Intake Questionnaire - Adolescent (Under 18)

Please fill out every question in this intake questionnaire as this is an important part of your child's treatment. You need to choose only one answer for each question, unless otherwise noted. If you are confused or have any questions or concerns about this form, please email Amanda@HeartofTherapy.com

Please answer the questions to the best of your ability.

* Indicates required question

1. Email *

2. What is your name? *

3. What is your address? *

4. What is the best number to reach you? *

5. Can you accept texts on the above phone number? *

Mark only one oval.

- Yes
- No

6. Can we use this number in our billing system? We utilize IvyPay which is a HIPPA compliant third party billing system. Once your number is added, IvyPay sends a text to your phone asking you to follow a link to add a credit card to the system. We do not have access to your credit card information (An HSA credit card can also be used). Once completed you are added to our system and your credit card will be billed. *

Mark only one oval.

- Yes
- No

7. If you answered "no" the the previous question, what number can we use for billing? This must be a number that can receive texts. If you do not fill comfortable using this system, please share that and then identify if you plan to pay with cash prior to the appointment. Payment must be received after each session in order to hold the next session time and date.

8. Please check all of the ways messages and information can be provided to you. This includes confidential information. *

Check all that apply.

- [ ] Email
- [ ] Text
- [ ] Voicemail

9. What is your relationship to the person seeking treatment? *

_____

10. Are you the legal guardian of the person seeking treatment and legally allowed to make the decision to have this person treated? *

Mark only one oval.

- ◯ Yes
- ◯ No

11. Are there any other people who are legal guardians of the person seeking treatment? *

Mark only one oval.

- ◯ Yes
- ◯ No

12. If you answered "yes" to the previous question, please provide the names and contact information of the other legal guardians, as well as their relationship to the person being treated. *

13. Do you, or does anyone in the family (including extended family), have any mental health diagnosis or a diagnosif of ADHD or autism? *

Mark only one oval.

- Yes
- No

14. If you answered “yes” to the previous question, who and what is the diagnosis?

15. What is the language spoken in the home? *

16. Does the person being treated require an interpreter or translator? *

Mark only one oval.

- Yes
- No

17. If you answered "yes" the the previous question, do you understand that you are responsible for providing a translator or interpreter?

Mark only one oval.

- Yes
- No

18. What is the name of the person being treated? *

_____

19. What is the birthday of the person being treated? *

_____

Example: January 7, 2019

20. How old is the person being treated? *

_____

21. Is this assessment needed for a legal or educational issue? *

Mark only one oval.

- Yes
- No

22. If you answered "yes" to the following question, please explain.

23. Does the person being treated have any allergies? (This includes medication, foods, chemicals, animals, etc) *

Mark only one oval.

- Yes
- No

24. If you answered "yes" to the following question, please explain.

25. Please provide an emergency contact, including the relationship to the client. If possible, please identify someone other than yourself. It does not have to be a family member. *

26. The following is the consent to treatment. By answering "yes" you acknowledge that you agree to the following and consent to treatment. *

I/We understand the following:
1. That our decision to seek services from Heart of Therapy is voluntary.
2. I have read the document entitled, “Office Policies and Practices 2024" that is located on the Heart of Therapy website, and I understand the policies and procedures detailed in it.
3. I agree to adhere to the policies and procedures detailed in the above mentioned document and I consent to receive services from Heart of Therapy.
4. That I/we have been fully informed about the nature, risks and benefits of treatment, and the availability of treatment options.
5. That I/we have had the opportunity to have all questions answered to my/our satisfaction.
6. That I am legally competent and have the authority to provide consent for treatment.
7. That I have the right to withdraw my consent for this treatment at any time.
8. That Heart of Therapy may receive professional consultation regarding patient care.
9. I consent to have Heart of Therapy disclose my private information to consultants and colleagues for the purpose of professional consultation.

Mark only one oval.

- Yes
- No

27. The following is the consent to use electronic communication. By answering "yes" you acknowledge that you agree to the following and consent to electronic communication. *

This section outlines the guidelines for electronic communication and documents your consent to use electronic communication with your or your therapist. In a medical emergency, do not use electronic communication. Dial 911, or proceed to your nearest emergency department.

