ASSOCIATED COUNSELING PROFESSIONALS

2255 South 132nd Street, Suite 200
Omaha, NE 68144
Telephone: (402) 334-1122 Fax: (402) 334-8171

CHILD AND ADOLESCENT INTAKE FORM

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

BACKGROUND INFORMATION

Child's Name: _____ Date of Birth____/____/____ Age_____

Child Lives With (check one): Both Biological Parents _____ Mother _____ Father _____ Other _____

If parents are divorced, describe custody arrangements: _____

_____

Child's Address: _____City:_____State:_____Zip:_____

Emergency Contact (other than parent): _____ Telephone Number____-____-_____

Custodial Parent's Contact Information:

Telephone_____
(Home) (Cell) (Work) (E-Mail)

Circle the best way to contact you for appointment reminders: Home Work E-mail Cell Don't contact

May we leave a message? Yes No

INFORMATION ABOUT CHILD'S MOTHER

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

(Address, if different from child) _____

Employer: _____ Occupation: _____ Hours/week: _____

Can you be contacted at work by telephone? Yes____ No____

Circle the best way to contact you: Telephone - _____ _____ _____ _____
(Home) (Cell) (Work) (E-Mail Address)

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, with whom? _____

How long?_____

INFORMATION ABOUT CHILD'S FATHER

Father's Name: _____ Age: _____ Race: _____
(Address, if different from child) _____

Employer: _____ Occupation: _____ Hours/week: _____

Can you be contacted at work by telephone? Yes _____ No _____

Circle the best way to contact you: Telephone - _____ _____ _____ _____
(Home) (Cell) (Work) (E-Mail Address)

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, with whom? _____

How long? _____

PLEASE PROVIDE A COPY OF YOUR DIVORCE DECREE TO YOUR THERAPIST, IF APPLICABLE

FAMILY MEMBERS

List all people now living in the household:

Name	Relationship to Child	Age	School Grade Completed	Occupation

DESCRIBE THE ISSUE the child is having. If possible, list question for which answers are sought:

_____

_____

_____

Check What Applies:

_____ Anger
_____ Depression
_____ School Problems
_____ Family problems
_____ Fearfulness
_____ Marital problems
_____ Physical problems
_____ Problems with social relationships
_____ Problems with children
Other _____

_____ Religious/Spiritual Concerns
_____ Sexual concerns
_____ Thoughts of suicide
_____ Trouble making decisions
_____ Unhappy most of the time
_____ Use of alcohol
_____ Use of drugs
_____ Work
_____ Worry
_____ Legal Issues
_____ Withdrawn or Isolated

CHILD'S MEDICAL HISTORY

List child's sicknesses, operations and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever or was delirious; difficult pregnancy or delivery:

_____

_____

List any medications your child is on - _____

Have there been any previous psychological, psychiatric, neurological or EEG evaluations? Yes _____ No _____

If so, please list names and dates of contact: _____

Describe previous speech or hearing therapy, if any: _____

What is the date of your child's last physical examination? ____/____/_____ Physician's Name_____

ACADEMIC/SCHOOL INFORMATION

School Name: _____ Grade: _____ Teacher: _____

How many previous schools attended, with dates: _____

_____

Has child ever repeated a grade? Yes _____ No _____ If so, when? _____

How does your child get along with peers and authorities at school? _____

Describe difficulties in learning at school: _____

_____

Please provide copies of all special testing(s) he/she has needed for educational or psychological purposes.

Have other family members had learning difficulties? Yes _____ No _____ What? _____

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

_____

_____

_____

Optional: Describe your child's religious background (denomination, church membership, attendance, spiritual training, bible reading, prayer, etc.):

_____

_____

I learned about Associated Counseling Professionals from: (Yellow Pages, Internet, friend, doctor, etc. If you could provide the name, address and telephone number, if known):

_____

_____

May we send a thank you note to this person? Yes _____ No _____

Your Signature: _____ Date_____/_____/_____

INSURANCE INFORMATION:

Insured's Name: _____ Social Security Number: _____

Address of Insured: _____

City State Zip Code

Telephone Number(s): _____ _____

Home Cell Work Insured's Date of Birth

Employer: _____

INSURANCE POLICY INFORMATION – Please give your insurance card to the support staff to photocopy. *Office Insurance Policy:* We will file your insurance, when possible, if we cannot file your insurance, we will give you the forms you need to file it. If we are unable to determine your benefits prior to your first visit, we require payment for the first visit in full.

Primary Insurance Company Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number to Verify Benefits: _____ Plan Name: _____

Identification Number/Social Security Number: _____ Policy/Group Number: _____

Champus Status (military): _____ Active _____ Retired _____ Deceased

I hereby assign all benefits otherwise payable to me to Associated Counseling Professionals, as payment towards the charges incurred for services rendered. I further instruct the insurance company named above to issue a check directly to Associated Counseling Professionals. I also authorize Associated Counseling Professionals to release any information pertinent to services rendered to any authorized representative of my insurance company, adjuster or review agency.

