Serenity Counseling LCSW PLLC
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CHILD/ADOLESCENT INDIVIDUAL INTAKE

Therapist Name: _____ Date: _____

Client's Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Social Security Number: _____ School: _____

Parent/Guardian 1 Name: _____ Address: _____

Telephone: Home: _____ Cell: _____Work: _____

Drivers License #: _____ Email Address: _____

Parent/Guardian 2 Name: _____ Address: _____

Telephone: Home: _____ Cell: _____Work: _____

Drivers License #: _____ Email Address: _____

Emergency Contact: _____ Telephone: _____

Referred By: _____

INSURANCE

Check Type of Insurance: ☐ Private ☐ Medicare ☐ EAP ☐ None Insurance Company: _____

Policy #: _____ Group #: _____ Relationship to Insured: _____

Policy Holder: _____ Insured's DOB: _____ Insured's SS#: _____

EAP Name: _____EAP Authorization #: _____ EAP Phone #: _____

FINANCIAL RESPONSIBILITIES (Please Initial)

Co-Payments are due at the time of service _____.

I hereby assign payment of insurance benefits directly to Serenity Counseling LCSW PLLC. While Serenity Counseling LCSW PLLC will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay _____.

It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied I will be responsible for all charges _____.

If my portion of the bill is not paid within 90 days from the last date it was incurred a letter will be sent giving you 14 days to pay your account or to arrange for a payment plan. If you do not respond you will be sent to collections _____.

Client Name: _____ Date: _____

It is my responsibility to inform my therapist of any changes to my insurance coverage. I am financially responsible for any lapses in insurance coverage _____.

While Serenity Counseling LCSW PLLC will provide me with a courtesy insurance benefits check, I am still responsible for understanding what my insurance covers and verifying this coverage _____.

I will be billed for phone consultations, letters and/or medical record copies at the therapists standard rate by 15 minute increments _____.

A 1% interest will be added to your portion of the bill that remains unpaid after 30 days _____.

Returned check fees $35.00 and the check amount _____.

You will be charged $95 for missing an appointment: no-show/not giving at least 24 hours prior notice to cancelling an appointment _____.

I have received the treatment agreement and disclosure statement. I understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company, if necessary, and any charges that my insurance company will not cover I am responsible for.

To enable my therapist with accurate and confidential services please complete the following:

Please be aware that fax transmissions arrive at Serenity Counseling LCSW PLLC office and are distributed to the individual therapist. Confidentiality is maintained with these records, as with all records in our office.

Messages regarding appointments may be left on my voicemail _____Yes _____No.

The following individuals may schedule and/or confirm appointments _____.

HIPPAA LAW: Notice of Privace Practice Achnowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to …

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payments from third-party payers.
- Conduct normal health care operations such as but not limited to quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices containing more complete descriptions of the uses and disclosure of my health information. I understand that a professional entity has the right to change its Notice of Privacy Practices from time to time and that I may contact that professional at the address above to obtain a current copy of this information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name (print): _____ Client Signature: _____
Parent/Guardian (print): _____ Parent/Guardian Signature: _____

Client Name: _____ Date: _____

CONSENT FOR TREATMENT OF MINORS (only fill out for under 18)

I (guardian name) _____ give my consent that (therapist) _____, will be conducting psychotherapy with (minor name) _____. My relationship to the client (parent, foster parent, guardian etc…) _____. I was also notified that all material discussed during psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in Office Policies for, which I have read and signed.

In the case of a minor special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept (therapist) _____ judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well-being.

To be Completed if Custody Arrangement Exists:

It is the responsibility of the consenting parent to inform the other legal parent of the participation of your child's counseling services and its progress. It is also the responsibility of the consenting parent to provide their therapist with the legal custody documentation, as well as advising your counselor of any changes to your custody agreements. I acknowledge I have (please check) ☐ sole legal custody ☐ joint shared legal custody

In the case of parents who have joint legal custody, please provide the name and contact information of the other parent. Serenity Counseling LCSW PLLC counselors believe that it is best clinical practice that an effort is made to connect with both parents. **We understand there are certain circumstances where this may not be appropriate or may not be possible and this can be discussed with your treatment provider.** Please provide the following information of the other parent, if known:

_____

Name Address Phone

Does this parent have (please check) □ sole legal custody □ joint/shared legal custody?

