Gracelight Counseling Center – Tonna Deal, LPC
2216 Shadowlake Drive
Oklahoma City, OK 73159
Phone: 405-545-0913
www.gracelightcounseling.com

Parent Questionnaire

Date _____Form Completed by_____ Relation to Adolescent_____

Adolescent's name _____M__F __ Date of birth _____ Age _____

Home street address _____Apt._____

City: _____ **State**: _____ **Zip**: _____

Mother's phone: _____ **Father's Phone**: _____

Adolescent's Primary Physician _____ Phy's Phone_____

Insurance Company_____ Insurance primary person_____

Who referred the Adolescent? _____ Phone: _____

May I have your permission to thank this person for the referral? Yes No Initial _____

FAMILY

Father's name: _____ **Birthdate**: _____

Address (if different from above) _____

Occupation: _____**Educational level**_____

# of dependents _____

Mother's name: _____ **Birthdate**: _____

Address (if different from above) _____

Occupation: _____**Educational level**_____

# of dependents _____

Date of Marriage _____Present Marital Status ____If divorced who has custody____
(Provide court order)

With whom does the Adolescent live? Birth parents_____

Adoptive Parents_____ Foster parents_____

List all other persons living in the home:

_____ _____

_____ _____

List any other people who care for the Adolescent a significant amount of time

Name _____

Relationship to Adolescent (grandmother, neighbor, etc.) _____ Age _____

ADOLESCENT

Has your Adolescent had any medical complications? _____
If yes, briefly explain _____

_____

Please list any jobs or chores your Adolescent has at home or school. (e.g., feeding the dog, making the bed, safety patrol)

_____

How well does your Adolescent do these chores? _____

What are your Adolescent's strengths?

_____

How many close friends does your Adolescent have? _____ How many times a week does your Adolescent do things with them? _____ How many friends in the neighborhood does your Adolescent have? _____

Compared to other Adolescents his/her age, how well does your Adolescent get along with other Adolescents? Poor Average Great

What are your Adolescent's after school activities?

_____ _____

FAMILY AND PERSONAL HEALTH HISTORY

Date of Last Physical Examination _____Adolescent's Height _____ Adolescent's Weight _____

Check condition and relationship of any blood relative who has or has had any of the conditions listed below

Alcoholism/Substance Abuse _____ Allergies _____

Birth Defects _____ Cancer _____

Colitis_____ Depression _____

Heart Attack _____ High Blood Pressure _____

Migraine _____ Mental Illness _____

Seizure Disorder _____ Mental Retardation _____

Learning/Attention Problems _____

Suicide/Suicide Attempt Other (Specify) _____

DISCIPLINARY STRATEGIES

Who generally disciplines the Adolescent?

_____

What methods are used? _____

Are these methods effective? _____Do parents agree on methods of discipline? ___

Elaborate, if no _____ _____

SCHOOL HISTORY

Father _____Paternal grandfather _____

Paternal grandmother _____Paternal aunt/ uncle _____

Mother _____Maternal grandfather _____

Maternal grandmother _____Maternal aunt/uncle _____

Siblings _____

Present grade and school _____ Does not go to school_____

Please indicate if your Adolescent is in a special class (gifted, learning disabled, emotionally handicapped, etc.)

School _____ _____ _____

Comments Regarding Behavior/Adjustment

_____

_____

Current School Performance (for Adolescent)

Indicate if failing, below average, average, above average, excelling

(History/Geography, etc.) _____ Writing _____

Arithmetic or Math _____ Spelling _____

Other Academic Subjects (science, foreign language, etc) _____

PARENTAL CONCERNS

What do you feel is your Adolescent's main problem?

_____
_____
_____

What do you feel caused your Adolescent's problem?

_____
_____
_____

What have you been told by doctors, teachers, and/or others about your Adolescent's problems?

_____
_____
_____

Has this Adolescent had any other mental health evaluations or treatment?

_____
_____
_____

Has any member of the Adolescent's immediate family had mental health treatment?

_____
_____
_____

Other comments

_____
_____
_____

May we contact the Adolescent's primary physician?

