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CHILD PERSONAL DATA INVENTORY

Please be sure to complete both sides of all sheets.

Thank you for completing these forms as accurately as possible. This information is used to help us, the Samaritan Counseling Center of Southwestern Michigan (SCC), do a better job of helping the child. All the information is completely confidential, and will not be released to anyone without the guardian's permission, unless ordered by a court of law.

SCC rev. 2/12

SECTION I: GENERAL INFORMATION

Child's Name _____ Date _____

Address _____ Home Phone _____ Message OK? Y N

City _____ State _____ Zip _____ Business Phone _____ Message OK? Y N

Sex _____ Birth Date _____/_____/_____ Age _____ Place of Birth _____

Religion _____ Place of Worship _____

Racial/Ethnic Identity: ☐ African American ☐ Asian ☐ Caucasian ☐ Latino/Hispanic ☐ Native American

☐ Other _____

Education: Current grade or last year of school completed:

1 2 3 4 5 6 7 8 9 9 10 11 12

Current school, teacher, and principal _____

_____

SECTION II: PARENT / GUARDIAN INFORMATION

Parent/Guardian Name _____

Parent/Guardian's current relationship status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Engaged ☐ Dating ☐ Living with significant other ☐ Spouse/partner deceased. If so, when? _____

Occupation _____ Employer _____ Business phone _____

Age _____ Education (last year finished or degree) _____ Religion _____

Spouse/Partner's Name _____

Address (if different) _____ Phone _____

Occupation _____ Employer _____ Business phone _____

Age _____ Education (last year finished or degree) _____ Religion _____

Who is living in the same home with the child right now?

Name	Relation to child
Name	Relation to child
Name	Relation to child
Name	Relation to child
Name	Relation to child
Name	Relation to child

Are there any spiritual concerns of which you would like your child's therapist to be aware?

_____

_____

_____

Nearest relative or friend of family: ***(this should be a person whom we could contact in case of emergency, including a mental health emergency)***

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____ Phone _____

Referred here by _____ Relationship _____

If we may thank the person who referred you to SCC, please initial here: _____
(No information about you will be released.)

SECTION III: CHILD'S PHYSICAL / MEDICAL / MENTAL HEALTH INFORMATION

Rate child's physical health: ☐ Good ☐ Average ☐ Poor

List important present or past illnesses or injuries: (***include any hospitalizations and dates)***

_____

_____

_____

Date of last medical examination _____ Physician's Name _____

Child's regular (primary care) physician, if different _____

Is child presently taking prescription medication? ☐ Yes ☐ No

What and how much?

_____

_____

Medication given by: ☐ Psychiatrist ☐ Personal Care Physician ☐ N/A

Has child ever been treated or seen by a psychiatrist or counselor? ☐ Yes ☐ No If so, when? _____

Name: _____ Approx. number of sessions _____

Name: _____ Approx. number of sessions _____

Does child have a history of or current problem in any of the following areas?

	Eating problems		Bed wetting		Masturbation
	Sleep difficulties		Wetting pants		Runaway
	Speech difficulties		Soiling pants		Truancy
	High temperatures		Constipation		Distractible
	Head injuries		Headaches		Temper tantrums
	Other serious injury		Hospitalizations		Social withdrawal

If child is 13-18 years of age, please have him/her fill out Section IV.

If child is 12 years of age or younger, parent/guardian must complete Section IV.

If filled out by someone other than child, please state who: _____

SECTION IV: WHAT BRINGS YOU TO THE SAMARITAN COUNSELING CENTER?

Please briefly describe your reason for seeing a counselor today:

_____

_____

_____

_____

Has this problem affected you/your child's:

- ☐ Relationships
- ☐ Work
- ☐ Mood
- ☐ Sexuality
- ☐ Eating
- ☐ Sleeping
- ☐ School
- ☐ Family
- ☐ Health
- ☐ Finances
- ☐ Anxiety level
- ☐ Concentration

Please list any deaths, significant losses, and/or traumas, with dates, and any recent major transitions:

_____

_____

_____

_____

Have you/your child ever or are you/your child currently experiencing any form of sexual abuse? ☐ Yes ☐ No

_____

Have you/your child ever been or are you/your child currently in a domestic violence situation? ☐ Yes ☐ No

_____

Do you/your child feel safe in your current living situation? ☐ Yes ☐ No

_____

Is there anything else that would be helpful for the therapist to know?