By signing this, I acknowledge that I have legal custody and that the information I am providing written and/or verbally is true and accurate. My child's treatment provider has the right to discontinue treatment if information is not provided accurately. **By signing below, I acknowledge my responsibilities and consent to treatment of my minor child.**

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Print Relationship Date

Client Name: _____ Date: _____

What brings you and your child to counseling and what goals/skills do you hope to gain?

Stregnths Assessment: Please check all items that you think apply to you

Trustworthy	Listens Well	Kind	Playful
Good Sense of Humor	Flexible	Spontaneous	Open to Grow
Courageous	Forgiving	Enjoys Learning	Creative
Exercises	Calm	Fun	Resourceful
Happy Most of the Day	Good Communication Skills	Living for a Purpose	Financially Stable
Family Support	Decisive	Organized	Keeps Word
Confident	Close Friendships	Does Not Make Assumptions	Does Not Take Things Personally
Do Your Best Most of the Day	Friendly	Team Player	Relaxes
Eats Nutritional Foods	Articulate	Generous	Accepting

Needs Assessment: Please check individual items that are of concern to you
Please circle the two most important

Learning Disability	Antisocial Behavior	Stress	Bullying Victim
School Difficulties	Animal Cruelty	Nervousness	Health Problems
Concentration	Fire setting	Shyness	Bowel Trouble
Memory	Self-Esteem	Guilt	Stomach Trouble
Impulsivity	Hopelessness	Anxiety	Appetite/Weight
High Energy/Low Energy	Withdrawal from Others	Nightmares	Headaches
Self-Control	Unhappy	Sleep Problems	Use of Time
Poor Judgment	Lack of Motivation	Phobias/Fears	Improve Communication Skills
Lying	Meaningless	Mood Shifts	Social Skills
Running Away	Negative	Repetitive/Intrusive Thoughts	Dating/Relationships
Irritability Temper/Anger	Crying Spells	Eating/Food/Hoarding	Sexual Activity
Irritability	Loneliness	Bed wetting/Soiling Self	Drug/Alcohol Use
Harm to Others	Depressed	Panic Attacks	Unresolved Grief
Aggression/Bullying	Harm to Self	Trauma	Sibling Issues
Physical Fighting	Suicidal	Abuse	Parenting Needs

Client Name: _____ Date: _____

Has there been any Significant Stressors in the Family? Please Mark "C" for Child or "F" for Family.

C	F		C	F	
☐	☐	Medical Complications	☐	☐	Car Accident
☐	☐	Death of a Loved One	☐	☐	Parent Separation
☐	☐	Frequent Moves	☐	☐	Legal Problems/Court Involvement
☐	☐	Deployment	☐	☐	New Siblings
☐	☐	Change of Schools	☐	☐	Parents Remarried
☐	☐	Financial Stressors	☐	☐	Natural Disaster
☐	☐	Divorce	☐	☐	Change in Living Situation
☐	☐	Significant Injuries	☐	☐	Witnessed Violence

DEVELOPMENTAL HISTORY

Pregnancy and Birth:

Were there any complications during pregnancy? (ie. High blood pressure, diabetes, hospitalizations)
Please describe: _____
_____
_____

List any Medications used during pregnancy: _____

Please Circle the following:

Smoking Yes No How much_____
Alcohol Intake Yes No How much_____
Drug Intake Yes No How much and type of drug _____
Legnth of Pregnancy _____weeks Age of mother at birth _____ Birth Weight _____

Please state any complications during delivery: _____
_____
_____

Developmental Milestones and Early Development:

At what age did your child do the following: (indicate approximate month or year for each):

Turn Over _____ Crawl _____ Stand Alone _____ Walk Alone _____
Toilet Trained _____ Days _____ Nights _____
Has your child wet him/herself after being trained? Yes ___ No ____ If yes, until what age? ___
Has your child soiled him/herself after being trained? Yes ___ No ____ If yes, until what age? ___

Family Information:

Please list your child's siblings in the order of birth (including adopted and/or step siblings).

