Kim A. Van Wuffen LPC, PLLC
Van Wuffen Counseling
NPI: 1114673837
LPC-20531
lifecounseling519@gmail.com
602-900-7046

Today's Date_____
Child's Name: _____
DOB: _____ Age: _____
Child's Primary Residence: _____
City: _____ Zip: _____
Caregiver (s) at this address: _____

Second Residence _____
City: _____ Zip: _____
Caregiver (s) at this address: _____

Relationship Status of Child's Parents: ☐Married ☐Divorced ☐Separated ☐Widowed ☐Other
If divorced, what is the custody agreement?
Custodian Parent: ☐Mother ☐Father
Joint Physical Custody: ☐50/50 ☐NON 50/50: ☐Mother ☐Father
Sole Physical Custody: Physical custodial parent: ☐Mother ☐Father
Non Legal/Physical Custodial Parent's Visitation Rights:
_____

4. Comments about custody and visitation (if applicable):

5. Primary reason you are concerned about your child?

SYMPTOM/PROBLEM CHECKLIST
Check any symptom that is a concern. How long has it been a problem?
a. Sleep problems Morbid thoughts

Lack of interest in activities Suicidal thoughts or threats
Unassertive Suicidal plans / attempts
Fatigue/low energy Mood swings
Concentration problems Depression
Appetite/weight changes Changed level of activity
Withdrawal Cries easily
b. Forgetful/memory problems Talks excessively / interrupts

Short attention span Easily distracted
Aggressive behavior Irritable

Can't sit still Impulsive
Not interested in peers Difficulty following rules
Picked on / bullied by peers Problem completing schoolwork

c. Excessive worry / fearfulness Nightmares
Anxiety or panic attacks Frequent tantrums
Social fears, shyness Resistive to change
Separation problems School refusal
Bedwetting / soiling Perfectionism
Headaches, stomachaches Odd hand / motor movements
Odd beliefs / fantasizing Hallucinations

d. Lying Stealing
Trouble with the law Being destructive
Running away Fire setting
Truancy, skipping school Hurting others / fighting
Hurting others sexually Acts as if has no fear
Alcohol / drug use Short tempered
Argumentative / defiant Easily annoyed / annoys others
Swears Discipline problem

c. Excessive worry / fearfulness Nightmares
Anxiety or panic attacks Frequent tantrums
Social fears, shyness Resistive to change
Separation problems School refusal
Bedwetting / soiling Perfectionism
Headaches, stomachaches Odd hand / motor movements
Odd beliefs / fantasizing Hallucinations
d. Lying Stealing
Trouble with the law Being destructive
Running away Fire setting
Truancy, skipping school Hurting others / fighting
Hurting others sexually Acts as if has no fear
Alcohol / drug use Short tempered
Argumentative / defiant Easily annoyed / annoys others
Swears Discipline problem
Blames others for mistakes Angry and resentful

Brothers and Sisters
First Name – Last Name Sex Age Relationship to child (full, step, half, foster)
1.
2.
3.
4.
5.
6.
SCHOOL HISTORY
1. Present School: _____Grade: ____ Teacher:

2. Has child ever repeated any grade?
3. Is child in special education services? No ____ Yes, what kind?

4. Please describe academic or other problems your child has had in school

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY
1. Pregnancy
Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____
Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____
Full-term _____ Premature ____if premature, number of weeks _____

Birth Weight: _____
Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)
_____
2. Developmental History
State approximate age when child did the following:
Walked alone _____ Said first word _____
Used 2-word phrases _____
Understood and followed simple directions _____
Reasonably well toilet trained _____
Did child cry excessively? _____ Rarely cried _____
3. Health History of Child
In the first two years, did your child experience: ___Separation from mother, ___Out of home care, ___Disruption in bonding, ___Depression of mother, ___Abuse, ___Neglect, ___Chronic pain, ___Chronic Illness, ___Parental Stress

Child's Doctor:
Date of last physical exam: _____
Vision problems? Yes _____ No_____ Hearing problems? Yes _____ No _____
Dental problems? Yes ____ No ____
Any head injuries or loss of consciousness? Yes _____ No _____
Child's history of serious illness, injury, handicaps, or hospitalization?
No _____ Yes – describe and give dates _____
Is your child currently taking any medications? No ____ Yes ____ name medications

Cancellation Policy:
A 24 hour notice is required for changes in appointments. Cancellations with less than 24 hours notice will incur a charge of 75% of the fee for service. No-shows and missed appointments incur a 100% of the fee for service.
Duty to warn or protect:
Based on case law, therapists are required by law to at least warn a responsible party if a patient or a client makes a threat against a given individual(s). The warning communication will be limited to those individuals who absolutely need to know and designed to provide only information necessary to protect the potential victim(s).
Report of suspected child abuse:
Therapists serving children and adolescents are mandated by law to report any suspected physical abuse, sexual abuse, and/or neglect which appears to have been inflicted upon such

minor by other accidental means or which is not explained by available medical history. The mental health provider shall immediately report such suspected abuse to a Police Officer or to Child Protective Services of the Department of Economic Security**.**

Custody/Guardianship

• Consent for services can only be authorized by a current legal guardian.