_____

_____

_____

_____

(See next page)

Put a check by anything below that you/your child has experienced within the past three months.
It is important that every question try to be answered.

CHILD'S THOUGHT PROCESSES

	Not at All	Mildly	Moderately	Severely	Extremely
Killing yourself or others	☐	☐	☐	☐	☐
Racing thoughts	☐	☐	☐	☐	☐
Seeing things others do not	☐	☐	☐	☐	☐
Always worried	☐	☐	☐	☐	☐
Paranoid thoughts	☐	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐	☐
Worried about health	☐	☐	☐	☐	☐
No one understands me	☐	☐	☐	☐	☐
Hearing voices inside head	☐	☐	☐	☐	☐
Experiencing flashbacks	☐	☐	☐	☐	☐
Out of body experiences	☐	☐	☐	☐	☐
Repetitive obsessive behaviors or thoughts	☐	☐	☐	☐	☐
Weakening Fears	☐	☐	☐	☐	☐
Confused easily	☐	☐	☐	☐	☐
Feel like in a fog	☐	☐	☐	☐	☐
Believe being watched	☐	☐	☐	☐	☐

CHILD'S FEELINGS

	Not at All	Mildly	Moderately	Severely	Extremely
Feel numb inside	☐	☐	☐	☐	☐
Feeling angry	☐	☐	☐	☐	☐
Feeling fearful	☐	☐	☐	☐	☐
Feeling low, worthless	☐	☐	☐	☐	☐
Feeling anxious, nervous	☐	☐	☐	☐	☐
Feeling angry often	☐	☐	☐	☐	☐
Feeling like others are secretly against you	☐	☐	☐	☐	☐
Feel like smashing things	☐	☐	☐	☐	☐
Feel like hurting someone	☐	☐	☐	☐	☐
Feeling easily hurt	☐	☐	☐	☐	☐
Feeling lonely	☐	☐	☐	☐	☐
Not enjoying things	☐	☐	☐	☐	☐
Grieving	☐	☐	☐	☐	☐
Feeling panicky	☐	☐	☐	☐	☐
Lacking confidence	☐	☐	☐	☐	☐
Afraid of going out	☐	☐	☐	☐	☐
Feeling tense	☐	☐	☐	☐	☐
Depressed	☐	☐	☐	☐	☐
Feeling guilty	☐	☐	☐	☐	☐
Feeling confused	☐	☐	☐	☐	☐
Feeling hopeless	☐	☐	☐	☐	☐
Feeling overly happy often	☐	☐	☐	☐	☐
Experiencing frequent mood shifts	☐	☐	☐	☐	☐

CHILD'S BEHAVIORS

	Not at All	Mildly	Moderately	Severely	Extremely
Explosive anger	☐	☐	☐	☐	☐
Withdrawn	☐	☐	☐	☐	☐
Can't make own decisions	☐	☐	☐	☐	☐
More impatient	☐	☐	☐	☐	☐
Don't like being alone	☐	☐	☐	☐	☐
Difficulties at school	☐	☐	☐	☐	☐
Impulsive	☐	☐	☐	☐	☐
Can't concentrate	☐	☐	☐	☐	☐
Easily excited	☐	☐	☐	☐	☐
Difficulties in relationship	☐	☐	☐	☐	☐
Very restless	☐	☐	☐	☐	☐
Full of energy	☐	☐	☐	☐	☐
Crying spells	☐	☐	☐	☐	☐
Unable to have fun	☐	☐	☐	☐	☐
Unable to pray	☐	☐	☐	☐	☐
Unable to relax	☐	☐	☐	☐	☐
Repetitive compulsive behaviors	☐	☐	☐	☐	☐
Spending a lot of money	☐	☐	☐	☐	☐
Strange sexual urges	☐	☐	☐	☐	☐
Cutting or hurting self	☐	☐	☐	☐	☐
Others have concern about risk behaviors	☐	☐	☐	☐	☐