Email: Email is not a private form of communication but is more like a postcard that can be viewed by anyone with access to certain areas of the Internet. We utilize a HIPAA compliant email server. However, email sent to or from your account may not be secured and encrypted. Email should not be used for urgent or emergent matters, as your therapist may not check email frequently enough to respond in a timely manner. Email may be used to address issues related to your care (e.g. appointment times, routine follow-up inquiries, referrals, billing questions) as long as you give consent.

If email is used, please note the following:
1) All clinically relevant emails regarding care with your therapist will be included in the patient's medical record.
2) If you have not received a response within 24 hours to an email you sent to your therapist, please phone them directly to follow-up.
3) Either you or your therapist may request via email or letter to discontinue using email as a means of communication.

Text Messaging: Your therapist may use a cell phone that receives and sends text messages. Text messaging is to be used for sharing non-personal information such as discussing appointment times or requesting a call back. Text messaging should not be used for discussing personal health information or urgent or emergent matters, as your therapist may not check texts frequently enough to respond in a timely manner.

If text messaging is used, please note the following:
1) All clinically relevant text message content regarding care with your therapist will be included in the patient's medical record.
2) If you have not received a response within 24 hours to a text message you sent to your therapist, please phone them directly for follow-up.
3) Either you or your therapist may request in writing to discontinue using text messaging as a means of communication.

DISCLAIMER: Heart of Therapy, nor your specific therapist, are responsible for electronic communications that are lost due to technical failures. Although reasonable technical safeguards have been implemented, Heart of Therapy cannot and does not guarantee the privacy, security, or confidentiality of electronic communications.

Due to the nature of electronic communications, and the fact most popular email services/cell phone carriers do not utilize encrypted emails/text messages, there is a potential that emails and/or text messages may be intercepted, altered, forwarded, or read by others. If any of the foregoing presents a concern to you, you should not communicate electronically with anyone from Heart of Therapy.

By checking "yes" you acknowledge that you have read and fully understand this consent form and that you voluntarily give permission to use electronic communications with Heart of Therapy to send and receive personal information related to your care.

Mark only one oval.

- ◯ Yes
- ◯ No

28. The policies and procedures manual can be found on our website using the following link: https://heartoftherapy.com/forms-%26-policies *

We ask that you copy and paste this link into a separate browser and take the time to read it in it's entirety. By checking "yes" you are acknowledging that you have read, understand and agree to the office policies and procedures.

Mark only one oval.

- ◯ Yes
- ◯ No

29. The privacy practices can be found on our website using the following link: https://heartoftherapy.com/forms-%26-policies *

We ask that you copy and paste this link into a separate browser and take the time to read it in it's entirety. By checking "yes" you are acknowledging that you have read, understand and agree to the privacy practices

Mark only one oval.

- ◯ Yes
- ◯ No

Assessment and Office Policy Information

30. Why are you seeking treatment for your child, at this time? *

31. What do you hope will be the result of treatment? *

32. Do you understand that while we do our best to provide your child with the best possible care, that we are limited in how we can support clients, and that a higher level of care may be suggested if your child is engaging in unsafe or harmful behaviors? *

Mark only one oval.

- Yes
- No

33. Related to sickness: The therapists at Heart of Therapy are committed to supporting a healthy environment for both clients and staff. As such it is our policy that if you are sick that you either see your clinician virtually for your session, or cancel. A fee will not be charged for the first cancellation that is due to illness. No fee will be charged if the appointment is cancelled before 24 hours. *

We ask that clients who are experiencing gastric illness that includes loose bowels or vomiting, not attend in person session.

We ask that clients who are experiencing cold/flu symptoms test for COVID prior to coming for an in person session.

By checking "yes" you acknowledge that you agree to follow this policy.

Mark only one oval.

- Yes
- No

34. Do you understand that payment is expected for each scheduled session, and that if payment is not received subsequent appointments will be canceled? *

Mark only one oval.