First Name	Biological/Adopted/Step	Current Age	School Grade	Male/Female	Lives With	Please List any Medical, Social, or Academic Difficulties

HEALTH INFORMATION

List all current medications and vitamins/dosage: _____

_____

_____

List all current health problems including allergies: _____

_____

_____

Past Psychiatric History (mental health and chemical dependency): hospitalizations (please explain)

_____

_____

_____

Prior outpatient therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment and/or medications: _____

_____

_____

Name of your Primary Care Physician: _____ May we contact? YES NO
Phone Number: _____ When were you last seen? _____

I give consent or do not give consent (circle one) for my therapist, _____
to release my records to my primary physician to discuss my treatment,

_____ _____ _____
Print Name Signature Date

RISK ASSESSMENT (Please Circle)

Suicidal Ideation: None Noted Thoughts Only Plan Means Attempt Able to contract

Homicidal Ideation: None Noted Thoughts Only Plan Means Attempt Able to contract

Client Name: _____ Date: _____

DRUG AND ALCOHOL ASSESSMENT

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office? (Please Circle) Yes No

If yes, self/other and their relationship to you: _____

Frequency of Alcohol Use:

_____Never _____Less than 1 time/month _____1-4 times per month _____2-3 times per week ____daily

Usual Alcohol Consumption:

_____Never _____1-2 drinks _____3-4 drinks per sitting _____5 or more drinks per sitting

Frequency of Use to Levels of Intoxication:

_____Never _____Less than 1 time/month _____1-4 times per month _____2-3 times per week ____daily

Self-Perception of Alcohol Use: (Check all that Apply):

___Occasional or Social ___Problem Use ___Psychological Dependence

___Addicted-Cannot Stop ___Do Not Want to Stop ___Motivated to Stop

History of Treatment Attempts: (Check all that Apply):

___None ___Stopped on Own ___ Attended AA/other 12 Step Program

___Attended Outpatient Program ___Attended Inpatient Program ___Attended Community Based Program

Please Describe any Drug-related Problems (ex. legal, job, physical, or social): _____

Self Perception of Drug Use: (Check all that Apply)

___Occasional or Social ___Problem Use ___Psychological Dependence

___Addicted-Cannot Stop ___Do Not Want to Stop ___Motivated to Stop

History of Treatment Attempts: (Check all that Apply):

___None ___Stopped on Own ___ Attended AA/other 12 Step Program

___Attended Outpatient Program ___Attended Inpatient Program ___Attended Community Based Program

List a Community Resource You are Currently Benefitting from: _____

Risk Factors to Include:

Non-Compliance with Treatment Domestic Violence Eating Disorder

AMA/Elopement Potential Child Abuse Suicidal/Homicidal

Prior Behavioral Health Inpatient Admissions Sexual Abuse Other:

Client Name: _____ Date: _____

Legal Information:

Do you have a probation officer or case worker? If yes, what is his/her Name, Phone number and Address:

_____

Do you have an attorney? If yes, what is his/her Name, Phone number and Address:

_____

Marital Information:

Married ___ Widowed ___ Widowered ___ Divorced ___ Living Together ___ Separated ___ Single ___

If other please explain: _____

List Dates and Legnths of Previous Marriages: _____

Write 3 of your beliefs that Support your Life: _____

_____

_____

Signature of Understanding

Please sign below to indicate that "I have read the above policies and I understand and agree to comply with them. The information shared is true and accurate. I further agree that I am personally responsible for all financial obligations incurred. I also consent to receive treatment by a Serenity Counseling LCSW PLLC provider."

_____

Parent/Guardian Print Name Date

_____

Parent/Guardian Sign Name Date

*****FOR OFFICE USE ONLY*****

Disclosure Statement Signed- Yes No	Insurance Card Copied- Yes No
CCA Completed and signed- Yes No	Treatment Plan Completed and Signed- Yes No
Intake Paperwork with HIPAA and Minor Consent form Completed and Signed- Yes NO	Release Form to Speak with Physician Completed and Signed- Yes No N/A
Billing Diagnosis Is:	For Billing: Consumer is Entered into System- Yes No

Client Name: _____ Date: _____