

# Family Counseling of Springfield



## Client Intake Information: Child

**Child's Name:** \_\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Date: \_\_\_\_\_

Birth date: \_\_/\_\_/\_\_ Age: \_\_\_\_ Adopted: Yes/No Country: \_\_\_\_\_ Placement age: \_\_\_\_\_

School Name \_\_\_\_\_ Grade \_\_\_\_\_ Counselor \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ p **IEP**---Yes /No p **504 Plan**---Yes /No p **OHI**---Yes /No

**Area of Disability:** p Emotional p Physical p Learning p Processing Problems: (please list)

If parents are **separated or divorced**, who has **legal** custody? \_\_\_\_\_

**Physical** custody arrangements: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ DOB: \_\_\_\_\_ Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address \_\_\_\_\_@\_\_\_\_\_

Phone: Home: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Mother's employer: \_\_\_\_\_ Position: \_\_\_\_\_ For how long? \_\_\_\_\_

Education: \_\_\_\_\_ Work days and hours: \_\_\_\_\_

Names and ages of all individuals in mother's home: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ DOB: \_\_\_\_\_ Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address \_\_\_\_\_@\_\_\_\_\_

Phone: Home: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Father's employer: \_\_\_\_\_ Position: \_\_\_\_\_ For how long? \_\_\_\_\_

Education: \_\_\_\_\_ Work days and hours: \_\_\_\_\_

Names and ages of all individuals in father's home: \_\_\_\_\_

Has your child been involved with the legal system? Yes / No Charge: \_\_\_\_\_

If yes, name of Probation Officer \_\_\_\_\_ Phone number \_\_\_\_\_

Suspended or expelled from school? Yes/ No Reason: \_\_\_\_\_

**Why are you seeking counseling for your child at this time?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If the client is younger than 18, parent or legal guardian please sign below**

I hereby consent for Family Counseling of Springfield Counseling Services, Inc., to provide diagnosis, treatment and evaluation to \_\_\_\_\_.

(Name of Child)

\_\_\_\_\_  
Signature of parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent

\_\_\_\_\_  
Date

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Insurance Information**

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Policy Holder's SSN: \_\_\_\_\_ Relationship to Client \_\_\_\_\_  
 Deductible: \$ \_\_\_\_\_ Has it been met? \_\_\_\_\_  
 Copayment (amount *not* covered by your insurance for each visit): \$ \_\_\_\_\_  
 Who will pay noninsured balance? \_\_\_\_\_  
 If you are required to get preauthorization, have you done so? \_\_\_\_\_ # visits authorized: \_\_\_\_\_

**Additional Insurance**

**Spouse's Insurance** (if any): Name of Plan: \_\_\_\_\_  
 Spouse's DOB: \_\_\_\_\_ Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_  
**Other Insurance Type:** \_\_\_\_\_  
 Deductible: \$ \_\_\_\_\_ Has it been met? \_\_\_\_\_  
 Copayment (amount *not* covered by your insurance for each visit): \$ \_\_\_\_\_

**All clients using health insurance please sign below; parent must sign if client is under 18**

I hereby grant authorization to Family Counseling of Springfield, to release any Protected Health Information that is necessary for billing (except Psychotherapy Notes) to my insurance company, or to process my claim for payment of services. I authorize my insurance company to send payment directly to Family Counseling of Springfield for all services provided. I agree that a photocopy of this authorization shall be as valid as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Phone number \_\_\_\_\_  
 Date of child's most recent physical examination: \_\_\_\_\_ List any allergies: \_\_\_\_\_

List all current medications and dosages including vitamins and supplements:

Name of Medication	Dosage	Prescribing Doctor	Approximate date prescribed

List all current or past health problems, and any major operations:

Health Problem or Surgery	Date	Currently a problem ?	Doctor seen

List all therapists your child has seen, and dates you saw them:

Therapist and location	Dates Seen

List any traumas your child may have experienced (accidents, loss of loved one, moves, etc. and the dates:

Event	Date

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate if your child is currently, or have in the past, experienced any of the following:

Problem	Current	Past Year	More than 1 year ago	Problem	Current	Past Year	More than 1 year ago
<b>Depression</b>				<b>Anxiety</b>			
Shortness of breath				Avoid Public Places			
Chronic Sadness				Trembling/Shaking			
Low frustration level				Agitation			
Crying Episodes				Fear of Dying			
Irritability				Panic Attacks			
Hopelessness				Chest Pain			
Thoughts of Suicide				Fearfulness			
Difficulty concentrating				Avoid social situations			
Withdrawing from Others				Fear of leaving home			
Weight Loss				Restlessness			
Difficulty functioning at work				Fear of loss of Control			
Weight gain				Excessive Worry			
Difficulty functioning socially				<b>Attention</b>			
Loss of appetite				Difficulty Waiting			
Low energy/fatigue				Don't finish what you start			
Over eating				Racing thoughts			
Reduced interest/pleasure				Constantly moving/pacing			
Nausea/Vomiting				Taking on too much at once			
Feelings of worthlessness/guilt				Difficulty starting a new task			
Difficulty making decisions				Difficulty concentrating			
No interest in daily activities				Difficulty Organizing			
Recurring thoughts of death or dying				Impulsive			
Sleeping too little/too much				Forgetfulness			
Extreme lows/highs				Difficulty following Directions			
Pounding heart/palpitations				<b>Substance Abuse</b>			
Difficulty Falling Asleep				Substance use causing problems with friends/family/work			
<b>Eating Problems</b>				Health problems/accidents due to substance use			
Worry about being underweight				Others think I have a substance problem			
Worry about being overweight				Adult child of an alcoholic parent			
Self-induced vomiting				Excessive use of alcohol/drugs			
Laxative use				Fail at effort to reduce use of alcohol/drugs			
Extreme exercising				Use of substances to cope with problems			
Obsessed with food				Legal problems related to substance use			
Obsessed with weight				Cigarette use causing health problems			

## Family Counseling of Springfield Practice Policies

This form has three purposes. First, it tells you about our procedures and policies concerning important aspects of your child's psychotherapy. Please let your therapist know if you have concerns about any of these policies. Your first visit will help us get a general understanding of your child's situation in order to determine how we might best help him or her. Because we want you to understand the counseling or play therapy process, please don't hesitate to ask questions.

Psychotherapy is a way of talking through problems in order to begin resolving them. Your child will need to take an active part in psychotherapy by working on and thinking about the things he or she would like to change. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and feeling much less distressed. However, there are no guarantees of what your child will experience, and at times a psychotherapy session may leave your child with unhappy feelings.

Second, this form is an Agreement between you and Family Counseling of Springfield. You may revoke (cancel) this Agreement in writing at any time. That revocation will be binding on Family Counseling of Springfield unless we have already relied on this Agreement to take action, *or* if your health insurer requires Family Counseling of Springfield to send information needed in order to process claims made for our services, *or* if you have not paid your bill in full.

Finally, this form also contains information a new federal law that affects your privacy rights. This law, called HIPAA (Health Insurance Portability and Accountability Act) regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices (the Notice). The Notice, which is attached to this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Please take home the Notice and read it before your next session; I will be happy to discuss any questions you may have about it next time.

### APPOINTMENTS

Individual and family sessions last 45-50 minutes and can be scheduled through the secretary or your therapist. *If you cancel an appointment, notify us at least 48 hours before the session, or you will be charged \$50 for the time you reserved for the appointment. Insurance does not pay charges for reserved time; you will personally be responsible for any such charges.* However, if you call in advance to cancel an appointment because you are ill, there will be no charge.

### FEES, HEALTH INSURANCE, AND MANAGED CARE

This packet contains a separate page to clarify fee arrangements. Your therapist will answer any questions about payment arrangements. For problems involving payments and insurance please call our benefits coordinator Susan, Monday through Friday between 10 am and 6 pm. If an account is overdue and no provision for payment has been made, we may turn the account over to a collection agency or lawyer, as authorized by state or federal law, and your failure to pay Family Counseling of Springfield will show up on your credit history.

