

Welcome to Canton Counseling

Child/Adolescent Therapy Client Form

Welcome and thank you for choosing Canton Counseling. This document is designed to answer some frequently asked questions about myself, the counseling process, my professional relationship with your child and the caregiver(s), confidentiality and your financial obligation. As you read this document, feel free to mark any places which are not clear to you or with any question you would like to further discuss.

Counseling is designed to increase the coping skills of your child, and allow for healing and growth. Success cannot be guaranteed with counseling; however I am committed to utilizing a number of highly researched approaches to therapy. The nature of the counseling process is very personal. Therefore, we maintain a professional relationship consistent with accepted ethical standards. You are in complete control and may end our professional relationship at any time. I do not take on a client whom, in my professional opinion, I cannot help using the knowledge and techniques I have available. If necessary, I will make these referrals at our initial conversation on the telephone or in our initial meetings. In some cases it takes multiple meetings to assess one's needs or we may come to a point where I feel that I can no longer meet your child's needs. If I do not feel that your child will benefit from my services, I will refer you to others or agencies which would be better able to serve your child's individual needs.

Parents have the right to any and all information regarding your child. Because the presence of trust is important in the therapeutic relationship between your child and myself, it is generally best that we do not share specifics of individual sessions with you. However, you have the right and responsibility to question and understand the nature of your child's treatment and the progress being made. If your child is able to understand the issues of confidentiality, I will discuss with him/her the type of information that will be shared with you. If you have any objections to the manner in which information is shared with you regarding your child, we will need to address and resolve those concerns before therapy begins.

What to expect at the first appointment:

The initial meeting will be 60 minutes in length. There will be an initial "intake session" with the therapist and caregiver(s) only. The initial session is designed to obtain the family history, a history of the child's development, background, reason for referral, and concerns the caregiver may have. During the initial session, caregivers have the opportunity to ask questions, and become educated on the therapeutic process. At the end of the session, the counselor will provide recommendations. It will be helpful at that time for you and the therapist to discuss and decide on the options and recommendations you want to pursue. Sessions with your child will be with the therapist and the child only; however, there may be occasions where the therapist invites other family members to participate in counseling sessions. Counseling sessions with children 7 years and younger will be thirty minutes in duration. For children older than 7 years of age counseling sessions will be fifty minutes in duration. Extended sessions can be arranged as needed by prior agreement with your therapist.

Canton Counseling

Child/Adolescent Client Information

The purpose of the following questionnaire is to help your therapist understand some important things about your child in order to help your child and your family most effectively. Please complete all pages.

Child's Full Name _____ Date _____

Child's date of birth _____ Age _____ Gender _____ M _____ F

Address _____

City _____ Zip Code _____ E-mail _____

Phone (H) _____ Permission to call ___Y___N Leave Message ___Y___N

Phone (W) _____ Permission to call ___Y___N Leave Message ___Y___N

Cell phone _____ Permission to call ___Y___N Leave Message ___Y___N

Caregiver/Parent Information

(1) Caregiver/Parent Name _____ Age _____

Marital Status:

Single___ Married___ Divorced___ Engaged___ Separated___ Widowed___ Partnership___

Name of Spouse/Significant other _____ Age _____

Length of time together _____ years _____ months

(2) Caregiver/Parent Name _____ Age _____

Marital Status:

Single___ Married___ Divorced___ Engaged___ Separated___ Widowed___ Partnership___

Name of Spouse/Significant other _____ Age _____

Length of time together _____ years _____ months

If divorces or separated-

Custody Status _____

Emergency Contact _____
(Name) (Relation) (Phone)

How did you hear about Canton Counseling? _____

If referral, who referred you to Canton Counseling? _____

Presenting Problem for Caregiver/Parent

Please circle stressors you have had in recent months–

Marital Issues

Health Issues

Job Issues

Financial Issues

Parent/Child Issues

Issues in past

Other– _____

Child's Presenting Problem(s) * Please circle all that apply.

Sexual abuse

Physical abuse

Neglect

Delinquent behavior

Nightmares

Suicidal thoughts

Sexually acting out

Sleeping problems

Anxiety

Shyness

Academic problems

Change in appetite

Concentration

Bed wetting

Stealing

Clinging behavior

Impulsivity

Temper outbursts

Withdrawn

Lying

Peer conflict

Drug use

Alcohol use

Stubborn

Running away

Missing school

Health issues

Strange thoughts

Legal trouble

Harming self

Head banging

Overactive

Skipping school

Sexual problems

Fearful

Other problems and/or concerns _____

How long have these problems occurred (number of weeks, months, years) _____

Why did you decide to seek counseling at this time? _____

Describe how you hope counseling will help your child. _____

Describe how you hope counseling will help you and your family. _____

Current Family Situation

List the occupants in the home, even if temporary _____

Biological siblings (list names and ages in order of oldest to youngest) _____

Are there any current concerns regarding siblings? (Please list concerns.) _____

Has the child ever been exposed to domestic violence? ____ Y ____ N

Traumas or losses (please indicate the loss or trauma and the age of the child) _____

