Linda K. Castor, RN, LCPC

Dependent Child/Adolescent/Young Adult Intake Form

Date: _____

Welcome! The information that you provide will help me get to know you better. All information is strictly confidential. If you have questions or are unable to answer any of the questions, simply leave them blank and we can discuss them further. ***Please provide your signature in all areas requested.***

Dependent's Name _____ Child or Parent SS# *(required for insurance billing)* _____

Address _____

(Street, Apt. No.) (City) (State) (Zip)

Date of birth _____ Age _____ Gender _____ School Name and Grade _____

Employer Name (*if applicable)* _____ Approximate date of last physical exam _____

Primary Medical Healthcare Provider:

_____

(Name) (Address/Office location) (Phone number)

Secondary Medical Healthcare Provider (if applicable):

_____

(Name) (Address/Office location) (Phone number)

1.) Parent's Name _____ Relationship _____

Cell Phone _____ Email Address _____

DOB _____ Lives with? (Circle one): Y or N

Address _____

(Street, Apt. No.) (City) (State) (Zip)

Employer _____ Occupation _____

2.) Parent's Name _____ Relationship _____

Cell Phone _____ Email Address _____

DOB _____ Lives with? (Circle one): Y or N

Address _____

(Street, Apt. No.) (City) (State) (Zip)

Employer _____ Occupation _____

Current custody arrangements/living arrangements _____

Sibling's names	Relationship	Gender & Age	Reside in your home?

Whom may we thank for referring you? _____

Current physical conditions and any chronic conditions: _____

_____

Please list all medications you are taking (prescription and over-the-counter) and include dosage if known: _____

_____

_____

Allergies (food-drugs-environmental): _____

Hobbies, exercise & recreation: _____

Client Financial Agreement

Payment of session fees, insurance co-payment, coinsurance and deductible, or other charges are due at the time of service unless prior arrangements have been made. Verification of insurance coverage, obtaining referrals and pre-certification is the responsibility of the client. It is also the client's responsibility to inform provider as **information changes**, such as address, phone number, **insurance coverage and co-pay.**
There will be a charge for all checks returned for any reason. *Please refer to the attached list of fees for service.*

Linda is *not a Medicaid or Medicare Provider.* Clients using out-of-network benefits must pay the full fee upfront for services and may file a claim for insurance reimbursement, according to their policy terms. Regretfully, any Memorial Medical Center Employee must pay full fee, due to employee-signed contracts.

Statements are typically sent on a monthly basis. You are financially responsible for all charges. This includes the balance remaining after payment of insurance benefits; charges for non-covered services or missed appointments, and any billing charges, collection agency fees of up to 60% of the delinquent balance, and legal fees related to payment of your account in full. We add a billing charge of 1.5% accrued on a monthly basis to all delinquent accounts. If payments are not made as agreed, your account may be turned over to a collection agency after 90 days delinquency.

Mental Health Evaluation/Assessments/Consultations: Reports for probation, court, disability, FMLA, and letters to physicians, teachers, schools and completion of paperwork are pro-rated for the amount of time taken to prepare the report. All reports and court testimony must be paid in advance of receipt of report or court testimony.

If you need to reschedule or cancel an appointment, 24-hour notice is required. If I have notice, I can offer the time to another client. Failure to provide notice will result in a **full private pay charge** for the missed appointment. This charge may be waived in the case of illness, unforeseen sudden circumstance or emergency.

Billing Insurance Information *(If different from client's information):*

Insured Name and Address _____

Insured Relationship to Client: _____

Insured SS#: _____

Insured Date of Birth: _____

Insured Phone Number: _____

Please allow me to make copy of your insurance card and photo ID. If I forget to ask you, please let me know.

By signing here I agree to the policies set forth in the Financial Agreement, and I authorize Linda Castor to submit claims for services to my insurance company, and authorize my insurance company to make payment for these services directly to my provider.

_____	_____	_____
PRINT Client or Guarantor Name	Client or Guarantor SIGNATURE	Date

Linda K. Castor, RN, LCPC

Standard Charges

Court appearance, hourly rate	$400.00
School visit, hourly rate	$300.00
Cancelled Session (less than 24 hours)	$190.00
Missed session (full private pay fee)	$190.00
Diagnostic interview	$230.00
Individual therapy	$190.00
Family therapy with client	$190.00
Family therapy without client	$190.00
Phone consultation, 1 - 15 minutes	$48.00
Phone consultation, 16 - 30 minutes	$95.00
Phone consultation, 31 - 45 minutes	$143.00
Correspondence/Report	$65.00
NSF check fee	$50.00
Copy fee for client records	$50.00