CHILD'S PHYSICAL CONDITIONS

	Not at All	Mildly	Moderately	Severely	Extremely
Always tired/lack of energy	☐	☐	☐	☐	☐
Poor appetite	☐	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐	☐
Weight loss	☐	☐	☐	☐	☐
Trouble sleeping	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Shaky hands	☐	☐	☐	☐	☐
Stomach trouble	☐	☐	☐	☐	☐
Frequent headaches	☐	☐	☐	☐	☐
Fainting spells	☐	☐	☐	☐	☐
Muscles twitching or jumping	☐	☐	☐	☐	☐
Chest feels tight	☐	☐	☐	☐	☐
Fast heartbeat	☐	☐	☐	☐	☐
Frequent sweating	☐	☐	☐	☐	☐
Nausea or vomiting	☐	☐	☐	☐	☐
Drugs/takes calming medicine	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Cold feet and hands	☐	☐	☐	☐	☐
Often feel sick	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Muscle aches	☐	☐	☐	☐	☐

MISSED APPOINTMENTS

Successful counseling requires a commitment to attending all scheduled appointments.

Missed appointments mean lost revenue for the Center, which hampers our ability to offer fees on a sliding scale.

You will be charged for appointments missed without 24 hour prior notice and you will not be able to schedule another appointment until the missed appointment has been paid for.

(Insurance cannot be billed for missed appointments.)

Please discuss any questions with your therapist.

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FORMS A, B, C – SIGNATURE PAGE

PLEASE RETURN THIS FORM TO THE CENTER – YOU MAY REQUEST A PHOTO COPY FOR YOUR RECORDS

This signature page acknowledges that the **Center[ed] On Wellness** has provided you (print name) _____ our new Client, with the following documentation:

- **Form A – Counseling Agreement** (PAGE 1 OF 5, *cow rev. 2/2020*)
  - _____ *(initial)* I/We have read, understand, and guarantee payment of all charges incurred for treatment of the above named client(s).

- **Form B – Client Documentation and Destruction Policy** (PAGE 2 OF 5, *cow rev. 2/2020*)
  - _____*(initial)* I/We have read and understand the information shared regarding client file documentation and destruction.

- **Form C – Notice of Privacy Practices** (PAGES 3 & 4 OF 5, *cow rev. 2/2020*)
  - _____ *(initial)* I/We have read and understand the information shared regarding PHI and HIPAA for treatment of the above named client(s).

Signature **Date**

Signature **Date**

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FORM A - COUNSELING AGREEMENT

PLEASE KEEP THIS FORM FOR YOUR RECORDS

Welcome to **Center[ed] On Wellness** (the **Center**). This document (**Form A – Counseling Agreement**) contains important information about our professional services and business policies. The second page (**Form B – Client Documentation Retention and Destruction Policy**) contains important information about the retention of your client file. The second, third and fourth pages (**Form C – Notice of Privacy Practices**) contains important information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and Client rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that the Center provide you with this notice for use and disclosure of PHI for treatment, payment and mental health care operations.

On page five (**Forms A, B, C – Signature Page**), the Law requires the Center to obtain your signature, acknowledging that you have been provided the information in Forms A, B, and C. Your signature also represents an agreement between us. Once outstanding obligations and/or unsatisfied financial obligations have been met, you may revoke this agreement in writing at any time.

CONSENT TO TREATMENT/CONFIDENTIALITY:

- The Client(s) consents to counseling treatment for him/her/their and/or his/her/their child at the Center. In giving consent, the Client understands that information about the Client and/or Client counseling will remain confidential, including the fact that the Client is being seen as a Client, with the following exceptions:
  - Information may be discussed, when deemed appropriate, for supervision or consultation with Center's clinical staff.
  - If the Center has reason to believe that a child, a developmentally disabled adult, or an elderly person is being abused or neglected, it must, under state law, report the suspected abuse to the proper authorities.
  - If the Center feels that a client is a danger to themselves or another person.
  - If the Center feels that a client is unable to take care of their basic living needs.
  - The Client may have to provide specific information to the court if a Court Order is issued.

