East-West PSYCHOTHERAPY

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 you 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, 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.*

East-West PSYCHOTHERAPY

Child/Adolescent Intake Form

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, 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
HIPAA Compliance Officer

Patient Name (print) _____

I have received a copy of the East-West Psychotherapy 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

_____ Home Phone: _____
City State Zip Code

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. _____

INFORMATION ABOUT CHILD'S FATHER (CONTINUED):

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? _____

FAMILY MEMBERS:

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:

Name	Relationship to Child	Age	Highest School Grade Completed	Occupation

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

_____ Depression

_____ Divorce/Separation of Parents

_____ Adjustment to Parent's Remarriage

_____ School Performance

_____ Family Problems

_____ Fearfulness

_____ Physical Problems

_____ Problems with Social Relationships

_____ Problems Sleeping

_____ Sexual Concerns

_____ Religious/Spiritual Concerns

_____ Nightmares

_____ Talks of Suicide

_____ Unhappy Most of the Time

_____ Use of Alcohol

_____ Use of Other Drugs

_____ Work

_____ Worry

_____ Self-esteem

_____ Poor Appetite

_____ Overeating

_____ Bedwetting

_____ Soiling

_____ Cruelty to Animals

_____ 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