Brightside Counseling, PLLC
Abigail Schaber M.Ed., LPCC
Phone: 502.338.9221
73 Cavalier Blvd., Suite #309, Florence, KY 41042
Email: brightsidecounselingnky@gmail.com

CLIENT INFORMATION

Client Information:
Client (Child's) Name: _____
Last First Middle

Gender: ____ Male ____Female

Primary Address: _____

City/State: _____Zip: _____

Phone Home: (____) _____-_____Cell: (____) _____-_____
Work: (____) _____-_____
OK to leave message at this number? (Y/N) Home: _____ Cell: _____ Work: _____

Email: _____

OK to send email to this address? Y/N: _____

Date of Birth: _____/____/_____

Primary Care Physician: _____

Phone: (____) _____-_____

May we contact your Primary Care Physician? (Y/N) _____ If so, you will be asked to sign a release of information granting permission.

Emergency Contact Information:

Name: _____

Relationship: _____ Phone: (____) _____-_____

Are you seeking counseling related to a court order or legal proceedings? _____Yes _____ No

Who referred you to our practice? _____

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INFORMED CONSENT

This form is to document that I, _____, Parent/Guardian of _____ (Child's name) give voluntary permission and consent to receiving professional clinical counseling services from Abigail N. Schaber, with Brightside Counseling, PLLC. Please read and initial the following statements below:

_____ **Purpose and Background:**
The purposes, goals and treatment procedures of the professional clinical counseling services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling services. Further, I have been given the opportunity to ask any additional questions regarding her credentials and expertise.

While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by my therapist. Potential benefits, risks and limitations of professional clinical counseling services have been explained to me as well as alternative procedures or interventions if they exist.

_____ **Confidentiality:**
I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case.

_____ **HIPAA**
I understand that this consent form acknowledges my right to privacy and the limitations on my privacy; I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have read and received a copy of the Notice of Privacy Practices (attached).

_____ **Attendance:**
I understand that regular attendance, a willingness to be open and honest and follow through on treatment suggestions will produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to discontinue treatment at any time. A termination session may be requested in order to provide for any continuing areas of concern.
I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of $75.00 per missed appointment.

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_____ **Contact Information:**
The office address for Brightside Counseling is 73 Cavalier Blvd Suite #309 Florence, KY 41042. I understand that for routine appointments and information I may call (502)338-9221. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned within 1-2 business days by my therapist. If for any reason I cannot reach my therapist and I feel that I am in danger of harming myself and would like to talk to someone immediately, I can contact the national suicide hotline at 1-800-273-TALK. I understand that I can also go to my nearest hospital ER or call 911 right away if I am experiencing a mental health emergency.

_____ **Complaints Procedure:**
If I am dissatisfied with any aspect of the services I receive, I understand that I can and am encouraged to raise my concerns with my therapist immediately. Dissatisfactions will make working together slower and more difficult if not resolved. If I feel that I have been treated unfairly or unethically and cannot resolve this problem directly, a complaint procedure is available through Kentucky Board of Licensed Professional Counselors 911 Leawood Drive, Frankfort, KY 40601 Phone: (502) 564-3296.

_____ **Email Communication:**
If you would prefer to be contacted via email or wish to email me with general questions, I understand that confidentiality **cannot** be guaranteed. I understand and agree to be contacted via email at the email address I have provided.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.

I release and hold harmless all Brightside Counseling, PLCC and Abigail N. Schaber from any action or liability arising out of my participation in treatment.

_____ ___/___/_____
Printed Name of Parent/Guardian Date

_____ ___/___/_____
Signature of Parent/Guardian Date

_____ ___/___/_____
Signature of Witness Date

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NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices Effective 12/01/2009
This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice takes effect 12/1/09 **and will remain in effect until we replace it.**

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available on request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you with your consent.

Payment: We may use and disclose your health information to obtain payment for services provided to you with your consent.

Healthcare Operations: We may use and disclose your general health information (excluding personally identifying information) in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, and evaluating practitioner and provider performance. We may use or disclose your general health information (excluding personally identifying information) in order for us to review our services and to evaluate our staff performance. We may also use or disclose your health information to obtain a medical consultation regarding your care or treatment.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any other disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you or someone in your home is a possible victim (or perpetrator) of abuse, neglect or domestic violence. We

may disclose health information to appropriate authorities if we reasonably believe that you are a serious danger to yourself or others.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. If you authorize release of information, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons involved in your care: We may use or disclose health information to notify or assist in notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required By Law: We may use or disclose your health information when we are required to do so by law such as in legal response to valid judicial, administrative subpoenas or court orders.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may provide you with appointment reminders (such as voicemail messages, postcards or letters) unless you make a specific request to the contrary. (See alternative communication section 33).

