Great Changes
Counseling Services
9435 Bormet Dr. #5 Mokena, IL 60448
Phone: 708-995-7226 Fax: 708-995-7227

Child & Adolescent Intake Form (Ages 1-17)

Today's Date: _____ Therapist's Name: _____

Client First Name: _____ Middle: ____ Last: _____

Sex _____ Birth Date _____

Parent Names – Mother _____ Father _____

Parents – married Y N If No, divorce date_____ Custody info_____

Address: _____ City, State, Zip: _____

Phone: _____

Will you be using **Employee Assistance Program** benefits for your initial sessions? **Y N**

If yes - Name of EAP Program – Ceridian Lifeworks Employee Resource Systems (ERS)
Compsych Cigna EAP Aetna EAP UBH EAP Magellan EAP
Other _____

How many sessions have been approved for EAP Services _____

Whose EAP benefit is this _____ Relationship to Client _____

EMERGENCY CONTACT Name & Number _____

Primary Insurance Policy Information:

Copy of Insurance Card must accompany this form – Therapist can copy it for you at first session.

Insured's Name: _____Birth date: _____

Address: _____

City, State, Zip: _____

Employer: _____

Patient's Relationship to the Insured: Self _____ Spouse _____ Child _____ Other _____

I authorize the release of any medical or other information necessary to process this claim.
Signed: _____ Date: _____

I authorize payment of medical benefits to The Kennedy Center for Counseling for services provided.
Signed: _____ Date: _____

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Notice of Privacy Practices - Summary

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. Though these laws are complicated, we must provide you with this important information. These two pages summarize the Notice of Privacy Practices which you received along with this. You may refer to the complete document for more information. We realize that it is not possible to cover all scenarios in this document, so please consult our Privacy Officer, Owner Rita Sanders if you have further questions or concerns.

The health information we will obtain will be documented primarily from you, but may also include information obtained from other family members or professionals involved in your case that you have given us permission to speak with. This information will be used to provide you with effective treatment, to arrange payment for our services or for other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a form acknowledging that you have received this notice. If you are not willing to sign this form, we cannot treat you.

If information regarding your treatment here needs to be disclosed to others for family involvement or for coordination of treatment services we will discuss this with you and ask you to sign an Authorization to allow this.

We will keep all of your health information private. However, there are some situations where the law requires us to disclose information about you even without your signed consent, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

See the complete text of the NPP for the full list of mandated disclosure scenarios.

Your rights regarding your health information

1. You have the right to determine how we get in touch with you if we need to (for appointment changes or cancellations). Let us know if you prefer us to call your home or your cell and whether it is okay to leave a message.

2. You have the right to determine what information is shared with others involved in your treatment.

3. You have the right to review your record, and can request a copy of your record (medical and billing).

4. If you believe the information in your records is incorrect or incomplete, you can request that changes or amendments be made to them. This request must be made in writing, and must include reasons for the request.

5. You have the right to receive a copy of this notice. If our Privacy Practices are changed, we will post a notice in our waiting room and a copy can be requested.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Donna Welter at 708-995-7226.

The effective date of this notice is February 28, 2011.

Notice of Privacy Practices: Receipt and Acknowledgment of Notice

Patient/Client Name:_____**DOB**_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Great Changes Counseling Services Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Donna Welter at 708-995-7226

I also verify that I understand the following:

All the information in my sessions is confidential **EXCEPT:**
If I am threatening to hurt myself, if I am threatening to hurt someone else, or if I tell of a child or an elderly person being abused, then the therapist must tell someone to protect me or another.

Patient/Client Signature:_____**DOB**_____

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Statement of Client Financial Responsibility

Client Name_____ Birthdate_____

Fees for Professional Services

Great Changes charges the following usual and customary rates for behavorial health sessions in an office setting.
$175 per 50 minutes for a New Client Visit (Intake evaluation)
$125 for 50 minutes for each follow-up/ongoing treatment session with an individual client
$175 for 50 minutes for couple or family sessions with more than one person present

48 Hour cancellation fee: Clients must give 48 hours' notice when cancelling any appointments. If a client misses an appointment without notifying the therapist 48 hours prior to the appointment time, the client may be billed $100.00.

Financial Responsibility

Any client over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate reimbursement by them outside of our office. This policy includes pending divorce proceedings.

Insurance Coverage

Behavioral Health Services are almost always covered by your medical insurance policy. With your permission, Great Changes Counseling Services agrees to verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

It is important for you to be an informed consumer, who understands the specifications of your insurance policy. Your insurance policy is a contract between you and your Health Insurance Company. It is **your responsibility** to know if your insurance has specific rules or regulations such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not your provider is in-network with your insurance company.

