



Informed Consent Child/Adolescent

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and your counselor to work most effectively together, we ask that you carefully read the information below. If you have any questions, your counselor will be happy to discuss them with you.

East-West Psychotherapy exists to provide counseling from a Christian perspective for individuals, couples, families, and groups. The Center's services are available to residents of the community regardless of religious affiliation.

_____ (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. An explanation of those rights is attached to this document.

Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of child abuse or threats of physical harm to self or others or subpoena of a court. If your clinician is unlicensed, communications with your counselor are not protected by privilege which means that they may be subject to subpoena by the courts should litigation be brought against you. If you believe that you may need the testimony of a counselor in a court of law, a licensed mental health professional would be an appropriate choice.

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) **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. Should the fee not be paid for two sessions, no further sessions will be scheduled until the balance is paid. ***A charge of \$25.00 will be made for returned checks plus the amount of the unpaid session.***

_____ (initial) **INSURANCE:**

Our individual counselors participate in a variety of payment forms. Please discuss your method of payment with your counselor.

_____ (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. ***A charge of \$75.00 will be made 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 50-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 East-West Psychotherapy Associates, 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.*



The Health Insurance Portability and Accountability Act (HIPAA) 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 HIPAA 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 HIPAA 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, East-West Psychotherapy is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

East-West Psychotherapy Associates
HIPAA Compliance Officer

Patient Name (print) _____

I have received a copy of the East-West Psychotherapy Associates 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

Patient Signature if patient is a Minor

Date

Guardian Signature if patient is Legal Charge

Date

To be completed by parent or guardian requesting services for a minor child. This information will help your counselor understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Georgia Law.



BACKGROUND INFORMATION:

Child's Name: _____ Date of Birth: _____ Age: _____

Child's Address: _____

Street

City _____ State _____ Zip Code _____ Home Phone: _____

Child lives with: Both biological parents _____ Mother _____ Father _____ Mother & Stepfather _____

Father & Stepmother _____ Other (specify): _____

If parents are divorced, describe custody arrangements: _____

INFORMATION ABOUT CHILD'S MOTHER:

Mother's Name: _____ Age: _____ Race: _____

Employer: _____ Occupation: _____ Hrs/wk: _____

Employer's Address: _____

Can you be contacted at work by phone? Yes _____ No _____ Work Phone: _____ Ext. _____

Religious Denomination: _____ Church: _____

Member? Yes _____ No _____ Active? Yes _____ No _____

Describe any physical problems you have that require medication or physical care: _____

Are you currently receiving medical treatment? Yes _____ No _____ Physician: _____

Medication(s) currently using: _____

Previous Counseling/Therapy? Yes _____ No _____ If yes, when? _____

With whom and for how long? _____

INFORMATION ABOUT CHILD'S FATHER:

Father's Name: _____ Age: _____ Race: _____

Employer: _____ Occupation: _____ Hrs/wk: _____

Employer's Address: _____

Can you be contacted at work by phone? Yes _____ No _____ Work Phone: _____ Ext. _____



Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. (You may add written comments after areas checked.)

0		1		2		3		4		5		6		7		8		9		10									
No Concern										Moderate Concern										Extreme Concern									
_____ Anger/Temper										_____ Talks of Suicide																			
_____ Depression										_____ Unhappy Most of the Time																			
_____ Divorce/Separation of Parents										_____ Use of Alcohol																			
_____ Adjustment to Parent's Remarriage										_____ Use of Other Drugs																			
_____ School Performance										_____ Work																			
_____ Family Problems										_____ Worry																			
_____ Fearfulness										_____ Self-esteem																			
_____ Physical Problems										_____ Poor Appetite																			
_____ Problems with Social Relationships										_____ Overeating																			
_____ Problems Sleeping										_____ Bedwetting																			
_____ Sexual Concerns										_____ Soiling																			
_____ Religious/Spiritual Concerns										_____ Cruelty to Animals																			
_____ Nightmares										_____ Other (specify): _____																			

Have there been any previous psychological, psychiatric, neurological, or E.E.G. evaluations? Yes _____ No _____

If yes, please list names, addresses, and dates of contact: _____

Has child had previous counseling? Yes _____ No _____ If yes, list names(s) of counselor(s), addresses, and dates of contact(s): _____

Reason for contact: _____



MEDICAL HISTORY:

Where her any complications surrounding the child's birth? Yes _____ No _____ If yes, 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:

List current medical problems: _____

Is child currently taking any prescription drugs? Yes _____ No _____ If yes, please list: _____

When did your child last have a physical examination? _____

Name of Physician: _____ Address: _____

How is the child's vision? _____ Hearing? _____

ACADEMIC/SCHOOL INFORMATION:

Name of school: _____ Grade: _____ Teacher: _____

List previous schools attended with dates: _____

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

How does your child get along at school? _____

Describe difficulties in learning at school: _____

Have other family members have learning difficulties? _____



Describe what your child likes to do for fun, special interests, hobbies, etc. _____

Describe your child's religious background (religious denomination is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.): _____

Anything else you think would be important for the counselor to know: _____

I have read the East-West Psychotherapy Information Sheet and voluntarily request counseling services for my minor child at East-West Psychotherapy in accord with terms described on the information sheet.

Custodial Parent/Guardian: _____ Date: _____



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 fell 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