Living Arrangements

Is there currently a custody dispute? _ __yes __no __possibly

Is there weekend visitation with a non-custodial parent? ____yes ____no

Has your child recently moved? ____yes ____no Number of moves in child's life _____

Who makes the decisions regarding the household money, discipline, routine? _____

What is your major form of discipline? (Example: grounding, spanking, taking away TV, etc.) _____

Who is the major disciplinarian? _____

Physical/Mental Health of Client and Family Members

Please note all health problems **your child** has had or has now.

High fever	Age _____	Dental problems	Age _____	Dizziness	Age _____	Sinus problems	Age _____
Pneumonia	_____	Weight problems	_____	Tonsils out	_____	Heart problems	_____
Flu	_____	Vision problems	_____	Allergies	_____	Hyperactivity	_____
Encephalitis	_____	Skin problems	_____	Meningitis	_____	Asthma	_____
Earaches	_____	Hearing problems	_____	Blood pressure	_____	Convulsions	_____
Headaches	_____	Fainting	_____	Unconsciousness	_____	Accident prone	_____
Head injury	_____	Anemia	_____	Stomach problems	_____		

Major illness or physical limitations _____

Has your child ever been hospitalized? If so please explain. _____

Please list all medications your child is taking. _____

Name of primary care physician _____

Name of other physicians your child is seeing, especially psychiatrists _____

Has your child ever seen a therapist before? ____yes ____no Duration of therapy _____

Name of therapist _____

What was the presenting problem? _____

Has your child ever had a psychiatric diagnosis? _____

Family Medical and Psychiatric History

Medical problems or disabilities in the family _____

Psychiatric history in family _____

Substance abuse history _____

Developmental History

Prenatal

Please list any problems or complications with pregnancy or delivery _____

Developmental Milestones

(Referring to age when the child walked, talked, potty trained, etc.) _____

Educational History

Name of child's school _____ Grade _____

Teacher(s) name _____ Average grades _____

Concerns regarding school academics or behavior _____

Have there been any significant changes or problems in school behavior or grades? _____

Child's best subject _____ Child's most challenging subject _____

Please check the following according to your child:

Learning disabilities ____yes ____no If yes, please explain. _____

Gifted program ____yes ____no

ADD ____yes ____no ADHD ____yes ____no

Participate in extracurricular activities? ____yes ____no If yes, please explain. _____

Social history

In school how many friends does your child have: ____a lot ____a few ____none

How much time does your child spend with other children outside of school during the week?

0-1 day____ 2-3 days____ 4-5 days____ more than 5 days____

Please list child's special interests, hobbies, skills. _____

Who does your child spend most of his/her time with? _____

How does your child get along with...

Peers-

Adults-

Teachers-

Parents-

Other-

Is your family connected with any groups, churches, or religious organizations? _____

Has your child ever had difficulty with the police? ____yes ____no If yes, please explain. _____

Has your child ever been on probation? ____yes ____no

Is your child employed? ____yes ____no

Additional comments, questions, or concerns _____

Print Full Name _____

Signature_____

Date_____

For Teens Only

Please complete the following sentences–

1. I worry about
2. I am happiest when
3. What I do best is
4. I have been criticized for
5. I sometimes feel guilty about
6. It makes me angry when
7. My biggest mistake was
8. My hobby is
9. It makes me nervous when
10. My experience with religion is
11. My personality would be better if
12. I often feel like my mother is
13. My younger childhood was
14. My biggest disappointment
15. I would be better liked if
16. I think sex is
17. Boys seem to be
18. I often feel my father is

19. An unspoken fear I have is

20. Girls seem to be

21. What hurts me most is

22. In relationships, I don't seem to be able to

23. My girlfriend/boyfriend is

24. Lately I have been feeling

Policies

Please initial where indicated, stating you have read and understand the information provided.

Confidentiality– A very important aspect of developing the openness, honesty, and trust between therapist and client is confidentiality. Whatever you share with your therapist will be kept in the strictest confidence and will not be disclosed to anyone without your express, written consent. At the same time, it is important for you to know that, under Georgia law; a few situations sometimes arise in which your therapist is both legally and ethically required to make disclosures that are necessary to ensure the safety of yourself or others. Those situations include: suspected child abuse, threat of physical violence to others, and/or suicidal intent. Your therapist will further discuss any aspect of confidentiality, which may concern you.

Initials _____

Court– Your therapist will not participate in divorce or child custody proceedings because the same professional should not perform evaluation and therapy. If subpoenaed by the court of law, I will first assert client–therapist privilege. However, if ordered by a judge to disclose information, my fees for appearing in court are an hourly rate of \$200 and must be paid at the end of each day in attendance.