- Yes
- No

35. Do you understand that if you cancel with less than 24 hours notice, that you will be charged the full session fee? This fee can not be included on any superbills for reimbursement. *

Mark only one oval.

- Yes
- No

36. Do you understand that we do not accept insurance and that all costs are out of pocket? *

Mark only one oval.

- Yes
- No

37. Do you understand that we can provide a Superbill for services that you can turn into your insurance for hopeful reimbursement, after payment has been received and services rendered? *

Mark only one oval.

- Yes
- No

38. Do you understand that your insurance company may deny your Superbill? *

Mark only one oval.

- Yes
- No

39. Do you understand that session fees are nonrefundable after the completion of each appointment? *

Mark only one oval.

- Yes
- No

40. We are required by law to provide the following Good Faith Estimate. This estimate is based on a year of treatment (52 weeks), at our regular rates. Your total may be less based on a negotiated rate with your clinician. *
Common service codes provided by Heart of Therapy, LLC:
90834: 45 minute counseling/psychotherapy session

Common service codes used by Heart of Therapy, LLC:
F43.20: Adjustment Disorder, Unspecified
Z91.49: Other Personal History of Psychological Trauma
Z62.820: Parent-Child Relational Problems
Z63.0: Relationship Distress with Spouse or Intimate Partner
Z72.89: Phase of Life Problem
Z62: Problems Related to Upbringing

Where services will be rendered:
350 S Main Street, Suite 213, Doylestown PA 18901
Online through agreed upon virtual format

Length of time in treatment:
Your clinician recognizes that every client comes into treatment with different needs and life circumstances. Each client's journey to healing is unique. The length of time in treatment is determined by many different factors, including: Your schedule and life circumstances,
Therapist availability, Ongoing life challenges, The nature of your specific challenges and how you address them

You and your therapist will continually assess the appropriate frequency and duration of therapy, and will work together to determine when you have met your goals and are ready for discharge.

The current full fee rates for psychotherapy services are:
45 minutes (Individual Psychotherapy): $175/session GFE: $9100 $150/session GFE: $7800
45 minutes (Couples/Family Psychotherapy): $200/session GFE: $10,400
45 minutes (Individual Psychotherapy + texting between sessions): $225/session
GFE: $11,700

Disclaimer
The Good Faith Estimate shows the cost of services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during the

course of treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) services that are more than $400 above the estimated cost of services.

The Good Faith Estimate is not a contract and therefore does not require you to obtain the items or services provided by Amanda Johns, LCSW. At the foundation of a good therapeutic relationship between client and therapist is the client's right to self determination and autonomy. Therefore you (as the client) have the right to terminate services at any time.

If you are billed for more than this Good Faith Estimate, you have a right to dispute the bill.
You may contact your clinician to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or as if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will pay the price of the Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider, you must pay the higher amount.

To learn more and to get a form to start the process, or to learn more about the Good Faith Estimate or No Surprise Act, go to www.cms.gov/nosurprises or call 1-800-985-3059

Do you understand this?

Mark only one oval.

- Yes
- No

Client Identities

This next section provides the opportunity to share the different identities of the client and their family. The answers to these questions are used to ensure that all of the client's identities are being considered in treatment. This helps the clinician to take into account the impact of issues related to culture, race, ethnicity, marginalization, oppression, bias, racism, antisemitism, bullying, etc.

41. What is the gender identity of the person being treated? *

42. What is the sexual identity of the person being treated? *

43. Has the person being treated experienced acceptance of their gender and sexual identity within their family and community? *

44. What is the race of the person being treated? *

45. What is the ethnicity of the person being treated? *

46. Is the race and ethnicity of the person being treated the same as the parents or caregivers? *

47. What, if any, are the religious or spiritual beliefs of the person being treated? *

48. Are the religious or spiritual beliefs of the person being treated the same as their parents or caregivers? *

49. Has the person being treated experienced foster care or adoption? *

50. If you answered "yes" to the previous question, at what age(s) was the person being treated adopted or involved with the foster care system?