CANCELLED OR MISSED APPOINTMENTS:

- Three missed appointments by a client will result in the termination of services by the Center.
- The charge for missed appointments or appointments cancelled with less than 24 hour notice is $25. This charge is the responsibility of the Client and cannot be billed to any insurance and must be paid before services can resume.

PAYMENT POLICY:

- The per session fee for counseling is: $150 for the initial evaluation; $120 for individual counseling; $135 for family counseling. May be subject to change without prior written notice. Payment is expected at the time of your session and before it begins.
- If you have insurance, which will cover all or a portion of the cost of service, the Center will file your insurance claim and will arrange to have your insurer pay us directly. You are responsible for paying your deductible and your co-pay. Failure to pay for two (2) consecutive sessions may result in suspended scheduling of another counseling session until an agreed upon payment is made.
- Unpaid insurance balances that are 60 days old or older automatically become the Client responsibility. Account balance payment in full, or arrangement for payment, is expected within 25 days of receipt of statement. Failure to make payment, or arrangement for payment, may result in suspended scheduling of another counseling session.
- Fees for legal testimony are $300 per hour calculated from portal to portal. Legal testimony fees are generally not covered by insurance and are the responsibility of the Client. Client must pay all outstanding fees not covered by insurance before counseling can resume.
- When telephone and/or electronic media consultation is provided, a Client consultant fee of up to $30 per quarter-hour may be charged. Telephone and/or electronic media consultation fees are generally not covered by insurance and are the responsibility of the Client. Client must pay all outstanding fees not covered by insurance before counseling can resume.
- When the Center is required to provide written reports, summaries, letters, and/or documentation, a Client consultant fee of up to $30 per quarter-hour may be charged. Consultation fees are generally not covered by insurance and are the responsibility of the Client. Client must pay all outstanding fees not covered by insurance before any documentation will be released or counseling can resume.
- If the client is court ordered, or otherwise needs documentation or reports sent to the courts, attorneys, or other offices or officials, must have a zero account balance with the Center before the documentation or reports will be released.

TELEPHONE MESSAGES OR ELECTRONIC NOTIFICATIONS:

- Permission is granted to the Center to leave messages (voice, text, or other mutually approved electronic notification) at the contact number(s) provided by the Client.

INSURANCE:

- Permission is granted to the Center to contact the Client's insurance provider by telephone, fax or internet, for the purpose of determining outpatient mental health benefits, getting authorization to provide outpatient mental health services, providing information required by the Client's insurance company for payment of claims, and/or other reasons that directly relate to the Center's ability to provide treatment or receive payment for services provided.

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FORM B - CLIENT DOCUMENTATION AND DESTRUCTION POLICY

PLEASE KEEP THIS FORM FOR YOUR RECORDS

This document contains important information about the **Center[ed] On Wellness** (The **Center**) Client document retention and destruction policy. According to the Public Health Code, Client records must be kept on file for a minimum of five years. The file includes any tests performed, observations and treatments. The requirement may be waived only if the Center receives a written consent form from the Client agreeing to the destruction of the record or if the Center sends notice to the Client indicating the record will be destroyed, but allows time for the Client to request a final copy of the file. Should the Center sell or close the business, the Center should send a written notice to the last known address of the Client indicating who shall have custody of the files and how the Client may request a copy of the records.

MICHIGAN MEDICAL RECORDS RETENTION ACT:

On December 22, 2006, a law was signed in Michigan which impacts the maintenance and retention of medical records. Key elements of the law include:

- 42 CFR ' 482.24(b)(1): Outpatient records must be retained in their original or legally reproduced form at least 5 years.
- MCL ' 330.1141: A licensee under the Mental Health Code must maintain a complete record for each Client treated. (No retention period is specified.)
- MCL ' 330.1746: A complete record must be kept current for each recipient of mental health services.
- 1998 Mich Admin Code R 330.1276: A licensed mental health hospital or unit must maintain current and accurate records and make them available for examination by the State. (No retention period is specified.)