• For divorced parents, consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. (A copy of the divorce decree must be included in the client file indicating the custodial arrangement).

• Permission from both parents, regardless of the custodial arrangement is the preferred practice of this office

Confidentiality:

In most cases (see "Exceptions to Confidentiality" below) communications between client and therapist will be held in strict confidence - unless you provide your therapist written permission to release information about your treatment. If you participate in couples or family therapy, the therapist will not disclose confidential information about treatment to a third party (other than to a third-party payer) unless all treatment participants (18 or older) provide written authorization to release such information.

Exceptions to Confidentiality

Therapists are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Therapists are also required to break client confidentiality when it has been determined that a client presents a serious danger of physical violence to another person. **A therapist may break confidentiality when she believes a client is likely to be dangerous to him or herself.**

Consultation: Therapists **<u>including interns</u>** participate in supervision of their clients with their clinical supervisor, Kim A. Van Wuffen, PLC (602-900-7046). **All licensed associate counselors and interns are required by the Arizona Board of Behavioral Health to participate in supervision.** We occasionally consult with other professionals regarding our clients; however, our client's identity remains completely anonymous, and confidentiality is upheld.

Electronic Correspondence:

E - Mails, Cell Phones, Computers and Faxes:

Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that digital transmission is not always guaranteed confidential. All correspondences aforementioned are by choice and relinquishing of the right to confidentiality.

<u>The client is your child.</u>

A client has the following rights:

1) To be treated with dignity, respect, and consideration;

2) Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;

3) To receive treatment that:

a) Supports and respects the client's individuality, choices, strengths, and abilities;

b) Supports the client's personal liberty and only restricts the client's personal liberty

14) To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the

proposed treatment;
15) To be offered or referred for the treatment specified in the client's treatment plan;
16) To receive a referral to another professional if the center is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
17) To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;
18) To be free from:
a) Exploitation;
b) Neglect;
c) Abuse of any kind;
d) Coercion;
e) Manipulation;
f) Retaliation for submitting a complaint or concern;
g) Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
h) Treatment that involves the denial of:
i) Food,
ii) ii. The opportunity to sleep, or
iii) The opportunity to use the toilet; and
iv) Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
19) To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
20) To control the client's own finances except as provided by **A.R.S. § 36-507(5);**
21) To participate or refuse to participate in research or experimental treatment;
22) To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;

I have read and understand the above **Client Rights**

Signature: _____

Date: _____

USE AND DISCLOSURE

Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your child's PHI without your consent for the following reasons:

• **FOR TREATMENT:** I may disclose your PHI to other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist. I may disclose your PHI to your psychiatrist in order to coordinate your care.

• **FOR PAYMENT:** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. I may also provide PHI to my business associates, such as my billing company, Comprehensive Billing Services, and others that process my health care claims.

• **FOR HEALTH CARE OPERATIONS:**

I may use and disclose your PHI to operate my practice.

Disclosures not requiring consent:

• When disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement. For example, I may make a disclosure to applicable officials

a. *The Right to Choose How PHI is delivered to you.*

You have the right to ask that I send information to you at an alternate address or by alternate means (for example, e-mail instead of regular mail). I will agree to your request so long as it is reasonable for me to do so.

b. The Right to see and Get Copies of Your Child's PHI. In most cases you have the right to get copies of your PHI, but you must make the request in writing. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected in connection with a legal proceeding. I will respond to you within 10 days of receiving your written request. **In certain situations, I may deny your request.** If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. Instead of providing the PHI you requested, **I may provide you with a summary or explanation of the PHI** as long as you agree to that and to the cost in advance.

c. The Right to Get a List of the Disclosures I have made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those named for treatment, payment, or health care operations directly to you, or to your family.

d. The right to ask that I limit how I use and disclose your Child's PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am " legally" required or allowed to make.

e. The Right to Correct or Update Your Child's PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 30 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) Correct and complete, (b) not created by me

NOTICE OF PRIVACY PRACTICES SIGNATURE PAGE

CONSENT TO USE & DISCLOSE
PROTECTED HEALTH INFORMATION (PHI)

This form documents your consent with HIPAA laws regarding Protected Health Information (PHI) about your child. This information is necessary to provide treatment, to arrange payment for services, and for business activities (“Health Care Operations”).

By signing this form, you agree to allow Van Wuffen Counseling Services (Kim Van Wuffen) to use this information and share it with others for treatment-related purposes. If this Notice changes, you will be notified at our next session. You may revoke your consent at any time after signing.
I hereby acknowledge that I have reviewed and received a copy of privacy practices

Print Name: _____
Signature: _____

Print Name: _____
Signature: _____
Date: _____