Problem Checklist

Please rate the following symptoms by circling a number

0 - Not at all 1 - Mild 2 - Moderate 3 - Severe

For couples counseling: please complete separately

decrease in energy or fatigue	0	1	2	3	distractibility/poor concentration	0	1	2	3
hyperactivity	0	1	2	3	impaired judgment	0	1	2	3
impulsivity/recklessness	0	1	2	3	indecisiveness	0	1	2	3
increased social activity	0	1	2	3	memory impairment	0	1	2	3
increased sexual activity	0	1	2	3	flight of ideas/racing thoughts	0	1	2	3
restlessness	0	1	2	3	incoherence/loose associations	0	1	2	3
decline at work/school	0	1	2	3	pressured speech	0	1	2	3
aggression or rage	0	1	2	3	anxiety	0	1	2	3
antisocial	0	1	2	3	fear of separation	0	1	2	3
compulsions	0	1	2	3	panic attacks	0	1	2	3
destructive	0	1	2	3	phobic responses	0	1	2	3
disorganized	0	1	2	3	worrying	0	1	2	3
oppositional or defiant	0	1	2	3	delusions	0	1	2	3
self-injurious	0	1	2	3	depersonalization	0	1	2	3
social withdrawal	0	1	2	3	hallucinations	0	1	2	3
violates rules	0	1	2	3	obsessions	0	1	2	3
sleep disturbance	0	1	2	3	paranoia	0	1	2	3
anger or hostility	0	1	2	3	flashbacks/recall stressful events	0	1	2	3
apathy	0	1	2	3	suicidal thoughts	0	1	2	3
depressed mood	0	1	2	3	bingeing/purging	0	1	2	3
elevated mood	0	1	2	3	decrease/increase in appetite	0	1	2	3
excitability	0	1	2	3	unable to maintain normal weight	0	1	2	3
feeling guilty/worthless	0	1	2	3	substance abuse	0	1	2	3
helplessness	0	1	2	3	substance abuse disrupts daily functioning	0	1	2	3
irritability	0	1	2	3	inability to decrease substance abuse	0	1	2	3
loss of interest in activities	0	1	2	3	tolerance to substance	0	1	2	3
low self esteem	0	1	2	3	withdrawal from substance	0	1	2	3
mood swings	0	1	2	3	excessive time using/recovering from use	0	1	2	3
diminished ability to think	0	1	2	3	Other:	0	1	2	3

What is your primary concern or reason for coming to therapy?_____

_____

When did the problem(s) arise?_____

What other issues do you want to address in counseling?_____

_____

_____

What are your goals for therapy/counseling?_____

_____

Linda K. Castor, RN, LCPC

Explanation of Confidentiality

The information you share with me is confidential. I am bound legally and ethically from sharing any of your information without your expressed written consent. However, there are certain situations or limits to this confidentiality that you need to know. The following are examples of specific instances when I am required to talk to someone about your care:

If I believe you or another person is in physical danger, I must tell others about it.
Specifically,

- If I come to believe that you are going to seriously physically harm another person, I must take all steps necessary to protect that person. This may involve calling the police, informing that person, or recommending you be hospitalized.
- If I believe you are going to seriously harm yourself, then I may need to recommend you be hospitalized or contact your family members or others that can help to keep you safe.
- In an emergency, where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life.
- If I suspect that you are abusing a child, an elderly person, or a disabled person, I must report this to a state agency. "Abuse" means to neglect, physically harm, or sexually molest another person.

In all of the above situations, I would try to talk about the situation with you in advance, if possible. I would reveal only what is needed to protect you or the other person.

In general, if you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. This is called "privilege," and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

- In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt
- In cases where your emotional or mental condition is important information for a court's decision
- During a malpractice case, investigation of me or another therapist by a professional group
- When you are seeing me for court-ordered evaluations or treatment. In this case, we need to discuss confidentiality fully because you do not have to tell me what you do not want the court to find through my report.

There are a few additional things you must know about confidentiality and your treatment:

- I may sometimes consult with another professional about your treatment. This other person is also required by law and professional ethics to keep your information confidential.
- I am required to keep records of your treatment, such as notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.

Explanation of Confidentiality (Continued)

When I treat children **under the age of 12**, I am obligated to share as much as their parents or guardians would like to know. Children that are between **the ages of 12 and 18** have more legal rights, and most of what is discussed with me during treatment is confidential. However, parents or guardians do have the right to general information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also need to talk about other family members with parents or guardians, specifically if their actions put them or others in any danger.

In cases where I treat several members of a family (parents and children or other relatives) the confidentiality situation can become complicated. At the start of our treatment, we must all have a clear understanding of our purposes and my role and the limits of confidentiality.

- If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. We will discuss the best way to handle situations like these.
- If you and your spouse have a custody dispute, or a court custody hearing is coming up, I need to know about it. My professional ethics prevents me from doing both therapy and custody evaluations.
- If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.
- At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create for therapy.

Confidentiality in group therapy is also a special situation.

In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.

Finally, here are a few other points:

- I will not record our therapy session on audiotape or videotape without your written permission.
- If you want me to send information about our therapy to someone else, you must sign a *Release of Records* form.
- Any information that you also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Situations that are not mentioned her come up only rarely. Please keep in mind that I am not able to give you legal advice. If you have special or unusual concerns or need special advice, I strongly suggest that you speak with an attorney.

The signature below shows that you have read, understand, and agree to abide by the points presented above.

_____ _____

Client's PRINTED Name Date

_____

Client's SIGNATURE

Linda K. Castor, RN, LCPC

Client Directives for Confidentiality

I typically contact each client with an appointment reminder. I also may periodically send billing statements to clients with outstanding balances and other mailings. Because these communications include confidential medical information, your preferences regarding how information is shared must be written below.

Please review the following **carefully**, check a box to indicate your preference and sign below:

1. **Appointment reminders:**

   ❑ Do not send appointment reminders

   ❑ Send appointment reminder via text message to cell phone #:_____
   This is provided as a courtesy for clients.
   You are responsible for attending your appointment, whether or not you receive a reminder.

2. **Billing Statement (for the clients with an outstanding balance):**

   ❑ Send billing statements to my home address that I have provided to you.

   ❑ Use the following special instruction regarding other mail:
   _____

3. **Other mail from our office:**

   ❑ Send to my home address that I have provided to you.

   ❑ Use the following special instruction regarding other mail:
   _____

4. **Consent to Authorize Release for Authorization**

   ❑ If indicated, I will sign a release for Linda K. Castor, RN, LCPC to communicate with my primary care physician, or anyone Linda and I determine necessary for treatment and continuity of care.

   ❑ I decline to give consent to authorize the release of information

I have read and checked my preferences regarding the four items detailed above.

_____ _____

Client's PRINTED Name Date

_____

Client's SIGNATURE