SIGNED BY: DATE:

X_____ X _____

BILLING INFORMATION:

If another individual or agency is responsible for payment, please complete the information below –

Responsible Party Name: _____ **Relationship to Client:** _____

Social Security Number: _____

Address: _____ _____

City State Zip Code

Home Phone Number: _____ **Work Phone Number:** _____ **Cell Phone Number:** _____

Employer: _____ **Percentage of Bill Responsible For:** _____

Please sign here if you read and understood ACP's "After-Hours Emergency Service" found in the Welcome Brochure –

_____ _____

Signature of Client **Date**

Referred By/How Did you Hear About Us? (Check One)

_____ *I am a former client returning*
_____ *Insurance Company/Managed Care*
_____ *Dex Yellow Pages*
_____ *Yellow Book*
_____ *Other* _____

_____ *Relative*
_____ *Minister/Priest/Rabbi*
_____ *US West (under hypnosis)*
_____ *Physician: Dr.* _____

_____ *Friend*
_____ *School*
_____ *Internet*
_____ *EAP*

****

FOR OFFICE USE ONLY:

Benefits –

EAP: _____

# of Sessions: _____

Self Pay: $_____

MANAGED CARE: _____

Deductible: $_____

Co-pay: $_____

Number of Sessions: _____**/Year**

Authorization Needed: _____ **Yes** _____ **No**

****

THERAPIST: _____ **DSM CODE:** _____ **ACCOUNT #:** _____

****

Consent to Treatment

For us to consider providing services to you, you must ***read and sign*** this consent form. This *is not* a contract. It just allows us to see you. You may withdraw this consent to treatment at any time and ask that your file be closed. You should also know that this is not an agreement by Associated Counseling Professionals to provide services to you. You may wish to talk with your therapist about your consent to treatment during the intake session. He or she will answer your questions.

Understanding Psychotherapy. Psychotherapy services are designed to help you change. Sometimes this kind of change is difficult because it raises feelings, thoughts and worries that you try to keep inside. The benefits may include improved behavior, relationships and mood. You may learn to communicate better with those around you. You should know that this is not a precise science. In many cases we are successful in helping people to change. In some cases we are not. Associated Counseling Professionals cannot guarantee the success of any treatment.

Associated Counseling Professionals is owned by persons who utilize psychotherapy with clients. None of our professionals is a medical doctor and, thus, not able to prescribe medications.

Confidentiality. You should know that all services provided are *strictly confidential*. We cannot release any information about your case to anyone outside of Associated Counseling Professionals without your written consent. In order to help you, we do share information between staff at Associated Counseling Professionals. For example, your therapist may talk to a colleague in our organization in order to understand your case better.

Notice of Privacy Practices. By signing this Consent, you are giving us permission to use or disclose your protected health information to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example: quality improvement activities).

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that Notice before signing this Consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room and on our website. You may ask for a printed copy of our Notice at any time, or download it from our website.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment or health care operations. However, we do not have to agree to these restrictions., If we do agree to a restriction, that agreement is binding. You may revoke the Consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the Consent prior to the revocation. This Consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this Consent is not granted, or, if the Consent is later revoked.

Breaking Confidentiality. You should also know *that there are three exceptions to confidentiality.* By law all therapists must break confidentiality: (1) If a client is deemed to be at risk of hurting himself/herself or someone else in order to protect the client or the other person; (2) if we suspect that a child is being abused; and (3) if a court of law subpoenas (demands to see) the records. If this happens, we will attempt to invoke *privileged communication* (a legal protection of your right to therapeutic confidentiality) if you or your attorney asks us to do so. However, under some circumstances, the court can override privileged communication and order us to disclose these records.

Email or Fax Contact. At your discretion you may contact your therapist via email for the same purpose you would initiate telephone contact. However, for therapy you are advised against using unsolicited fax transmissions as they are not monitored as closely. Associated Counseling Professionals does not consider email contact to be therapy and does not bill it as such. It is instead considered administrative and supportive contact. By initiating email contact you are accepting this understanding and agreeing to act accordingly.

For evaluations, both emails and fax contact are acceptable but **are** considered part of the evaluation. By initiating this contact you are accepting this understanding and agreeing that the email may be used in your evaluation.

You are advised that email communication is protected by federal law, but should not be considered secure. It is possible that someone on the Internet might read your communication or our communication back to you. By initiating this sort of contact you are waiving this level of confidentiality unless you specify in your email a limitation of the expected response (i.e., "please don't reply"). Fax communication for evaluations is secure within our office and within the limits of electronic security in general (i.e., someone could be wiretapping telephone lines but this would also be a federal offense). If you are especially concerned about this issue, please discuss it with your therapist at your initial visit.

In Case of an Emergency. ***If you feel you are experiencing an emergency, please go to the nearest hospital or call 911 for help***.

_____ **(Client initial showing you understand the above statement regarding an emergency situation)**

_____ **(Therapist Initial)**

_____ _____ _____

Client or Legal Representative **(Printed Name)** Date of Birth Today's Date

_____

Client or Legal Representative **(Signature)**

_____ _____

Witness Today's Date