐	
Constipation	☐	☐	☐	☐	
Diarrhea	☐	☐	☐	☐	
Over-eating	☐	☐	☐	☐	
Mood swings	☐	☐	☐	☐	

OTHER CONCERNS

Smoking (tobacco): ☐ Yes ☐ No Packs per week ______

Alcohol Intake: ☐ Yes ☐ No Frequency (per week): ______ How Much? ______
What do you drink? ______

Recreational/Illegal Drugs: ☐ Yes ☐ No What kind? ______
Frequency (per week): ______ How Much? ______
When do you use drugs and how do you get them? ______

MINOR'S MEDICATION HISTORY

Please check all that apply to you:

	Never	Seldom	Sometimes	Often	Comments
Appetite suppressants	☐	☐	☐	☐	
Pain Relievers	☐	☐	☐	☐	
Sedatives/Tranquilizers	☐	☐	☐	☐	
Sleep Aids	☐	☐	☐	☐	
Stimulants	☐	☐	☐	☐	
Blood Pressure Meds	☐	☐	☐	☐	
Heart Medicine	☐	☐	☐	☐	
Allergy Medicine	☐	☐	☐	☐	
Vitamins	☐	☐	☐	☐	
Other (please specify)	☐	☐	☐	☐	

Please list all current medications and supplements:

Medication	Dose	Reason

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Current Weight: ________ One Year Ago: ________ Maximum: ________ When? ________

Does minor exercise regularly? ☐ Yes ☐ No How? ________

Does minor sleep well? ☐ Yes ☐ No Amount (hours): ________ Easy to get to sleep? ☐ Yes ☐ No

What recreation does minor enjoy? ________

Physician / City / Date of last physical: ________

The hardest time in minor's development was: ☐ Preschool ☐ Grade School ☐ Jr. High ☐ High School

MINOR'S TREATMENT/COUNSELING HISTORY

Has minor ever had any previous counseling or psychotherapy? ☐ Yes ☐ No If YES, please list from most recent:

Dates	Problem	Therapist & Location	Helpful?

Has minor ever attempted suicide? ☐ Yes ☐ No If YES, when? ________

If YES, method used: ________

Has minor ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No If YES, when? ________

If YES, describe hospital stay: ________

OTHER INFORMATION

Do you consider your family to be religious? ☐ Yes ☐ No

If yes, what is your faith? ________

If yes, do you feel that your faith should be a significant part of your therapy? ☐ Yes ☐ No

Please describe: ________

If no, do you consider yourself to be spiritual? ☐ Yes ☐ No

Please describe: ________

Please describe minor's religious/spiritual status, if different than family: ________

What are minor's strengths/talents: ________

Who is supportive of minor outside of family? (best friend, teacher, coach) ________

Is there anything else you think would be helpful for me to know? ________

Parent/Guardian Signature ________ Date ________

Minor Signature ________ Date ________

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POLICIES, GENERAL INFORMATION & CONSENT FOR TREATMENT & PSYCHOTHERAPY SERVICES

Please read and initial next to each paragraph:

______ **CONFIDENTIALITY**: All information disclosed within sessions and the written records pertaining to those sessions *are confidential* and may not be revealed to anyone without your (client or parent's) written permission, except when required by law or for supervision purposes as previously stated.

> * **When Disclosure Is Required By Law**: Where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled.

> * **When Disclosure May Be Required**: Disclosure may be required if related to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain psychotherapy records and/or testimony from me. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. Records will not be released to any outside party unless authorized by all adult family members who were part of the treatment.

______ **EMERGENCIES**: If there is an emergency during our work together, or after termination where I become concerned about your personal safety, the possibility of you injuring someone else, or you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and ensure that you receive proper medical care. For this purpose, I may contact the person you indicated on the biographical sheet. If you have an emergency or crisis, please indicate so clearly in your phone message. If you need help before I can return your call, you or someone you trust should call the emergency room at your local hospital, your medical doctor, or 911. If you have experienced suicidal thoughts or other severe psychiatric symptoms in the past, please inform me so we can develop a specific emergency plan.

______ **CONFIDENTIALITY OF COMMUNICATION**: E-mail, fax and cell phone communication can be relatively easily accessed by unauthorized people and thus compromise your confidentiality. Please notify me if you decide to avoid or limit the use of any or all of these modes of communication. Please do not use e-mail or fax for communication in emergency situations.

______ **YOUR RIGHT TO REVIEW RECORDS**: Both law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when releasing such information might be harmful in any way. In such cases, I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering the above exclusions, if appropriate and upon your request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way.