Initials _____

Emergencies– If you have an emergency (something that cannot wait for your next appointment), please call 770.351.6674. I will make every effort to return your call in the same day you make it, with the exception of weekends and holidays. If you feel that you cannot wait, please call 911 or go to the nearest Hospital Emergency Room for help. Please do not wait for your therapist to contact you to utilize those resources. If I am going to be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Initials _____

Insurance– Canton Counseling does not file insurance. Since each insurance company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although your therapist is a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with your therapist in order to reimburse you for services provided at Canton Counseling, you will be asked to provide specific written consent for the therapist to communicate with your insurance company. Please let your therapist know if you intend to file a claim. **Are you planning to file a claim for reimbursement of services with your mental health insurance provider?** _____ Y _____ N

Initials _____

Cancellation Policy– All cancellations should be made over the phone; I will not accept cancellations via email. Your therapist will confirm your cancelled appointment over the phone. For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours prior to your appointment time, the full charge for your scheduled session will be applied. For appointments not kept (and not cancelled) the full amount will be charged. For those who are on a sliding scale, the full rate (not the sliding scale rate) will be charged.

Initials _____

Payment and Returned Check Fee– Payment in full is due when services are rendered unless other arrangements have been made in advance. Fees are charged for in office sessions, phone consultations and Skype sessions. There is a \$30 returned check fee in addition to the fee for service.

Initials _____

Please sign below, indicating that you have read, understood, and received a copy of this information. If you have any questions or concerns, please discuss before signing.

Print Full Name _____

Signature _____

Date _____

Policies

Keep This Copy for Your Records

Confidentiality– A very important aspect of developing the openness, honesty, and trust between therapist and client is confidentiality. Whatever you share with your therapist will be kept in the strictest confidence and will not be disclosed to anyone without your express, written consent. At the same time, it is important for you to know that, under Georgia law; a few situations sometimes arise in which your therapist is both legally and ethically required to make disclosures that are necessary to ensure the safety of yourself or others. Those situations include: suspected child abuse, threat of physical violence to others, and/or suicidal intent. Your therapist will further discuss any aspect of confidentiality which may concern you.

Court– Your therapist will not participate in divorce or child custody proceedings because the same professional should not perform evaluation and therapy. If subpoenaed by the court of law, I will first assert client-therapist privilege. However, if ordered by a judge to disclose information, my fees for appearing in court are an hourly rate of \$200 and must be paid at the end of each day in attendance.

Emergencies– If you have an emergency (something that cannot wait for your next appointment), please call 770.351.6674. I will make every effort to return your call in the same day you make it, with the exception of weekends and holidays. If you feel that you cannot wait, please call 911 or go to the nearest Hospital Emergency Room for help. Please do not wait for your therapist to contact you to utilize those resources. If I am going to be unavailable for extended time, I will provide you with the name of a colleague to contact, if necessary.

Insurance– Canton Counseling does not file insurance. Since each insurance company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although your therapist is a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with your therapist in order to reimburse you for services provided at Canton Counseling, you will be asked to provide specific written consent for the therapist to communicate with your insurance company. Please let your therapist know if you intend to file a claim.

Cancellation Policy– All cancellations should be made over the phone; I will not accept cancellations via email. Your therapist will confirm your cancelled appointment over the phone. For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours prior to your appointment time, the full charge for your scheduled session will be applied. For appointments not kept (and not cancelled) the full amount will be charged. For those who are on a sliding scale, the full rate (not the sliding scale rate) will be charged.

Payment and Returned Check Fee– Payment in full is due when services are rendered unless other arrangements have been made with your therapist in advance. Fees are charged for in office sessions, phone consultations and Skype sessions. There is a \$30 returned check fee in addition to the fee for service.

Please sign below and keep the two subsequent pages of information for your records.

Georgia Notice Form

By signing below, I am acknowledging that I have received a copy of the Georgia Notice Form concerning the policies and practices protecting my health information.

Print Full Name _____

Signature_____

Date_____

Georgia Notice Form

Notice of Licensed Professional Counselor Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as family physician or another psychologist.
- "Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health care insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to
- information about you to other parties

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides that insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight Activities – If I am the subject of an inquiry by the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is

privileged under state law, and I will not release information without your written consent or a court order.

- **Serious Threat to Health or Safety** – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- **Workers Compensation** – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Licensed Counselor's Duties

Patient's Rights:

- **Right to Request Restrictions** – you have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction that you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** -- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- **Right to Inspect and Copy** -- You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Licensed Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will inform you of that change in a session or on the phone, and that information may be also provided to you in written form while you are in a session or through the mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please inform me. You may also contact the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, I will promptly distribute the revised Notice, post it in the waiting area of my office, and make copies available to my patients.