TALLAHASSEE COUNSELING CENTER

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Child Client Information

All information on this form is 100% confidential

Child:

Name: _____ Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Gender (circle): Male Female Other: _____ Social Security #:_____-_____-_____

Primary Care Physician: _____ Physician's Phone: _____-_____-_____

Address: _____ City: _____ Zip: _____

School (if applicable): _____

Parent:

Name: _____ Relationship to Child: _____

Marital Status: Single Married Divorced Separated Other: _____

Phone Numbers: (cell) _____-_____-_____ (work) _____-_____-_____ (home) _____-_____-_____

Email: _____ Preferred Contact: ( ) Cell Phone ( ) Work ( ) Home ( ) E-mail

Address (if different from above): _____

City: _____ State: _____ Zip: _____ Employer: _____

Other Parent:

Name: _____ Relationship to Child: _____

Marital Status: Single Married Divorced Separated Other: _____

Phone Numbers: (cell) _____-_____-_____ (work) _____-_____-_____ (home) _____-_____-_____

Email: _____ Preferred Contact: ( ) Cell Phone ( ) Work ( ) Home ( ) E-mail

Address (if different from above): _____

City: _____ State: _____ Zip: _____ Employer: _____

Please initial the following items after reading:

____ All co-payments / payments are due at the time services are rendered.

_____ I acknowledge that I have been given access to Tallahassee Counseling Center Notice Of Privacy Policies and that I *may request* to keep a paper copy of this Notice of Privacy Policies.

Please attend to your children at all times. Unattended children in our lobby will receive an espresso. ☺

Insurance Information:

Primary Insurance Coverage

Ins. Company Name: _____ Member ID #: _____

Ins. Company Address: _____ Group #: _____

Primary Insured Name: _____ Primary's DOB: _____/_____/_____

Primary's Address: _____ City: _____ Zip: _____

Primary Insured Place of Employment: _____ Primary's Cell: _____-_____-_____

Treatment Needs

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

List your goals for treatment:

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood	( ) Inattentive	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety/Panic attacks
( ) Sleep pattern disturbance	( ) Enuresis (bedwetting)	( ) Declining school performance
( ) Loss of interest	( ) Night terrors	( ) Stress
( ) Concentration/forgetfulness	( ) Increased need for sleep	( ) Suicidal Thoughts
( ) Change in appetite	( ) Excessive energy	( ) Lack of confidence
( ) Increased irritability	( ) Fatigue	( ) Crying spells
( ) Increased aggressiveness	( ) Headaches	( ) Changes in weight
( ) Social anxiety	( ) _____	( ) _____

Date of last medical examination: _____ Current Weight: _____

List all medications your child is *currently* taking:

Medication Name: Daily Dosage: Estimated Start Date: Prescribed by:

1._____

2. _____

3. _____

4. _____

5. _____

Is your child experiencing any side effects from any medication? ( ) Yes ( ) No. If yes, explain.

_____

_____

History

Is there a history of mental illness in the child's family? If yes, list family member(s) and the illness(es):

_____

_____

_____

Has there ever been any thought of suicide or self harm? ( ) Yes ( ) No

If yes please explain:_____

Is your child *currently* suicidal or engaging in self harm? ( ) Yes ( ) No

Does your child have a history of alcohol consumption or drug use? ( ) Yes ( ) No

If yes please explain:_____

If your child has experienced any of the following, fill in the chart accordingly:

Incident:	**Age of Child:**
Death of significant family member.	
Physical abuse.	
Sexual abuse.	
Long-term financial instability.	
Hospitalization of a parent.	

Divorce/separation of parents.	
Alcohol/drug use by parent.	
Incarceration of a parent.	
Other:	

Child Development:

Was your child raised by his or her biological parents? ( ) Yes ( ) No. If no, explain.

_____

Were there any complications with the pregnancy or birth? ( ) Yes ( ) No. If yes, explain.

_____

_____

Did the mother take any drugs or medications during the pregnancy? ( ) Yes ( ) No

Did the mother drink alcohol during the pregnancy? ( ) Yes ( ) No

Did the mother smoke during the pregnancy? ( ) Yes ( ) No

Did your child enjoy being held during the first three years of life? ( ) Yes ( ) No

Child Education:

Current grade in school: _____ School Performance: ( ) Great ( ) Average ( ) Poor

Has your child skipped or repeated a grade? ( ) Yes ( ) No. If yes, explain.

_____

Does your child have any behavioral or attendance problems at school? ( ) Yes ( ) No. If yes, explain.

_____

If there is a point of contact at your child's school with whom your therapist should be in touch, please provide their name and contact information on the Release of Information Authorization on the following page.

Consent for Treatment

I, _____ give permission for my child, _____, to receive therapeutic treatment services from Tallahassee Counseling Center. If I am involved in divorce or custody litigation, or believe that I may be in the future, I am aware that the role of the therapist is not

to make recommendations to the court concerning custody, parenting issues, or to testify in court concerning opinions on issues involved in the litigation.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Medical Disclosure/Release of Information Authorization

Clients that provide us with permission to contact their primary care physician will have a form sent to their doctor indicating that contact has been made at our office. Diagnosis information may also be released to the physician. By signing below, you give us permission to inform your doctor of your mental health.

