LIVING WELL
INTERNATIONAL CENTER

312 W. Millbrook Road, Suite 121● Raleigh NC, 27609 ● Office (919) 825-1339 ● Fax (919) 301-8957
Web address: www.livewellintlcenter.org

CHILD/TEEN INTAKE FORM

Subscriber # _____
Group # _____
Medicaid #:
Date of Birth: _____

IDENTING INFORMATION

Client Name: _____ Date: _____
Home Address: _____

Home Phone: _____ School/Grade: _____

Legal Guardian: _____

Mother's Name: Daytime Phone: _____

Father's Name: Daytime Phone: _____

EMERGENCY CONTACT

First Contact: Relationship to Client: _____

Daytime Phone: _____ Evening Phone: _____

Physician's Name/Phone:

Others in the Home (Names/Relationship to Client/Ages if appropriate):

Significant Others Involved with Client:

MENTAL HEALTH/BEHAVIORAL INFORMATION

Reason for Seeking Services:

Recent Treatment History (last 12 months):

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Has your child had any previous trauma? ☐ Yes ☐ No ☐ Uncertain If so, please indicate what kind:

☐ Physical ☐ Emotional ☐ Sexual ☐ Abortion ☐ Witness to crime ☐ Victim of crime

Please select any of the events that have occurred within the last 12 months.

- ☐ Death of Parent(s)
- ☐ Divorce of Parents
- ☐ Separation of Parents
- ☐ Remarriage of Parents
- ☐ Death of close family member
- ☐ Personal injury or illness
- ☐ Change in schools
- ☐ Addition to the family
- ☐ Death of close friend
- ☐ Starting or finishing school
- ☐ Change in living conditions
- ☐ Change in sleeping habits
- ☐ Brother/Sister leaving home
- ☐ Change in eating habits

Does the child report thoughts of suicide? ☐ Yes ☐ No

Does the child report having thought about suicide in previous 12 months? ☐ Yes ☐ No

Pertinent Medical Issues:

Client Medications: _____

Other Active Service Providers (last six months) _____

Court Involvement and/or Pending Charges: _____

Other:_____

_____

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CHILD/TEEN INTAKE FORM

_____

_____

CONSENTS/RIGHTS INFORMATION

I. Consent for Treatment

I hereby give my consent for Living Well International Center, PC, to provide mental health services to my child. I have been informed of the scope and purpose of the service and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Guardian: _____ Date: _____

II. Financial Release

I further understand that Living Well International Center, PC may use confidential information about me to bill and be paid for services. I hereby consent Living Well International Center, PC to release information to the billing agent and/or funding source (commercial insurance/referring area program) and for (commercial insurance/referring area program) to release information to Living Well International Center, PC.

Guardian: _____ Date: _____

III. Permission to Seek Emergency Medical Care (if under 18)

I hereby give consent for Living Well International Center, PC, to seek and sign consent for emergency medical care if I am unable to do so for myself. It is understood that Living Well International Center, PC will attempt to locate me, or another legally responsible adult, as quickly as possible in the event of an emergency.

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CHILD/TEEN INTAKE FORM

Guardian: Date:

Client Rights/Grievance Policies (**See Handout**)

I have received and had explained to me the Client Rights handout.

Living Well International Center PC gave me this handout and verbally explained my rights as a client.

Guardian: Date:

IV. Privacy Rights (See Handout)

I have received and had explained to me the Privacy Rights handout. Living Well International Center, PC gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Guardian: Date:

I understand that one of my rights as a person served by, Living Well International Center, PC is to be able to choose how I am contacted.

I ***do/do not*** *(circle one)* give permission for Living Well International Center, PC staff to contact me at work.

Furthermore, I ***do/do not*** *(circle one)* give permission for Living Well International Center, PC to leave voice messages for me at ***home/work/both/neither*** *(please circle one).*

Client/ Guardian: Date:

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CHILD/TEEN INTAKE FORM

I, Living Well International Center, PC, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Legal Guardian of the client to be served.

Signature: Date:

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

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Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____
Signature (Client's Parent/Guardian) Date