CHILD INTAKE AND INFORMED CONSENT

iChooseChange

PERSONAL INFORMATION:

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

OFFICE USE ONLY:
CSLR: _____
DX: _____
FEE: _____

Legal Guardian(s): _____

Address: _____

City / State / Zip: _____

Ok to send correspondence to this address? ☐ Yes ☐ No

Home Phone: _____ Ok to leave a message here? ☐ Yes ☐ No

Guardian Phone: _____ Ok to leave a message here? ☐ Yes ☐ No

Cell Phone: _____ Ok to leave a message here? ☐ Yes ☐ No

Guardian Email: _____ Ok to send email here? ☐ Yes ☐ No

Birth Date: ___ / ____ / ____

Who is the primary custodian? _____

*Note: We may request a copy of divorce decree noting who has custodian rights to healthcare decisions, should both parents not be involved in treatment.

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

REFERRAL:

How did you hear about I Choose Change? (Check all that apply)

- ☐ Living Magazine
- ☐ Allen Image
- ☐ Facebook
- ☐ Physician: _____
- ☐ Relative: _____
- ☐ Internet Search
- ☐ Community Paper
- ☐ Psychology Today
- ☐ Friend: _____
- ☐ Other: _____

Can we add you to our newsletter mailing list? (We never share your information.) ☐ Yes ☐ No

PARENT EMPLOYMENT INFORMATION:

Employer: _____ Length of Employment: _____

Occupation: _____

LIVING ARRANGEMENTS

With whom does the child primarily you live?

Name & Relationship: _____ Age: _____

Name & Relationship: _____ Age: _____

Name & Relationship: _____ Age: _____

Name & Relationship: _____ Age: _____

FAMILY OF ORIGIN:

List mother, father, brothers, sisters (including steps) and any other family members not who you believe affects your child positively or negatively, and who are not listed above:

Name	Current age (or year of death)	Relationship to child

MEDICAL AND MENTAL HEALTH HISTORY:

Relevant illnesses or trauma: _____

Current medications:

_____ Purpose: _____

_____ Purpose: _____

_____ Purpose: _____

_____ Purpose: _____

Who prescribes current medications: _____

Name of Pediatrician: _____

Name of Psychiatrist: _____

Can we contact your physician(s)? ☐ Yes ☐ No

Describe the reason you're seeking counseling for your child:

How long have you had concerns about this / these issue(s)?

What have you tried to help your child with this issue?

Describe current family stress such as relocation, financial burdens, sibling rivalry, family conflicts, or divorce:

Check YES or NO to each of the questions below. For any "YES" question, please briefly explain below.

- Is there a history of mental illness in the child's family? ☐ Yes ☐ No
- Is there a history of drug abuse in the child's family? ☐ Yes ☐ No
- Are you willing to participate in your child's therapy? ☐ Yes ☐ No
- Does your child get regular physical activity? ☐ Yes ☐ No
- Do you have concerns about your child's diet? ☐ Yes ☐ No
- Is there a history of physical, emotional, or sexual abuse in the home? ☐ Yes ☐ No
- Is there a history of alcohol and drug abuse in family? ☐ Yes ☐ No
- Are all caregivers willing to participate in your child's therapy? ☐ Yes ☐ No
- Have you sought counseling for this or any other reason in the past? ☐ Yes ☐ No
- Does your child get regular physical activity? ☐ Yes ☐ No
- Do you have concerns about your child's diet? ☐ Yes ☐ No

Check any symptoms you have noticed or you have been concerned with in the past 6-8 weeks.