Client Social and Educational Experiences

This next section provides the opportunity to share the different social experiences of the client. These questions provides your clinician with additional information that helps to inform the overall treatment.

51. Are the parents of the child divorced, separated or deceased or have they ever been divorced or separated? *

Mark only one oval.

- Yes
- No

52. Who lives with the person being treated? *

_____

_____

_____

_____

_____

53. Is the person being treated in school? *

Mark only one oval.

- Yes
- No

54. Where does the person being treated attend school? *

55. What is the current grade level of the person being treated? *

56. What kinds of grades does the person being treated receive in school? *

57. Does the person being treated have a 504 or IEP? *

Mark only one oval.

- Yes
- No

58. Does the person being treated like going to school? *

Mark only one oval.

- Yes
- No

59. What concerns, if any, do you have about the person being treated and school? *

60. Does the person being treated have friends? *

Mark only one oval.

- Yes
- No

61. Does the person being treated get invited to do things with friends? *

Mark only one oval.

- Yes
- No

62. Does the person being treated invite friends to do things with them? *

Mark only one oval.

- Yes
- No

63. Do you have any concerns about the person being treated and friends or friendships? *

64. Does the person being treated have any current or past legal involvement? *

Mark only one oval.

- Yes
- No

65. If you answered yes to the previous question, what is the current or past legal involvement? *

66. Has a Childline report ever been made related to the person being treated or others in the home, or a Children and Youth report or case made? *

Mark only one oval.

- Yes
- No

67. If you answered "yes" to the previous question, please explain.

68. Is the person being treated engaging in, or historically engaged in, substance use (including nicotine)? *

Mark only one oval.

- Yes
- No

69. If you answered "yes" to the previous question, please explain.

70. Has the person being treated ever directly experienced or witnessed racism, antisemitism, homophobia or bullying? *

Mark only one oval.

- Yes
- No

71. If you answered "yes" to the previous question, please explain.

72. What are the special interests or hobbies of the person being treated? Please explain in detail. *

73. Is the person being treated currently employed? *

Mark only one oval.

- Yes
- No

74. If the person being treated is currently employed, where are they working and what is their typical schedule.

Mental and Physical Health History

This next section provides the opportunity to share the mental and physical health history of the client. These questions provide the therapist with additional information that helps to inform the overall treatment.

75. Who is the primary care doctor of the person being treated? *

_____

76. When was the person being treated last seen by their primary care doctor? *

_____

77. Does the person being treated have any physical health diagnoses? *

Mark only one oval.

- ◯ Yes
- ◯ No

78. If you answered "yes" to the previous question, please explain.

_____

_____

_____

_____

_____

79. Has the person being treated ever complained of, or do they experience issues with appetite or their stomach? *

Mark only one oval.

- Yes
- No

80. Has the person being treated ever complained of, or do they experience issues with coordination or balance? *

Mark only one oval.

- Yes
- No

81. Does the person being treated have any physical health specialists that they see? *

Mark only one oval.

- Yes
- No

82. If you answered yes to the previous question, please explain.

83. Does the person being treated take any medication for physical ailments or diagnoses? *

Mark only one oval.

- Yes
- No

84. If you answered yes to the previous question, please explain. Include the names, reason, dosages and times that the medication is taken.

85. Has the person being treated ever engaged in any mental health treatment? *

Mark only one oval.

- Yes
- No

86. If you answered yes to the previous question, please explain.

87. Does the person being treated have any mental health diagnoses? *

Mark only one oval.

- Yes
- No

88. If you answered yes to the previous question, please explain.

89. Does the person being treated take any medication for mental health issues? *

Mark only one oval.

- Yes
- No

90. If you answered yes to the previous question, please explain.

91. Has the person ever experienced hospitalization or long term treatment for any physical or mental health issue? *

Mark only one oval.

- Yes
- No

92. If you answered yes to the previous question, please explain.

93. Thank you for taking the time to fill out this form. By writing your name below you affirm that you filled out this form, that the information is honest and accurate, and that you agree to the information which requires consent, unless otherwise noted. *