**I look forward to working with you!**

**This information is confidential.**

**Please submit this document at least 48 hours before your appointment**

**Child Intake Form**

Child’s Name

Birth Date:

Today’s Date:

Behavioral Excesses

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:

What does your child do that you like? What does he/she do that other people like?

Others Concerns:

Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Family History:

The name of the child's biological parents:

Mother: Father:

Who has legal guardianship of your child?

Who are other household members with your child?

Names Ages Relationship to child

Who are your child's significant others NOT living with your child?

Names Ages Relationship to child

Please describe any past counseling that either your child or any family member

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? \_\_\_\_\_\_\_\_\_ if yes, please describe:

Education History:

What school does your child attend?

Address:

Phone: Teacher’s Name:

Current Grade:

What does your child's teacher say about him/her?

Other schools attended (including pre-school):

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School? Please click inside box

[ ] Fighting [ ] Lack of friends [ ] Drug/Alcohol [ ] Detention

[ ] Suspension [ ] Learning Disabilities [ ] Poor attendance [ ] Poor grades

[ ] Gang influence [ ] Incomplete homework [ ] Behavior problems

**Medical History**:

What is the name of your child's primary care physician?

Address:

Phone:

Date of your child's last medical examination:

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems? Please click inside box

[ ] A serious accident [ ] Hospitalization [ ] Surgery [ ] Asthma

[ ] A head injury [ ] High fever [ ] Convulsions/seizures

[ ] Eye/ear problems [ ] Meningitis [ ] Hearing problems

[ ] Allergies [ ] Loss of consciousness [ ] Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?

If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her

family?

**\*All parents/families of adolescent clients are at liberty to sit on individual therapy sessions, in fact we encourage it!! In order to help your child, a family should work together.**

**Telehealth Clients**

So that I as your clinician can get you help in case of an emergency and for your safety, the following are

important and necessary. In addition, by signing this agreement form you are acknowledging that you

understand and agree to the following:

• You, the client will inform your clinician of the location in which you will be consistently during your sessions, and you will inform him/ if this location changes.

• You, the client, will identify on your client intake form a person whom your clinician can contact in the case that he/she believes you are at risk.

• Depending on the assessment of risk, you, the client, or your clinician may be required to verify that your emergency contact person is able and willing to go to your location in the event of an emergency, and if your clinician deems necessary, call 911 and/or transport you to a hospital. In addition, your clinician may assess, and therefore require that you create a safe environment at your location during the entire time that you are in treatment. The definition of safe environment may differ for each client. Therefore, if your clinician assesses the need for a safe environment, the specifics will be discussed and made clear by your clinician at that time.

**BACK-UP PLAN IN CASE OF TECHNOLOGY FAILURE**

The most reliable backup is a phone. Therefore, it is recommended that you always have a phone available and that your clinician knows your phone number. If you get disconnected from a video conference, end and restart the session. If you are unable to reconnect within five minutes, call me at

215-703-8573. If I do not hear from you within five minutes, you agree (unless you request otherwise) that I can contact you on your phone number of record provided on your patient questionnaire. If we are unable to connect via the phone, the clinician will send you a message via email.

**Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal
2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made, they will be disclosed to you or your legal representative unless disclosure increases risk of further
3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.
4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site.
5. You may request corrections to your records.
6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.
7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.
8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions, but information gathered while required by law or in an emergency. We may also revoke such restrictions, but information gathered while the restriction was in place will remain restricted by such an agreement.
9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.
10. This agreement may be modified or amended as required by law or during health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

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

Individual or Legal Representative (please print and initial) Date

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

Signature of Individual or Legal Representative Date

**No Show, Late Cancellation and Policy**

1. I understand that therapy sessions with SHI Mental Health Counseling, LLC is $80.00 per session.

2. I understand that payment can be due prior to the beginning of the session or within 60 minutes of the conclusion of the session.

3.I understand that I will be charged a LATE CANCELLATION fee of $25 if I fail to give at least 24-hour notice prior to cancelling my appointment.

4. I understand that I will be charged a full session fee of $80 if I fail to show for my appointment.

5. I understand that I will be charged a $10 service charge if I fail to make my payment at the time of my appointment.

6. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

7. I understand that the therapy session will last 53 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

Please initial

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

Date

**Credit/ Debit Card Payment Consent Form**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name on Card if different than client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize SHI Mental Health Counseling, LLC to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Atiya W. Pope, MA CMHC will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials: \_\_\_\_\_\_\_

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