CLIENT RESPONSIBILITY:

When pertaining to the Client Documentation And Destruction Policy, it is the responsibility of the Client to advise the Center of the any change of physical address.

FORM C - NOTICE OF PRIVACY PRACTICES

PLEASE KEEP THIS FORM FOR YOUR RECORDS

This document contains important information about the Health Insurance Portability and Accountability Act (HIPAA) effective 3/16/06, a federal law that provides privacy protections and Client rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that **Center[ed] On Wellness** (the **Center**) provide you with this notice for use and disclosure of PHI for treatment, payment and mental health care operations.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We create a record of the care and services you receive at the Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Center. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed.

- For Treatment. We may use health information about you to provide you with treatment or services. We may disclose information about you to doctors, nurses, clinicians, case managers, interns, or other Center personnel who are involved in providing services to you.
- For Payment. We may use and disclose health information about you so that the treatment and services you receive at the Center may be approved by, billed to, and payment collected from a third party such as an insurance company or other services.
- For Health Care Operations. We may use and disclose health information about you for the Center operations. These uses and disclosures are necessary to run the Center and make sure that all individuals receiving services from us receive quality care.
    - We may also combine the health information we have with health information from other mental health agencies to compare how we are doing and see where we can make improvements in the services we offer. We will remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific consumers are.

- Appointment Reminders. We may use and disclose information to contact you as a reminder that you have an appointment.
- Alternative Treatment and Benefits and Services. We may use and disclose information about you in order to obtain and recommend to you other treatment options and available services as well as other health-related benefits or services.
- Fundraising Activities. Should the need arise where information about you or where your participation is desired for fundraising activities, The Center would obtain your authorization. No information would be released for this purpose without your authorization.
- Research. We may use and disclose health information about you for research purposes. No information would be released for this purpose without your authorization.
- As Required by Law. We will disclose information about you when required to do so by federal, state or local law.
- To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS:

- Military and Veterans. If you are a member of the armed forces, we may release health information about you as required by military command authorities.
- Workers' Compensation. We may release health information about you as authorized for workers' compensation or similar programs as authorized by state law. These programs provide benefits for work-related injuries or illnesses.
- Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:
    - To report deaths;
    - To report child abuse or neglect;
    - To report abuse, neglect or exploitation of vulnerable adults; any suspicion of abuse, neglect, or exploitation of the elderly (age 60 or older), or a disabled adult with a diagnosed physical or mental impairment, must be reported;
    - To notify an individual who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law.
- Legal Proceedings and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.
- Public Health Officials and Funeral Home Directors. We may release information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors thereby permitting them to carry out their duties.
- Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

OTHER USES OF HEALTH INFORMATION:

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the services that we provided to you.

YOUR RIGHTS REGARDING INFORMATION ABOUT YOU:

You have the following rights regarding information we maintain about you:

- Right to Review and Copy. You have the right to review and copy health information that may be used to make decisions about your care. This may include both health and billing records. To review and copy health information that may be used to make decisions about you, you must submit your request in writing to the Office Manager or Executive Director. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny or limit access to your request to inspect and copy in certain very limited circumstances. If you are denied or limited access to health information, you may request that the decision be reviewed. Another health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

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- Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Center. To request an amendment, your request must be made in writing and submitted to the author or Executive Director. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support that request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the designated record set kept by or for the Center;
  - Is not part of the information which you would be permitted to inspect and copy; or,
  - Was determined accurate or complete by the Center.
- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Office Manager or Executive Director. Your request must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you for the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care.
- Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way, either in person, by phone, letter, or electronic communication.
- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of the current notice at any time.
- Security of Health Information. Due to the nature of community-based human service practices, a Center representative may possess individually identifiable information beyond the physical security of the Center. In these cases, the Center representatives will ensure the security and confidentiality of the information in a manner that meets LCMHS policy, State and Federal Law.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will have a copy of the current notice in all satellite offices.

COMPLAINT NOTICE OF PRIVACY PRACTICE:

If you believe your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center, contact: Compliance Officer at 269.926.6199.