______ **LITIGATION LIMITATION**: Due to the sensitive nature of therapy and the information shared and addressed, you agree that I am not obligated to supply any documentation, correspondence, or presence regarding any legal proceedings. Should you or your attorney desire any documentation or service for court/legal purposes, I must receive such request in writing and will have 2 weeks to give a response. I may

decline the request if disclosure of the requested information may be harmful in any way to the client; no request will be acknowledged unless it is accompanied by the client's written permission. Any documentation, consultation, or testimony requests will incur a charge of $200 per hour. Testimony charges may include time spent traveling, preparing reports, attendance, and other case related costs.

_____ **MEDIATION & ARBITRATION**: Any disputes in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, initiation of arbitration. The mediator must be a neutral third party chosen by agreement of me and the client(s). The cost of such mediation, if any, shall be split equally. In the event that mediation is unsuccessful, any unresolved controversy related to the agreement should be submitted to and settled by binding arbitration in Bell County, Texas, in accordance with the rules of the American Arbitration Association in effect at the time the demand for arbitration is filed. If your account is overdue by more than 60 days and there is no agreed payment plan, I may use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection shall be entitled to recover a reasonable sum as and for attorney fees. In the case of arbitration, the arbitrator will determine that sum.

_____ **DUAL RELATIONSHIPS**: Dual relationships should be avoided whenever possible, especially when ethics or your treatment progress may be in question. Therapy *never* involves sexual or any other dual relationships that may impair my objectivity, clinical judgment and effectiveness or could be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients, discuss with you the potential benefits and difficulties that may be involved, and will discontinue the dual relationship if I find it interfering with the effectiveness of our therapeutic process. Should we encounter each other in any public setting, I will never approach you or even acknowledge you unless you first initiate contact so that I may protect your confidentiality and the nature of our professional relationship.

_____ **THE PROCESS OF THERAPY**: Participation in therapy can result in a number of benefits to you, including improving relationships and resolution of the specific concerns or symptoms that led you to seek therapy. Working toward these benefits requires effort on your part both in and outside of sessions. Although therapy has been shown to improve relationships and symptoms, it may create uncomfortable feelings in the short-term. For example, remembering or talking about unpleasant events, feelings, or thoughts can result in experiencing discomfort or strong feelings of anger, sadness, worry, insomnia, etc. Please inform me if such issues arise. I cannot guarantee what you will experience or benefits you might receive; however, it is most likely to be successful with your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your experience in therapy, and will welcome your honest response. During the course of therapy, I am likely to draw from various psychological approaches according to the problem that is being treated and my assessment of what will best benefit you. These approaches include cognitive-behavioral, solution-focused, family systems, or psycho-educational therapy.

_____ **MINOR CLIENTS**: Parents have a right to receive progress reports on their child's counseling. However, personal information shared by a child during an individual session will be kept confidential unless it involves imminent danger to the child or someone else. Young people will not confide in a counselor if they believe that personal information will be revealed to their parents. If applicable, I must receive a copy of the most recent divorce decree or custody order at our first session; this is to ensure proper consent, confidentiality and disclosure of information. All parent/guardian parties must at least be informed of treatment, and all with custody rights must consent to treatment of minor at or prior to the first session. Exceptions to parental consent may apply to minors 16 years or older who present for emergency counseling regarding sexually transmitted diseases, substance abuse, pregnancy issues, and/or are emancipated.

_____ **DURATION & TERMINATION**: The duration of treatment depends entirely on your presenting concerns, treatment goals, and effort toward those goals in and outside of sessions. I typically discuss duration more specifically with the client in the 3rd or 4th session, depending on factors such as duration limitations by your insurance carrier. I request a two-session notice before therapy is terminated in order to process gains made during treatment, as well as issues to be addressed in the future either by me or another therapist.

_____ **PHONE CALLS & E-MAIL**: In the event that you need to contact me between sessions, 10 minutes per week is allowed without charge. After the first 10 minutes there will be a charge prorated according to your session fee. I check my phone and e-mail messages between 9:00 a.m. and 5:00 p.m., Tuesday through Thursday. Messages left late in the day may be returned on the next business day. You may e-mail me to make, cancel, or reschedule an appointment, to make brief reports about your progress, or to ask simple questions that can be answered in a few words. Therapy issues, questions, or crises will not be addressed by e-mail. Please see above for emergency protocol.

_____ **CANCELLATION**: An appointment is considered cancelled when not attended at the agreed time/date, and not rescheduled and attended within the same calendar week as the original appointment. If you cancel your appointment two weeks in a row, that time slot will be available to other clients. A late fee/no show fee will be charged for all appointments cancelled less than 24 hours before the scheduled time. Payment is due for any missed appointment at the beginning of the next session.

CLIENT/GUARDIAN: I have carefully read, understand, and agree to comply with the above policies and information, and consent for treatment and psychotherapy services.