- ☐ Sad, depressed or withdrawn
- ☐ Anxious, nervous or worrisome
- ☐ Change in appetite (eating more or less than usual)
- ☐ Excessive preoccupation with video games or fictional characters
- ☐ Abusing or hurting animals
- ☐ Change in sleep patterns or afraid to sleep alone
- ☐ Nightmares/Night terrors
- ☐ Hyperactive or excessively energetic
- ☐ Bed wetting or incontinent throughout the day
- ☐ Cutting, scratching or hurting self
- ☐ Getting into verbal or physical fights with peers or family members
- ☐ Talks of death or says that others would be better off without him/her
- ☐ Running away or threats of running away
- ☐ Bullying others or reports being bullied
- ☐ Worries that something bad is going to happen
- ☐ Frequently caught lying
- ☐ Anger Outbursts
- ☐ Lonely or complains of not having friends
- ☐ Unrealistic fears such as being alone

PROFESSIONAL DISCLOSURE STATEMENT:

Qualifications: We are Professional Counselors. Our formal education has prepared us to counsel individuals, groups, couples, parents and families.

Nature of Counseling: Our theory of counseling is that people have specific behaviors they would like to change, which are caused by our irrational, self-defeating beliefs learned early in the developmental cycle. These behaviors are brought to counseling in various forms of unhappiness in one's life. Our goal will be to assist with change of the irrational and self-defeating beliefs, so as to change undesired behaviors and circumstances. While we use various techniques and exercises to help aide the change process, we most closely subscribe to the foundation of Cognitive Behavioral Therapy (CBT) and Attachment Theory.

Types of Counseling: Counseling is the application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology. *Face-to-face counseling* for individuals, couples, and groups involves synchronous interaction between and among counselors and clients using what is seen and heard in person to communicate. *Technology-assisted distance counseling* for individuals, couples, and groups involves the use of the telephone or the computer to enable counselors and clients to communicate at a distance when circumstances make this approach necessary or convenient.

CONSENT TO TREAT:

Counseling Relationship: While we work together, usually we will meet weekly for approximately 50 minute sessions unless we mutually agree to different terms. Child and teen appointments are often slightly shorter. Our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social or personal one. *Please do not invite us to social gatherings, offer us gifts, ask us to write references for you, or ask us to relate to you in any way other than the professional context of our counseling sessions.* You will be best served if our sessions concentrate exclusively on your concerns.

Our in-person contact will be limited to counseling sessions you arrange with us. We schedule appointments based on availability and your need. If you experience a mental health emergency, obtain crisis services by dialing 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though we do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful.

We assure you that our services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaints in writing to the Complaints Management and Investigation Section, Texas State Board of Examiners of Professional Counselors P.O. Box 141369, Austin, Texas 78714-1369 or by calling 1-800-942-5540 to obtain more information.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, we encourage you to sign a release so we may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with us, you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with us and sign a release that enables us to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against our advice, we may consider this your decision to change counselors.

We also reserve the right to postpone and/or terminate counseling of clients who come to session under the influence of alcohol or drugs. In addition, we reserve the right to terminate counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Internet Counseling and Telephone Therapy: Distance counseling supplements face-to-face counseling by providing increased access to counseling on the basis of necessity or convenience. Barriers, such as being a long distance from counseling services, geographic separation of a couple, or limited physical mobility as a result of having a disability, can make it necessary to provide counseling at a distance. Internet counseling shall include e-mail-based individual counseling, chat-based Individual, couple or group counseling, and video-Based Individual, couple and group counseling.

Cancellation: In the event that you will not be able to keep an appointment, please notify us by telephone at least 24 hours in advance, whenever possible. *If this 24-hour notice is not respected, you will be billed for your session at the rate in which we discussed during your initial session*.

Referrals: We recognize that not all conditions presented by clients are appropriate for treatment with us. For this reason, you and/or we may believe that a referral is needed. In that case, we will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Session Fees: Please see the enclosed fee schedule. Should fees ever be a hindrance to therapy, please discuss with your counselor and we will make every effort to work with you within our agency. If we are unable to help, we will find a counselor who better fits your financial needs.

Legal Fees: We have no forensic experience and being master level therapists we would generally not be a good expert witness. However, in the event of court proceedings where we are court-ordered to appear, or our records are needed, our hourly fee is $200 for any amount of work performed including copies, drive time, wait time, depositions and court proceedings.