I, _____, parent and/or legal guardian of, _____, authorize Tallahassee Counseling Center to discuss treatment and release confidential medical information, including psychiatric records to the following parties:

- Primary Care Physician (PCP): _____
- Other: _____

This authorization will remain active unless revoked in writing by me. I understand that once our protected health information is disclosed, it is no longer considered protected and parties to whom this information is released may choose to further disclose this information. I agree that Tallahassee Counseling Center is not responsible for disclosures made pursuant to this authorization.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Consent for Uses and Disclosures

During the course of providing treatment to you or your child, there may be times when it will be necessary to use or disclose your protected health information (PHI) to carry out treatment, obtain/receive payment, or perform other health care operations on your behalf. This consent signifies your permission for us to use your PHI for these purposes. Some examples of these uses of your information include:

- Billing/ receiving payment from insurance companies for services provided to you or your child
- Obtaining pre-authorizations for treatment or determining your coverage under a health plan
- Sharing information between practitioners here at the office to provide you with optimum mental health treatment

The Health Insurance Portability and Accountability Act of 1996 defines your protected health information (PHI) as health information, including personal information, that is created or received by us concerning you and that relates to your past, present, or future physical or mental health condition, or payment for health care, and that identifies or can be used to identify you. The terms use or disclosure, refer to the release, transfer, provision of access to, or divulging of information outside of this office. A full description of instances involving disclosure and of other terms used in this consent can be found in our

Notice of Privacy Practices, which is posted here in the office. You can obtain a written copy for your review. We reserve the right to change the terms of this Notice of Privacy Practices at any time and will provide you with a copy of the revised Notice upon your request. You have the right to review our Notice of Privacy Practices, before signing this consent.

Under this same Act, there are a number of rights to which you are entitled concerning your protected health information. You have the right to restrict how your protected health information is disclosed including having it be disclosed by alternative means other than those we would normally use. We are not required to agree with your restrictions, but will consider your requests as binding in the event that we should agree to them.

You also have the right to revoke this consent at any time, but must do so in writing. We are not responsible for actions or disclosures taken during the effective time of this consent and any service costs incurred while this consent is active, are subject to payment. Additionally, we may refuse treatment to you, if you do not agree to this consent, and in the event that you revoke this consent, we have the right to discontinue further treatment.

Our policies concerning the protection of your health information have always been to take every safeguard possible in protecting your health information. We consider your information as private and take every necessary precaution to see that it is protected.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

No Show & Late Cancellation Policy

You may request a copy of this policy for your records.

When appointments are scheduled for you, we offer you an appointment card/print-out of upcoming appointments (if you are in the office) and provide you with the opportunity to participate in our courtesy appointment reminder service. After you have scheduled an appointment, it is your responsibility to remember the appointment.

Our office operates on a pre-determined appointment schedule. When a patient does not show up for their scheduled visit, or does not provide adequate notice (preferably 24 hours, but no later than 2:00 PM on the business day prior to a scheduled appointment) of a cancellation of their scheduled appointment, they are depriving another patient of the opportunity to be seen by our office. Furthermore, we cannot bill insurance for appointments not kept.

If you need to cancel an appointment, please contact our office immediately. Failure to call the business day before your appointment, or failure to show up to your appointment will result in the following fee:

- **Late Cancellation & No Show Fee $50.00**

Depending on your Late Cancellation and No Show history with our office, you may be asked to pay all outstanding balances/fees prior to our office rescheduling your missed appointment. We also reserve the right to terminate treatment with you, should your history of late cancellations and no shows become excessive.

I, _____, parent and/or legal guardian of, _____, have read and understand the above policy. Furthermore, I agree to act in accordance with this policy and accept financial responsibility in the event I do not adhere to the guidelines outlined above.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Courtesy Appointment Reminder Service

In order to serve you better, Tallahassee Counseling Center offers a free courtesy appointment reminder service. This means that the business day prior to your appointment, you will receive a phone call, text, or e-mail reminding you of your scheduled appointment.

If you want to keep your appointment, you do not have to call/text/e-mail us back. If we do not hear from you, we assume you are keeping your appointment. However, it is imperative that you respond accordingly if you need to cancel or reschedule the appointment to avoid the Late Cancel/No Show fees.

You may call our office at 850-385-9046 at any time, if you have questions regarding your scheduled appointments or if you believe you have an appointment and do not receive a reminder call/e-mail.

Please remember that this service is provided free of charge, however, you are still held responsible for the appointments you schedule. Failure to receive a courtesy reminder call, text, or e-mail due to technical issues does not excuse you from fees associated with any missed appointments.

Child's Name: _____

Parent/Guardian's Name: _____

I prefer my child's appointment reminders via (please only select ONE – ** please see note below):

___ Text Number: (_____) _____-_____

___ Phone Number: (_____) _____-_____ Select: ___ cell ___ home *Please do not leave a work number*

___ E-mail: _____

___ I choose to OPT OUT of appointment reminders & I will not receive a reminder call/e-mail

By signing below, I acknowledge that I am responsible for keeping track of my child's appointments. Reminders are provided as a courtesy to me. Any fees associated with any missed appointments are my responsibility.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

It is the parent's responsibility to notify the child's other parent of scheduled appointments. If requested, divorced/separated parents are able to select **one phone call reminder and **one** e-mail reminder per child. However, we are unable to have the reminders set to the same preference for each parent (in other words, we cannot do two phone call reminders nor two e-mail reminders). Please see Office Staff with any questions or concerns.