To receive information _____ To give information _____

_____

(Signed) Parent or Guardian

Agreement to Pay for Professional Services

I, the client (or guardian/legal representative), request that Tonna Deal, LPC, provide professional services to _____, who is my _____, and I agree to pay this therapist's fee of $ _____ per 45/50 minute session. This same fee will be applied per each hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing. Fees for legal issues may be substantially different and should be clarified.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform her, in person or by certified mail that I wish to end it.
I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I understand that if I do not pay for services that the services provided may be terminated by the therapist. Continued non-payment of fees may result in further consequences such as my case being referred to a collection agency.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. If my any part of my fees is being paid by an insurance company or other third-party payer, I understand that this may result in limitations to my confidentiality.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

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CONSENT FOR TREATMENT FOR ADOLESCENTS

Client's Initials

Therapy sessions and file information are confidential.
Except in cases of: (a) court orders/subpoenas, (b) to defend legal action against Gracelight Counseling Center or therapist, (c) need to prevent harm to self or others, and (d) suspected Child abuse/neglect. Third party billing and lawsuits I bring related to mental health issues may also limit the confidentiality of my Adolescent's file. _____

There are some limitations to my access to my Adolescent's file.
I understand that confidentiality is very important to my Adolescent's ability to use therapy. While I have the right to access my Adolescent's file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my Ms. Deal about any questions I have concerning the content of my Adolescent's file or sessions. _____

I must sign release forms before information can be exchanged with others.
The privacy of any electronic communication cannot be assured. Do not use email for urgent matters. I may request restrictions on the use/disclosure of information in my Adolescent's file for treatment, payment and health care operations, but the therapist is not bound to agree with my request. _____

Some information from my Adolescent's file may be used in research.
I understand that any identifying information will not be used in research. _____

Gracelight Counseling Center and Tonna Deal do not provide after-hours or emergency services (Contact 911 or go to the ER for after-hours crises). _____

The practice of psychology and related disciplines is not an exact science.
No guarantees have been made to me regarding the results of Tonna Deal's services. _____

Tonna Deal is not a medical doctor and cannot prescribe medications. _____

I consent to undergo all recommended testing and treatment procedures.
I can refuse or discontinue testing or treatment at any time. _____

I agree to pay my clinic bill. Payment is due at the beginning of sessions and I must cancel at least 24 hours before my session or I am responsible for the cost of the session.
Consequences of non-payment may include termination of services or being referred to a collection agency. _____

I acknowledge that my therapist has reviewed the General Consent for Treatment with me.

_____	_____	_____
Signature of Therapist	Signature of Guardian/Legal Rep.	Signature of Adolescent
Date: _____	Date: _____	

CONFIDENTIAL

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Notice of Privacy Practices

This notice talks about **privacy information**. We've always taken great care to safeguard your privacy. What is new is a government regulation requiring us to explain your rights. This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. In the event that the notice is changed, a new notice will be sent to you by mail or at the time of your next appointment. You may request a copy of our Notice at any time. This takes effect January 2011, and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information
You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment by signing the consent form, this agency will use or disclose your protected health information as described below.

- **Treatment:** We may use and disclose, as needed, your protected health information to provide, coordinate, or manage your health care and any related services.
- **Health Operations:** We may use and disclose, as needed, your health information in connection with our operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:
Will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

- **Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to object
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required by Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Health Oversight:** We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- **Abuse or Neglect:** We may disclose your protected health information to the Department of Human Services which is authorized by law to receive reports of Adolescent abuse or neglect. In

addition, we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the Department of Human Services.

- **Legal Proceedings:** We may disclose your protected health information in the course of any judicial proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights - Access: You have the right to inspect and copy your protected health information. We will use the format you request unless we cannot practicably do so. You must submit your request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $1.00 for the first page, and $.25 each page thereafter to locate and copy your health information plus postage if you want the copies mailed to you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request restriction of your protected health information. You may also request that any part of your protected health information not be disclosed by family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions we will be able to abide by our agreement (except in an emergency). We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for you amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment or healthcare operations as described in this Notice of Privacy Practices.

Questions and Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I have read and understand Gracelight Counseling Center's Notice of Privacy Policy.

Client's signature_____Date_____

ADOLESCENT PROBLEM SCREENING FORM

Adolescent's name: _____Adolescent's date of birth: _____ Age: _____Rater's name: _____

Relationship to Adolescent: _____ Today's date: _____

Directions: Below is a list of ways that Adolescent may act, think, or feel. Please (1) circle the number showing how often your Adolescent has behaved this way in the past 3 months and (2) circle "Yes" if it is currently a problem or "No" if it is not a problem.

