FOUNDATION COUNSELING

_____ (initial) CONFIDENTIALITY: The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of child or elderly abuse or threats of physical harm to self or others or subpoena of a court. Your counselor will be discreet if it is necessary to contact you at home or at work. If you have a specific number that is best for contact please let your counselor know.

_____ (initial) COMMUNICATION: Secure and private communication cannot be fully assured utilizing cell/smart phone or email technologies. By initialing, you are acknowledging that the use of any of these technologies to contact your counselor are considered non-secure. Any contact to your counselor by these means will be considered implied consent for your counselor to return messages via the same non-secure technology unless you present a written statement of further clarification.

_____ (initial) COUNSELING FEES: The nominal fee for counseling sessions will be determined by your individual counselor. We ask that your account be kept current and that payment be made prior to beginning each session. A charge of $25.00 will be made for returned checks plus the amount of the unpaid session. Some counselors may charge a $3.00 fee for use of credit/debit cards to pay for sessions.

_____ (initial) CANCELLATION OF APPOINTMENTS: Your appointment time is important to you, to your therapist, and to others who are in need of therapy. If you must cancel your appointment, please phone your counselor and leave a message on their voicemail at least 24 hours in advance of your scheduled appointment. The fee for the session will be charged for the time reserved when cancellations are received less than 24 hours in advance, except in case of illness or emergency. You are personally responsible for this charge and all future appointments may be cancelled until this fee is paid.

_____ (initial) TELEPHONE CALLS: Should you need to contact your counselor, you may leave a message on their provided phone number. All calls that are over 15 minutes in length, your counselor may ask if you would like to schedule a session or continue the telephone call for your nominal fee for a 45-minute session.

_____ (initial) EMERGENCY PROCEDURES: If you have an emergency, you will need to contact either a hospital emergency room or the police depending on the situation. If you feel your life or someone else's is in danger call 911.

I have read the above information and voluntarily request counseling services at Foundation Counseling LLC, and I agree with these terms and conditions*

Signature_____ Date_____

*The signature of the custodial parent or guardian is required for clients under 18 years of age.

Foundation Counseling, LLC

The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPPA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPPA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Foundation Counseling, LLC is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

I have received a copy of the Foundation Counseling, LLC Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may at any time now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

_____	_____
Patient Signature	Date
_____	_____
Signature of Parent or Guardian	Date

* The signature of the parent/guardian is required for clients under 18 years of age

Identifying/Contact Information

Name of person participating in counseling: _____

Name of person filling out intake: _____

Relationship to child: _____

Child's Birthdate: _____ Age: _____ Sex: M F

Child's Street Address: _____

City: _____ State: _____ ZIP: _____

Child lives with: _____

Parent's Marital Status: Single ___ Married ____ (# of years ___)

Divorced ____ Separated ____

Years of Education: _____

Religious Affiliation (if any): _____

Emergency Contact: Name _____ Phone: _____

Information about Child's Mother:

Mother's Name:_____ Birthdate:_____

Address:_____

Email Address: _____ OK to email messages? Yes ____ No ____

Telephone: (H)_____(C)_____(W) _____

OK to leave messages? Yes ____ No ____ OK to send texts? Yes ____ No ____

Occupation:_____ Employer:_____

Information about Child's Father

Father's Name:_____ Birthdate:_____

Address:_____

Email Address: _____ OK to email messages? Yes ____ No ____

Telephone: (H)_____(C)_____(W) _____

OK to leave messages? Yes ____ No ____ OK to send texts? Yes ____ No ____

Occupation:_____ Employer:_____

Family

Relationship	Name	Age	Grade in school last completed	Occupation
Siblings				

List any other family members in the home and their relationship to your child:

_____

_____

Medical/Developmental History:

Were there any complication surrounding the child's birth? Yes ____ No ____

If yes, please describe: _____

_____

Were there any difficulties with developmental milestones? (walking, talking etc.):

Yes ____ No ____

If yes, please describe:_____

_____

List child's sicknesses, operation, and injuries. Indicate age when occurred, and describe how severe. Pleas pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:

_____

_____

_____

Please list any of the child's current medical problems: _____

_____

_____

_____

Is child currently taking any prescription medications? Yes ____ No ____

If yes, please list:

Name of Drug	Dosage	Condition	Prescribed by:

When was your child's last physical exam? _____

Name of primary care physician: _____

Has child ever received any previous counseling? Yes ____ No ____

If yes, please list the names of the counselor(s), dates of counseling and reason for treatment: _____

_____

_____

Academic/School Information:

Name of school child attends:_____ Grade: _____

Has child ever repeated a grade? Yes ____ No ____ If yes, which grade? _____

How does child tend to perform in school? _____

How does child do at school socially? _____

Does child have any learning difficulties? Yes ____ No ____ If yes, please describe:

_____

_____

Describe your child's behavior at school: _____

_____

What kind of extracurricular activities does your child participate in? _____

_____

_____

Describe what your child likes to do for fun at home: _____

_____

_____

Current Situation

Briefly describe the reason you are seeking counseling for your child:

_____

_____

When did the problem appear?

_____

_____

When has the problem improved? What do you think helped?

_____

_____

When has the problem worsened? What do you think contributed to it?

_____

_____

Is there anything else that you believe might be important for your counselor to know at this time?

_____

_____

Current Concerns Using the scale below, please choose a number that reflects the extent of your current concern about the issues listed below. Please rate each item.

0 1 2 3 4 5 6 7 8 9 10
No concern Moderate concern Extreme concern

_____ Abused as a child
_____ Aggression
_____ Anger or Temper
_____ Anxiety
_____ Bitterness
_____ Completing Tasks
_____ Concentration
_____ Depression
_____ Difficulty in Communication
_____ Eating Difficulties
_____ Excessive Behaviors
_____ Family Problems
_____ Fearfulness
_____ Feeling Manic
_____ Feeling Overwhelmed
_____ Fidget Frequently
_____ Finances
_____ Grief or Loss
_____ Hopelessness
_____ Irritability
_____ Isolation
_____ Marital Problems
_____ Nightmares
_____ Personality Conflicts
_____ Physical Problems
_____ Problems in Relationships
_____ Problems with Children
_____ Problems with Parents
_____ Resentment
_____ Sexual Concerns
_____ Sleep
_____ Social Withdrawal
_____ Spiritual Concerns
_____ Stress
_____ Thoughts of Hurting Yourself
_____ Thoughts of Suicide
_____ Trouble Making Decisions
_____ Unhappy Most of the Time
_____ Use of Alcohol
_____ Use of Alcohol by a Family Member
_____ Use of Drugs
_____ Use of Drugs by a Family Member
_____ Work
_____ Worry
_____ Other:_____

Please complete the following: (To be completed by child/adolescent)

1. I would like

2. If I were older

3. Girls

4. My friends think

5. What makes me mad is

6. My father

7. I miss

8. I am scared

9. I often think of myself as

10. My only trouble

11. I dream of

12. Being younger would

13. I hate

14. If I don't get what I want at home

15. What worries me is

16. When I grow up

17. Nothing bothers me more than

18. Other people think I'm

19. I feel unhappy sometimes because

20. Boys

21. There are times when I

22. Being my age is

23. I don't think I can

24. It's tough when

25. At home

26. Teachers are

27. If I am left behind

28. Sometimes I think about

29. If I were smarter

30. Sometimes I feel like

31. It is more important to

32. I wonder if I should

33. My mother

34. If my parents had only

35. I would be happier if

36. I'm glad I'm

37. I wish I were

38. If I could choose my family

39. If only I were not so

40. It would be funny if