Client Name (Print) ______________________________ Date __________

Signature ______________________________

Client Name (Print) ______________________________ Date __________

Signature ______________________________

Terry A. Strong M.A., LPC

Jacquiline Paprzycki, M.S, LPC, DBT

Lisa Peterson, LMFT, LPC

Sheila Hoogandam, M.S LPC

If psychotherapy services are not rendered in a professional and ethical manner, you may file a complaint with the Texas State Board of Examiners of Professional Counselors/MFT:

Texas Board of Examiners of Professional Counselors
Texas Department of State Health Services MC-1982
1100 West 49th Street
Austin, Texas 78756-3183, USA
E-mail: lpc@dshs.state.tx.us

Telephone: (512) 834-6658
Fax: (512)834-6677

PROVIDER STATEMENT

(To be completed by provider)

I have discussed the above issues and policies with the client. My observations of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent to treatment.

Signature________________________ Date______________

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Please Read and Sign/Date ALL of the following whether they apply to you or not. This will insure you know our policies.

Release of Medical Information:
I authorize the release of any personal information concerning my (or my child's) mental health care, advice and treatment necessary to process this insurance claim. I permit a copy of this authorization to be used in place of the original.

Signature Date

Assignment of Benefits:
I authorize the release of medical benefits to Counseling Solutions as described on insurance claims forms. I also understand that this assignment of benefits is irrevocable and a photo copy shall be considered as legal and binding as the original.

Signature Date

Payment Policy:
All payment for professional services rendered are due at the time of service unless insurance is applicable. We will file insurance, but all co-pays, co-insurance and deductibles are due at the time of service. Non-covered services and balances after insurance payment will be billed to the patient. I understand that I am responsible for the total changes of services rendered.

Signature Date

Fee Policy: IMPORTANT PLEASE READ!
1. There will be a **$40.00** charge for all no shows (A no show/late cancel is any appointment that is not cancelled with at least **24 hour notification**). Fee must be paid at the next appointment. After two no shows/late cancelations you can be dropped as a client from our facility.
2. A reasonable fee will be charged for writing of letters. Fees will be set by each therapist.
3. A **$25.00** fee will be charged for the copy of your medical records.
4. court fee of **$200.00** per hour will charged to the client. This fee is accessed if you need the therapist to go to court.
5. Should any balance become **30 days** or more past due the account will be sent to a collections agency. An additional charge of **40%** will be added to the balance for collection fees.

6. A $40.00 fee will be charged for NSF checks.

Signature

Date

HIPPA - CONSENT FORM FOR CLIENTS

Counseling Solutions

I consent to the use or disclosure of my protected health information by Counseling Solutions, for the purpose of Treatment, Payment and Health Care Operations.* I have received a copy of the Notice of Privacy Policies and understand I have a right to review prior to signing this document.

I UNDERSTAND:

- Service to me may be conditioned as to how my protected health information is used or disclosed to carry to treatment, payment or health care operations of the practice. If Counseling Solutions agrees to a restriction that I request, the restriction is binding on Counseling Solutions.
- I have the right to revoke this consent, in writing, at any time, except to the extent that Counseling Solutions has taken action in reliance on this consent.
- My protected health information, including my demographic information, is collected from me, created or revised by my physician, another health care provider, a health plan or a future physical or mental health or condition and identifies me; or there is a reasonable basis to believe the information may identify me.

THE NOTICE OF PRIVACY PRACTICE DESCRIBES:

- The types of uses and disclosures of my protected health information that will occur if my treatment, payment of my bills or in the performance of health care operations performed by Counseling Solutions.
- My rights and the duties of Counseling Solutions with respect to my protected health information.

Counseling Solutions reserves the right to change its privacy practices. All current or revised notices can be obtained by visiting our office located at 14138 State Highway 195, Killeen, Texas 76542.

Full Name (PLEASE PRINT)

Address City State Zip Code

Signature of Parent/Guardian

Date

*Treatment includes activities performed by a health care provider, office staff, and other of health care professionals providing care to you, coordination or managing your care with third parties, and consultation with and between other health care providers. Payment includes activities involved in determining your eligibility for health plan coverage, billing, and receiving payment for your health benefit claims, and utilization management activities, which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization. Health Care Operations includes the necessary administrative and business functions of our office.

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES AND STATEMENT OF UNDERSTANDING

I have reviewed Counseling Solutions' Informed Consent to Treatment and limits of confidentiality statement as well as the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of the Notice and Privacy Practices if I choose.

I also give permission and consent to Counseling Solutions, for the administration of any and all treatment determined by the therapist. I understand that primary treatment procedures will be determined as an agreement between myself and the therapist and will identify major goals and alternative treatment options.

Signature ______________________ Date ______________________

SERVICE PROVIDER'S STATEMENT

(To be completed by provider)

I have inquired to insure that the patient understood the above description of the Limits of Confidentiality and informed the patient if I am under supervision and by whom.

Signature ______________________ Date ______________________