Patient Rights

Access: You have the right to view or obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may request that we provide copies in a format other than photocopies. We would use the format requested unless it is not practical for us to do so. We will respond to your request for access within 30 days of receiving the request. We reserve the right to charge you a reasonable cost-based fee for expenses such as photocopying and staff time after the first requests for copies. We will charge $.20 per page and $25 an hour for staff time and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or explanation of your health information for a fee. If we deny your request to review or obtain a copy of your health information you may submit a written request for a review of that decision. The person conducting the review will not be the person who denied your request. In some circumstances, our denial of your request to inspect and receive copies of your information is not subject to review.

Disclosure Accounting: You have the right to receive a record of disclosures made by us of your health information when you submit a written request. This record will not include disclosures made for treatment payment or healthcare operations; disclosures made directly to you; disclosures authorized by you pursuant to a signed authorization or disclosures made for law enforcement purposes. You may request one such record at no charge every twelve (12) months. The record requests must state the time desired and may not exceed six (6) years prior to the date of the request and may not include any dates prior to 12/1/09. **The first disclosure record requests a 12 month period is free; additional requests will be provided for a fee. We will inform you of the fees before you incur any cost.**

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Restriction: You have the right to request to place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except when required by law or in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. The request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternate the means or location of the request. We will make reasonable efforts to accommodate your request.

Amendment: You have the right to request that we correct your records if you believe information in your record is incorrect or important information is missing, by submitting a written request that provides the reason for requesting the amendment. We have the right to deny your request to amend the record if the information was not created by us; if it is not part of the health information maintained by us; if it is not part of the information which you would be permitted to inspect and copy; or if in our opinion the record is accurate.

Questions and Complaints: If you are concerned that we have violated your privacy rights, disagree with the decision made about access to your health information, you may contact (in writing) our Privacy Officer (listed below). You may also send a written complaint to the US Dept. of Health and Human Services Office of Civil Rights. We will provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint

Privacy Officer: Brightside Counseling
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CHILD INTAKE QUESTIONNAIRE

Child's Name: _____ Date: ___/___/_____

Date of Birth: ___/___/_____ Age: _____

1. Why have you come for therapy (Presenting issue(s)/concern(s) for your child)?
_____
_____
_____

2. How long has this been an issue? _____ Weeks _____ Months _____ Years

3. What have you tried to do to resolve this issue? _____
_____
_____

4. What are your goals for counseling?
_____
_____
_____

5. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol and substance use/abuse):
_____
_____
_____
_____

6. Who is primarily responsible for the care of your child? List all that apply.

Name:	Relationship to Child:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Who resides with you in your home?

Name:	Relationship to Child:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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8. What are the most common disciplinary techniques used in the household? (Verbal reprimands, yelling, ignoring, grounding, time outs, removal of privileges, spanking, etc.…)

_____
_____
_____

9. Are disciplinary techniques used consistently and with good follow-through?
❑ No ❑ Yes

10. Are current disciplinary techniques effective at controlling undesirable behaviors?
❑ No ❑ Yes

11. Does your child respond to one parent or caretaker's disciplinary measures better than another?
❑ No ❑ Yes: If yes, who _____

12. Has your child experienced any of the following?

❑ Parental Divorce	❑ Parental Separation	❑ Death of Parent
❑ Death of Sibling	❑ Death of Grandparent	❑ Death of Close Friend
❑ Financial Problems	❑ Parental Alcoholism	❑ Parental Drug Abuse
❑ Domestic Violence	❑ Physical Abuse	❑ Verbal/Emotional Abuse
❑ Sexual Abuse	❑ Family Bankruptcy	❑ Prolonged Marital Discord

13. Has any member of your family ever been diagnosed with a mental illness or substance abuse problem including alcoholism? ❑ No ❑ Yes If yes, please provides further details.
Relationship: _____ Diagnosis: _____
Relationship: _____ Diagnosis: _____
Relationship: _____ Diagnosis: _____
Relationship: _____ Diagnosis: _____
Relationship: _____ Diagnosis: _____
Relationship: _____ Diagnosis: _____
Relationship: _____ Diagnosis: _____

14. Was your child born premature? ❑ No ❑ Yes Explain: _____

15. Birth Weight: _____ lbs. _____ oz.

16. Approximate age when your child first began:
Walking: _____ Talking: _____ Toileting: _____

17. Does your child have any immediate health problems (colds, injuries)? ❑ No ❑ Yes
If yes, please explain:

_____
_____

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18. What are your child's strengths (what your child is good at, qualities or personality traits that you admire about your child?