Most group health insurance plans cover *part* of our fee. Insurance claims require a diagnosis, which your therapist will discuss with you if you ask. There may be two kinds of noninsured costs to you: (1) a deductible, which is an amount you must pay before your insurance coverage begins to pay; and (2) a copayment, which is a portion of the fee for each visit that you must pay yourself. Please pay any deductible and copayment at the time of each visit. Family Counseling of Springfield has contracted with some insurance companies to accept less than our standard fee as payment in full. If this is the case, your account balance will be adjusted when we receive payment from the insurance company. However, if the insurance pays less than 100% of the contracted fee, you will owe the balance of the fee up to 100% of the contracted fee.

Many insurance plans are managed care plans. Under a managed care plan, the insurance company periodically requires the therapist to submit your diagnosis, progress, and treatment plan to their reviewer, who then determines if further treatment is medically necessary. We want you to know that if you have a managed care insurance plan, this information will be released to the reviewers.

### TELEPHONE CALLS

Please try to make any telephone calls to your therapist during normal business hours, Monday through Friday, 9-5. Lengthy telephone consultations may be billed at our standard hourly rate for professional service and are not reimbursable by insurance. ***In emergencies, you may contact Joan at 703-447-4007. (An emergency is generally a situation in which your child is in danger of hurting yourself or someone else). If the emergency is serious and you cannot wait until your therapist returns the call, please call 911 or the 24- hour mental health emergency number at 703-573-5679, or go to the nearest hospital emergency room.***

### CONFIDENTIALITY AND FILES

The laws governing confidentiality can be quite complex. The attached Notice explains some specific Patient Rights that you have under the HIPAA law. We will maintain a Clinical Record file on your case, which is the property of Family Counseling of Springfield. You may examine and/or receive a copy of your file *if* you request it in writing *and* the request is signed by you *and* dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials. In most situations, Family Counseling of Springfield can release information about your treatment to others *only* if you sign a written authorization form for each release. However, in other situations, Family Counseling of Springfield needs only written, advance consent to release information.

**Your signature on this agreement is written, advance consent for the following releases of information:**

- I participate in group supervision with other mental health professionals; if we discuss your case, it is done without revealing your identity. The other professionals are also legally bound to keep the information confidential and I will note all consultations in your Clinical Record. Please let me know if you would prefer that other clinical staff *not* be consulted about your case. I also employ secretarial staff. In most cases, your therapist needs to share information with them for purposes such as billing, scheduling, and quality assurance. All of our staff are bound by the same rules of confidentiality, and all secretarial staff have training in privacy rules and have agreed not to release any information outside of the practice without permission of a professional staff member.
- I may find it helpful to share information with your primary care physician or other health and mental health professionals who are currently treating you. When working with children and adolescents, I am often asked to share information with the school in order to help them provide appropriate education and accommodations for your child. If we determine it would be helpful I will ask you to complete and sign a "Permission to Exchange Information" form, listing the individuals and/or organizations with whom I may exchange information. You may rescind this permission at any time. A record of these disclosures will be kept in your Clinical Record.
- Family Counseling of Springfield uses a benefits coordinator who will help determine your insurance benefits. As required by HIPAA, she promises to maintain the confidentiality of protected health information except as required to file your insurance claims.

**There are some situations where Family Counseling of Springfield is permitted or required to use or disclose information *without* either your consent or authorization:**