	How Often Does This Occur?					Is This A Problem Now?
	Never	Seldom	Sometimes	Often	Always	
Argues with others	1	2	3	4	5	Yes No
Can't concentrate/pay attention	1	2	3	4	5	
Acts sad or depressed	1	2	3	4	5	
Feeding/eating problems	1	2	3	4	5	
Teases or fights with others	1	2	3	4	5	
Is teased	1	2	3	4	5	
Appears lonely	1	2	3	4	5	
Can't sit still/hyperactive	1	2	3	4	5	
Too fearful or anxious	1	2	3	4	5	
Disobeys at home	1	2	3	4	5	
Disobeys at school	1	2	3	4	5	
Moody	1	2	3	4	5	
School Academic Problems	1	2	3	4	5	
Temper tantrums/hot temper	1	2	3	4	5	
Impulsive/acts without thinking	1	2	3	4	5	
Threatens/tries to hurt others	1	2	3	4	5	
Low self esteem	1	2	3	4	5	
Toilet problems/wetting/soiling	1	2	3	4	5	
Self-conscious/embarrassed	1	2	3	4	5	
Perfectionistic	1	2	3	4	5	
Threatens/tries to hurt animals	1	2	3	4	5	
Threatens/tries to hurt self	1	2	3	4	5	

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CONSENT FOR TELE-COUNSELING SERVIES

According to Oklahoma state law, "Telemedicine" means the practice of health care delivery, diagnosis, consultation, evaluation, treatment, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine uses audio and video multimedia telecommunication equipment which permits two-way real-time communication between a health care practitioner and a patient who are not in the same physical location. Telemedicine shall not include consultation provided by telephone or facsimile machine; In the following section "you" refers to the person receiving mental health services from Tonna Deal, LPC, including adults, children, teens, and any family member or others in the home. Ms. Deal uses a HIPAA compliant platform called Doxy.me which provides secure audio and video transmission specifically for the purpose of providing tele-counseling services.

Benefits of tele-counseling include but are not limited to:

- Receiving services at times or in places where the service may not otherwise be available.
- Receiving services in a fashion that may be more convenient and less prone to delays than in-person meetings.
- Receiving services when you are unable to travel to the service provider's office.

Risks of tele-counseling services include but are not limited to:

- Internet connections and cloud services could cease working or become too unstable to use. Interruptions may disrupt services at important moments, and your provider may be unable to reach you quickly via other tools such as via telephone, email, or in-person.
- Cloud-based service personnel, IT assistants, and malicious actors ("hackers") may have the ability to access your private information that is transmitted or stored in the process of telemental health-based service delivery.
- Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out.
- Due to video or audio quality, your counselor may miss verbal or behavioral cues, therefore not acting on those cues and subsequently hindering or causing a degradation in your mental health.

Ongoing assessment for the appropriateness of tele-counseling services

During the first session and all subsequent sessions, your mental health provider will assess the appropriateness of providing mental health services to you. If the counselor believes that your treatment is being hindered by tele-counseling or would be better served via

in-person counseling, she will switch to in-person sessions, a combination of in-person and tele-counseling sessions, or refer you to a different mental health provider.

Tele-counseling environment
By Oklahoma state law, you are required to inform the counselor of your physical location (physical address) at the beginning of each counseling session. You will be responsible for creating a safe and confidential space during tele-counseling sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with your provider during the session. You will be responsible for guarding against excessive interruptions or outside noises (dogs barking, trucks, etc). You will be responsible for providing adequate lighting in your space to aid in video transmission. Your environment should have good wi-fi connection or cellular signal. If you or your counselor determine that the environment is not conducive for counseling, or if the wi-fi or cellular connection is inadequate, the session may end and be conducted via telephone or rescheduled.

Danger to self or others and mandated reporting
Just as with in-person sessions, your mental health therapist has legal and ethical mandates to follow if you should become a danger to yourself or others. If your therapist believes that you are in danger of hurting yourself or others, she may call the police in your local area and ask them to do a "wellness check". In such situations, your therapist is not bound by confidentiality and may share any information she feels is required for your and others safety. You are asked to identify a person in the home or near your physical location for the therapist to contact and ask to check on you, if your mental health degrades and the counselor is unable to reach you.

Mandated reporting
Just as in in-person counseling sessions, your therapist is required by law to report any allegations or suspicions of child/elder abuse or neglect to the Oklahoma Department of Human Services.
I have read and understand the Tele-Counseling Consent for Treatment

_____
Signature of Client's Guardian

_____
Date:

Emergency Contact Name and Number

_____