Administrative Fees: A fee of $25 for requested copies of your file, plus mailing charges. A 10% charge will be added to all outstanding balances, and all returned checks will incur a $30 fee.

Records and Confidentiality: All of our communication becomes part of your clinical record. Adult client records are disposed of five years after the file is closed. Minor client records are disposed of five years after the client's 18th birthday. All of our communication is confidential, except in the following cases: a) We are using your case records for purposes of supervision, professional development and research. In such cases, to preserve confidentiality, we will identify you by first name only; b) We determine that you are a danger to yourself or someone else; c) You disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; d) You disclose sexual contact with another mental health professional; e) We are ordered by court order to disclose information (although we make every effort to shield information); f) You direct us to release your records; or g) We are otherwise required by law to disclose information. If we see you in public, we will protect your confidentiality by acknowledging you only if you approach us first.

In the case of marriage or family counseling, we will keep confidential (within limits cited above) anything you disclose to us without your family member's knowledge. However, we encourage open communication between family members and we reserve the right to terminate our counseling relationship if we judge the secret to be detrimental to the therapeutic progress.

While engaging in internet counseling, steps are taken on behalf to provide as much confidentiality as possible, but we wish to make clients aware of the potential hazards of unsecured communication. As such, we will take steps to verify your authenticity at every session. We use encryption methods whenever possible.

By signing the next page, you are indicating that you have read and understood your rights as a mental health client at I Choose Change, and that any questions you had about this statement been answered to your satisfaction and that you were furnished a copy of this statement if requested (this information can also be located on our website).

Note Couples and Families: All adults involved in counseling are to initial and sign below (i.e. involved parents and couples, for example).

INITIAL FOR AUTHORIZATION:

_____ 1. I have read and understand the enclosed Patient Disclosure Statement and am aware of my rights as a mental health client **at I Choose Change** including HIPAA privacy policies.

_____ 2. I give consent to **I Choose Change** to perform necessary procedures to diagnose, treat and care for the mental health needs for my child or me.

_____ 3. I understand that all receipts will be emailed to the address above, but I can request a paper copy anytime.

_____ 4. I understand that **I Choose Change** is an out-of-network provider who will assist in submitting my insurance paperwork if requested.

_____ 5. I am aware of session fees and agree to pay session fees in full at the time of my appointment.

_____ _____

Printed Client Name Date

_____ _____

Signed Client Name Date
(Or Guardian if under 18)

SERVICE	TIME	THERAPIST	FEE
Individual, Couples, Family Counseling	45-60 minutes	Licensed Counselors / Therapists	Standard fee: $135 (Please notify counselor of hardship)
Individual, Couples, Family Counseling	45-60 minutes	Counselor Intern	$70
Telephone, Video or Chat	45-60 hour	All Therapists	Same as above
Email Counseling	15-minute increments	All Therapists	$20 per 15-minutes
Group Counseling	Varies by group	All Therapists	Varies by group
Phone Consultations	As needed	All Therapists	Prorated accordingly
Report Writing	1 hour	All Therapists	$165
Legal Fees	1 hour	All Therapists	$200

PAYMENT INFORMATION:

How you be paying for your sessions? (Circle one) Cash - Check - Visa - MasterCard - AMEX - Discover

If paying by credit card, please fill out the following. Your card will be kept on file and run on the day of your session in most cases.

Name on card: _____

Card number: _____

CVV Code: _____ Expiration Date: _____

Signature: _____

CANCELLATIONS:

24-hour notice is required for all cancellations. *If there is no notification of cancellation by phone (214-548-1318) in the 24-hour time frame, you will be billed for your session as normal.* This is to allow for those waiting for an appointment to have the opportunity to schedule an appointment. Your credit card will be billed automatically for phone consultations if another form of payment is not established at the time of service. By signing below, you agree to the terms listed and are aware of required fees for services.

_____ _____

Responsible Party Printed Name Responsible Party Signature