- If a client is clearly likely to seriously harm him/herself, we may be required to take action to prevent self-harm.
- If there is a clear risk that a client plans to seriously harm another person, we may have a duty to warn the potential victim and/or disclose the risk to appropriate public authorities.
- If a therapist suspects that abuse of a child or senior citizen may have taken place, the therapist is required to report the suspected abuse to the Department of Child or Adult Protective Services.
- If the client is a minor, both parents have access to the minor client's complete Clinical Record, excluding Psychotherapy Notes, unless there is a court order prohibiting one of the parents from access. In the case of adolescents I will ask that you sign a form giving the right to confidentiality to the adolescent.
- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the therapist/client privilege law. Family Counseling of Springfield cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders Family Counseling of Springfield to disclose information, I am required to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency (such as Medicare) is requesting the information for health oversight activities, Family Counseling of Springfield may be required to provide it for them.
- If a client files a complaint or lawsuit against Family Counseling of Springfield or any of its staff, Family Counseling of Springfield may disclose relevant information regarding that patient in order to defend itself.
- If a client files a worker's compensation claim, the client must sign an authorization so that Family Counseling of Springfield may release the information, records or reports relevant to the claim.
- Family Counseling of Springfield staff may present disguised case material in seminars, classes, or scientific writings; in this situation, all identifying information and Protected Health Information is removed, and client confidentiality and anonymity is maintained.
- Your health insurance plan has the right to review your Clinical Records for any services you have asked them to pay for. Unless your treatment is being paid for by a Workers Compensation plan, a health insurance company is *not* entitled to see Psychotherapy Notes, which are detailed notes your therapist may make concerning what you have talked about in therapy. However, they *are* entitled to see other Protected Health Information in your clinical record, including information about dates of therapy, symptoms, your diagnosis, your overall progress towards those goals, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES DESCRIBED ABOVE.**

\_\_\_\_\_  
Client or responsible party                      Witness                      Date

## Family Counseling of Springfield Counseling Services Fee Agreement

1. **FEE:** The fee for an initial consultation is \$125.00. After that, your fee will be \$100.00 per 45-50 minute session. Although health insurance may aid in payment, you are responsible for paying for all services and appointments at Family Counseling of Springfield. ***If you cancel or do not keep an appointment without giving forty-eight hours' advance notice, you must pay for the time you have reserved.*** Insurance companies do not pay for canceled appointments. If you are ill and call in advance to cancel your appointment, there will be no charge. *Please initial here \_\_\_\_\_*

Psychological testing, report writing, hospital visits, consultation with other professionals, home visits, telephone counseling, school meetings and any court-related services (such as consultations with lawyers, depositions, or attendance at courtroom proceedings) are **not** covered by insurance. My fee for **these services is \$130 per hour**, including travel time to other locations. These services may require payment in advance. Please inform me in advance if you anticipate that you will require my services in a court or school proceeding. *Please initial here \_\_\_\_\_*

If Family Counseling of Springfield has contracted with your insurance company to accept a lower fee, your deductible and any noninsured portion of each session's fee will be based on that contracted amount. If the insurance company decides to increase the fee that Family Counseling of Springfield is allowed to charge, your deductible and any noninsured portion of each session's fee will be based on the increased amount. Sometimes managed care companies will authorize more sessions than your insurance benefits will pay for. If you see your therapist for visits *that are authorized* but not paid for by your insurance benefits, by signing this form you agree to pay Family Counseling of Springfield's fee, as listed above, for each authorized visit that is not covered by your insurance benefits.

**If your insurance company requires you to get authorization from them before seeing a therapist and you do not do so, you are responsible for payment in full of the fees listed above.**

### 2. **PAYMENT ARRANGEMENT:**

All accounts are payable in full within 30 days after billing. Overdue accounts may be charged interest at the rate of 10% per year.

\_\_\_\_\_ STANDARD PAYMENT ARRANGEMENT: Payment for any deductible or noninsured portion of your fee is due at the time of each session.

\_\_\_\_\_ ALTERNATIVE PAYMENT ARRANGEMENT: \_\_\_\_\_

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3. **COLLECTIONS PROCEDURES:** Family Counseling of Springfield Counseling Services, Inc., reserves the right to collect any unpaid balance due to them. If a client is not making regular monthly payments on the account balance, Family Counseling of Springfield may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections action will become a part of your credit record. Clients will be notified in writing before Family Counseling of Springfield takes action to collect.

4. **LIMIT ON UNPAID BALANCE:** Family Counseling of Springfield may terminate treatment and refer the client elsewhere for continued care if the unpaid balance exceeds \$300.00.

***I have read and understood the above fee agreement, and I agree to abide by its terms.***

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date