Great Changes will submit claims to your insurance company for behavioral health services rendered. **You agree that you will pay any deductible, co-payment, or co-insurance as determined by your insurance plan. Those payments will be due at the time of service.** Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. **If problems arise regarding coverage issues, we will attempt to work with your insurance company to resolve them prior to making the balance your responsibility. You are nevertheless, ultimately responsible for payment of all balances.**

ACKNOWLEDGEMENT:

I have read and understand the financial policy above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

Client Signature_____Date:_____

Authorized Representative Signature (if client is a minor)_____

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Authorization To Use Credit Card

For your convenience, you may authorize Great Changes to charge your credit card for balances due on your account. I authorize Great Changes Counseling Services, P.C. to keep my signature on file and to charge my credit or debit or HSA card for:

___ Monthly balance of charges due.

___ Balance of charges not paid by insurance within 90 days and not to exceed $250.

___ Recurring charges of $ _____ weekly/monthly for required co-payments.

I understand that this form is valid only during the term of my treatment services at Great Changes, and that I can cancel the authorization through written notice to Great Changes at any time.

Name on Credit Card: _____Client Name: _____
Credit Cardholder Address: ____ same as client address on Intake Sheet
Different Address associate with Credit Card _____
_____Zip Code_____

Email Address – necessary for our credit card processing site & receipt _____

Credit Card Account Number: _____ - _____ - _____- _____
Card Expiration Date: ___/____/____ 3-digit Security Code: _____

Cardholder's Signature: _____

Date: _____

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CONSENT TO TREATMENT

I hereby authorize and voluntarily consent to all care, treatment, and other related services that may be ordered, requested, directed, or provided by Great Changes providers.

I understand and agree to the above provisions

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date

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Consent to release information to Primary Care Physician

Communication between your therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified.

_____ _____

Patient name Date of Birth

Please check one:

□ I agree to allow my Kennedy Center therapist to release mental health/substance abuse information to my Primary Care Physician.

□ I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name:

_____

Physician Address:

_____

City, State, Zip:

_____

Physician Phone: _____Fax: _____

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

Information for PCP

This patient was seen by me on (date) _____

for (diagnosis) _____

_____ _____

Provider Signature Date

_____

Provider Printed Name

Client's Name:_____ Birth Date:_____

Guardian Name:_____ Relationship to Client:_____

In your own words, tell us why you are seeking counseling at Great Changes:

_____
_____
_____
_____
_____
_____
_____
_____

What is/are your goals for counseling?

_____
_____
_____
_____
_____
_____
_____
_____

What have you tried that has helped your child?

_____
_____
_____
_____
_____
_____
_____
_____

Is there anything else you think the therapist should know?

_____
_____
_____
_____
_____
_____

Child Intake Symptom Check List

Please check all that apply

☐ Financial difficulties ☐ Legal Problems ☐ Depression ☐ Anxiety ☐ Problems Sleeping

☐ Voices in my head ☐ Suicidal thoughts ☐ Attempts ☐ Crying spells ☐ Hyperactivity

☐ Difficulty with relationships ☐ Loneliness ☐ Anger ☐ Loss of appetite ☐ Trauma or Abuse

☐ Weight gain ☐ Weight loss ☐ Eating disorder ☐ Self-abuse ☐ Mood Swings

☐ Memory loss ☐ Agitation ☐ Poor Concentration ☐ History of delayed development

☐ Difficulties at school ☐ Problems using or understanding nonverbal communication

☐ Difficulty with social interactions or situations ☐ Poor Impulse control ☐ Poor Grades

☐ School Refusal or truancy ☐ Bullying ☐ Victim of bullying ☐ Vandalism or stealing

☐ Sexting ☐ Viewing Pornography ☐ Gambling ☐ Cruelty to people or animals

☐ Fire-starting ☐ Nightmares ☐ Sibling Rivalry ☐ Picky eater ☐ Accident-Prone

☐ Problems separating from parents/family ☐ Perfectionism

Previous Mental Health Treatment

If your child has received mental health treatment/hospitalization in the past, please tell us:

Provider: _____ When Seen: _____ Helpful? Y N

Provider: _____ When Seen: _____ Helpful? Y N

Provider: _____ When Seen: _____ Helpful? Y N

Provider: _____ When Seen: _____ Helpful? Y N

Please list any mental health diagnosis given to your child in the past: _____
_____

Please list any mental health medications that your child has taken in the **past**:
_____
_____
_____
_____
_____

Please list all of your child's **current** medications (including herbs and over the counter medicines):

_____
_____
_____
_____
_____

Medical History

Medication Allergies:

_____

Food/Environment Allergies:

_____
_____
_____
_____

Please list any conditions that your child has been diagnosed with or take medications for:

_____
_____
_____
_____

Medical History Check List- Check all that apply

☐Hospitalizations ☐Surgeries ☐Prematurity ☐Asthma ☐Head Trauma

☐Heart murmurs ☐Heart palpitations ☐Fainting ☐Seizures

☐Use of tobacco, alcohol, recreational drugs, or pills (including one time use)

☐Sexual activity in the past 3 years ☐Birth control pill or injection

☐Other: _____

_____
_____

Birth & Developmental History

Were there complications during pregnancy? Y N
If so, what happened?_____

Was There tobacco, alcohol, drug, or toxin exposure during pregnancy? Y N
If so, what exposure occurred?_____

Were there any complications during delivery? Y N
If so what happened?_____

Birth Weight:_____ __Full term __Premature(___ weeks early) __Other

Did your child leave the hospital within 2-3 days of birth? Y N
If not, what was reason for delay?_____

Please tell us when your child:

Spoke his/her first word(s): _____ Began using 2-3 word phrases: _____
Began sitting unassisted: _____ Began walking: _____
Completed toilet training: _____

Has your child ever regressed or unexpectedly lost development milestones? Y N
If so, what skills were affected?_____

Does your child have any current problems with wetting or soiling him/herself? Y N
If so, please explain:_____

Social History

Child's Father: Living? Y N Date of Death:_____ Cause:_____

Age:_____ Occupation:_____ Education:_____

Relationship with child is: __Great __Good __Okay __Fair __Poor

Child's Mother: Living? Y N Date of Death:_____ Cause:_____

Age:_____ Occupation:_____ Education:_____

Relationship with child is: __Great __Good __Okay __Fair __Poor

Child's Parents Status: __Never married __Married __Separated since_____(year)

Divorced since_____(year)

Child's Siblings: (If additional room is needed for siblings, please use the back of this page)

Name:_____ Age:_____ Gender: M F

Relationship with child is: __Great __Good __Okay __Fair __Poor

Name:_____ Age:_____ Gender: M F

Relationship with child is: __Great __Good __Okay __Fair __Poor

Name:_____ Age:_____ Gender: M F

Relationship with child is: __Great __Good __Okay __Fair __Poor

Name:_____ Age:_____ Gender: M F

Relationship with child is: __Great __Good __Okay __Fair __Poor

Name:_____ Age:_____ Gender: M F

Relationship with child is: __Great __Good __Okay __Fair __Poor

Please tell us who lives in the home with your child: _____
_____

Alcohol & Drug Screen Questionnaire (child's use)

Child has never used alcohol, drugs OR tobacco_____ If checked, form is completed

1. Do you feel you are a normal drinker? ("normal" – drink as much or less than most other people) **YES NO**
2. Have you ever awakened the morning after some drinking the night before and found you could not remember a part of the evening? **YES NO**
3. Does any near relative or close friend ever worry or complain about your drinking? **YES NO**
4. Can you stop drinking without difficulty after one or two drinks? **YES NO**
5. Do you ever feel guilty about your drinking? **YES NO**
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)? **YES NO**
7. Have you ever gotten into physical fights when drinking? **YES NO**
8. Has drinking ever created problems between you and a near relative or close friend? **YES NO**
9. Has any family member or close friend gone to anyone for help about your drinking? **YES NO**
10. Have you ever lost friends because of your drinking? **YES NO**
11. Have you ever gotten into trouble at work because of drinking? **YES NO**
12. Have you ever lost a job because of drinking? **YES NO**
13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? **YES NO**
14. Do you drink before noon fairly often? **YES NO**
15. Have you ever been told you have liver trouble such as cirrhosis? **YES NO**
16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations? **YES NO**
17. Have you ever gone to anyone for help about your drinking? **YES NO**
18. Have you ever been hospitalized because of drinking? **YES NO**
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward? **YES NO**
20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was a part of the problem? **YES NO**
21. Have you been arrested more than once for driving under the influence of alcohol? **YES NO**

22. Have you ever been arrested, even for a few hours, because of other behavior while drinking? **YES NO**

If Yes, how many times_____

Alcohol & Drug Use

At what age did you have your first drink? _____ At what age did you first try a drug? _____

Current use: alcohol – frequency ____ daily ____ weekly ____monthly ____ none

amount each episode _____

drugs – frequency _____ daily ____weekly ____ monthly _____ none

drug of choice _____

Check any of the following that you have experimented with or used:

Valium or Xanax_____ Sleeping Pills_____ Marijuana _____ Cocaine _____

Hallucinogens (LSD, STP, PCP) _____ Opiates (heroin, morphine, Demerol) _____

Ecstasy _____ Inhalants _____ other drugs ____ Over the counter medications _____

Does the child/adolescent smoke cigarettes or cigars **Y N**

If yes, for how long _____

What have they tried to quit_____ When _____