_____
_____

19. Does your child have any chronic (long-term) health problems (asthma, seizures, allergies, etc.)?
❑ No ❑ Yes
If yes, please explain:

_____
_____

20. Has your child ever sustained any serious head injuries (unconscious, auto accident, fight, etc.)?
❑ No ❑ Yes
If yes, please explain:

_____
_____

21. Does your child have any developmental disorders (intellectual disability/mental retardation, learning disabilities, hearing disabilities, speech delays, etc.)? ❑ No ❑ Yes
If yes, please explain:

_____
_____

22. Is your child currently under the care of a physician? ❑ No ❑ Yes

If yes, Doctors Name: _____ Phone: _____

Conditions being treated: _____
_____
_____

23. Is your child currently on any medication? ❑ No ❑ Yes

Medication	Dosage	Date Started
_____	_____	___/___/_____
_____	_____	___/___/_____
_____	_____	___/___/_____
_____	_____	___/___/_____

24. Please list all previous mental health medications:

Medication	Dosage	Date Started	Date Stopped
_____	_____	___/___/_____	___/___/_____
_____	_____	___/___/_____	___/___/_____
_____	_____	___/___/_____	___/___/_____
_____	_____	___/___/_____	___/___/_____

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25. Please rate the nutritional value of your child's diet.
____ Good ____ Fair ____ Poor
If fair or poor, please explain:

_____

Check any of the following that apply.

- ❑ Significant weight gain/loss in last 6 months (10 pounds or more)
- ❑ Problems chewing or swallowing
- ❑ Food allergies or allergies to medication
- ❑ Dieting
- ❑ Overeating or eating too little

If any box is checked please explain:

_____

_____

26. Has your child had a recent vision check? ❑ No ❑ Yes
If yes, describe results: _____

27. Has your child had a recent hearing exam? ❑ No ❑ Yes
If yes, describe results: _____

28. What grade is your child currently in?
K 1 2 3 4 5 6 7 8 9 10 11 12 None

29. Where does your child attend school?

_____

30. Circle any grade(s) failed. K 1 2 3 4 5 6 7 8 9 10 11 12 None

31. Circle any grades skipped. K 1 2 3 4 5 6 7 8 9 10 11 12 None

32. What grades does your child normally get in school? (Circle all that apply)
A B C D F

33. Have there been any tendencies toward improving or deteriorating school performance over the years?
❑ No ❑ Yes
If yes please provide further details:

_____

_____

34. What are your child's **strongest** subjects in school? (Circle all that apply)
Math History English Reading Spelling Science Social Studies N/A

35. What are your child's **weakest** subjects in school? (Circle all that apply)
Math History English Reading Spelling Science Social Studies N/A

36. Has your child ever been:
Reprimanded at school: ❑ No ❑ Yes

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Served detention: ❑ No ❑ Yes
Been suspended: ❑ No ❑ Yes
Been expelled: ❑ No ❑ Yes
If yes to any, please explain: _____
_____

37. Has the school ever performed psychological or educational testing on your child?
❑ No ❑ Yes
If yes, describe results: _____
_____

38. Does your child have many friends? ❑ No ❑ Yes

39. Does your child make friends easily? ❑ No ❑ Yes

40. What are the most common activities that your child engages in? (bike riding, playing with friends, TV, etc.)
_____
_____
_____

41. Has your child ever been in trouble with the law? ❑ No ❑ Yes
If yes, please explain.
_____
_____

42. To your knowledge, does your child use tobacco? ❑ No ❑ Yes

43. To your knowledge, does your child drink alcohol? ❑ No ❑ Yes
If yes, how often, how much, and for how long?
_____
_____
When was the last time? ___/___/_____ How many drinks? _____

44. What problems has your child suffered as a result of his/her drinking?
❑ Arrest ❑ DUI ❑ Peer problems
❑ Public intoxication ❑ Financial problems ❑ Arguments
❑ None of the above

45. To your knowledge, has your child ever tried drugs? ❑ No ❑ Yes
If yes, what drug(s)?
_____
_____

46. To your knowledge, does your child regularly us any drugs?
❑ No ❑ Yes
If yes, how often, how much and for how long?
_____
_____

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When was the last use? ___/___/_____What drug(s) was used?
_____
_____

47. To your knowledge, is your child sexually active? ❑ No ❑ Yes

48. Does your child have concerns about his/her sexual orientation or sexual experiences?
❑ No ❑ Yes

49. Is your child pregnant or the parent of a child? ❑ No ❑ Yes

50. Who has legal custody of your child?
❑ Both parents ❑ Mother only ❑ Father only
❑ Other guardian: _____
Please bring a copy of ANY custody papers showing who has custody to your initial appt

51. Does your child have any sleep issues? ❑ No ❑ Yes
❑ Trouble falling asleep ❑ Trouble staying asleep ❑ Nightmares ❑ Sleep walking

If yes, please explain:
_____
_____

52. Other information you would like your therapist to know:
_____
_____
_____
_____
_____