THE CARING TREE
CHILD & FAMILY COUNSELING

New Patient Paperwork Packet
Ages 3-17 years old

Patient Name:_____**DOB:**_____

Patient Information

Patient's Legal Name:_____ Preferred Name:_____ DOB:_____
Address:_____ Apt:_____ City, State & Zip:_____
Phone number:_____ Email:_____
Birth Sex:_____ Gender Identity (please circle): Male Female Other Prefer not to say Sexual Orientation (if known:)_____ Name of School:_____
Race (please circle): American Indian Alaska Native Asian African American/Black Hispanic/Latino Native Hawaiian/Pacific Islander White Prefer not to say
Languages:_____ Do you need an interpreter or translator? Y/N

Responsible Parent/Guardian Information: **Must bring valid photo I.D. to initial appointment for responsible party.* Name:_____ Parent or Guardian? Y/N Emergency Contact? Y/N Relationship to patient:_____ DOB:_____
Address:_____ Apt:_____ City, State & Zip_____
Main Phone:_____ Other Phone:_____ Initial if ok to leave voicemail:____
Email:_____ Initial if ok to send email:_____
Preferred contact method:_____ Best time of day to contact:_____
Employer:_____

Other Parent/Guardian Information: **Must bring valid photo I.D. to initial appointment for responsible party.* Name:_____ Parent or Guardian? Y/N Emergency Contact? Y/N
Relationship to patient:_____ DOB:_____
Address:_____ Apt:_____ City, State & Zip_____
Main Phone:_____ Other Phone:_____ Initial if ok to leave voicemail:____
Email:_____ Initial if ok to send email:_____
Preferred contact method:_____ Best time of day to contact:_____
Employer:_____
Who is bringing the patient to appointments?_____ **Please note a signed ROI must be on file for a child to be seen without parent/guardian.*
How did you hear about the Caring Tree?_____

Insurance Information:
Primary Insurance:_____ Member ID #:_____ Policy Group:_____
Employer:_____ Plan Name:_____ Insured Party:_____
Client SSN:_____
Secondary Insurance:_____ Member ID #:_____ Policy Group:_____
Employer:_____ Plan Name:_____ Insured Party:_____
Client SSN:_____

Patient Name:_____**DOB:**_____

Emergency Contact Information: *Please list at least one emergency contact*

Name:_____ Parent or Guardian? Y/N

Relationship to patient:_____ DOB:_____

Address:_____ Apt.:_____ City, State & Zip:_____

Phone number:_____ Email:_____

Payment Policy, Financial Acknowledgment, and Insurance Assignment

The Client is responsible for costs of services provided. This may include the client, the client's spouse, or the client's parent or legal guardian.

The Caring Tree or Balance for Growth policy is to pursue the collection of all monies due to facility from third-party sources, the client, or any other responsible party. Accounts greater than 90 days from the date of service are considered delinquent at which time it is the counselor's discretion whether or not the counselor will continue to see the patient. Failure to make monthly payments or failure to make payment arrangements will cause collection efforts, which includes calls, emails, postal mail, etc. If collection efforts are unsuccessful the account will be sent to collections at 180 days after the date of service. If collection efforts are unsuccessful the account will be turned over to a collection agency thereafter all services provided may be on a cash only basis.

The Caring Tree or Balance for Growth will make every attempt to collect from your insurance company. Please check your insurance policy or discuss your coverage with your employer or insurance agent. The Caring Tree and Balance for Growth accepts Mastercard and Visa for payment services. Medicaid covers most outpatient services. Clients are required to pay their copayment at the time of their service. If you have any questions please call The Caring Tree at 715-301-0667 or email info@caringtree.us. You have the right to request a copy of this paperwork.

Please complete the following……

I request and authorize The Caring Tree-Children's Counseling Center or Balance for Growth to release to:

Primary Insurance_____ **Secondary Insurance**_____ Information from my records necessary to pre-certify/authorize services and process my claim for insurance benefits, Medicaid payment, for services provided by The Caring Tree or Balance for Growth. This includes mental health, alcohol/drug, developmental or other medical diagnoses, discharge summaries and clinical notes to include physician's orders, treatment plans (where required), and test results. The purpose of this authorization is to enable the recipient to pre-certify/authorize and process my claim. I understand I have the right to inspect and receive a copy of this form and the material to be disclosed as required under SS. DHS 92. 05 and 92. 06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this consent at any time except to the extent that action has been taken in reliance on it (45 CFR 164. 508 (c) (2) (I). This consent unless expressly revoked earlier is valid for one year from signature date. I authorize and request payment directly to The Caring Tree-Children's Counseling Center or Balance for Growth of all benefits otherwise payable to me for services provided by The Caring Tree or Balance for Growth, not exceeding its regular charges. I understand that, as a patient, I'm financially responsible for all charges regardless of whether paid by the insurer. This assignment cannot be revoked without written consent of The Caring Tree or Balance for Growth.
Also, if needed, to initiate or facilitate enrollment/recertification in the medical assistance program, I authorize The Caring Tree or Balance for Growth to contact and share information with the County Department of Social Services.

Client or Parent/Legal Guardian Signature:_____ **Date:**_____ **I understand The Caring Tree or Balance for Growth will attempt to collect payment from this patient's insurance as a courtesy.**

I, _____ (printed name), **parent or legal guardian of** _____ (patient), **DOB**_____, **understand that I am financially responsible for services provided today.**

Signature:_____ **Date:**_____

Patient Name:_____**DOB:**_____

Animal Waiver & Release

I, _____ (printed name), the legal parent or guardian of _____(patient's name), agree to release, discharge, indemnify, and hold harmless The Caring Tree or Balance for Growth, its contractors, and employees for any and all claims, demands, losses, costs, liabilities, settlement agreements, damages, expenses and suits at law or in equity to my personal property or the property of my child that arise out of my child handling animals used by The Caring Tree or Balance for Growth. I recognize handling animals poses a risk of injury, including but not limited to, personal physical harm. I hereby release, discharge, indemnify and hold harmless The Caring Tree or Balance for Growth, its contractors and employees for any and all claims, demands, losses, costs, liabilities, settlement agreements, damages, and expenses connected with my child's participation whether caused directly or indirectly by any negligence (active or passive) attributable to The Caring Tree or Balance for Growth, its employees and contractors.

I acknowledge that I have read and fully understand the terms and conditions of the foregoing Waiver and Release and, that as the legal parent or guardian, agree and will comply with the same. **If a patient, employee or contractor is injured, an Accident/Injury Report must be completed as soon as possible following the injury.*

Patient's Full Name:_____ **DOB:**_____
Parent/Guardian Printed Name:_____
Parent/Legal Guardian Signature:_____ **Date:**_____
_____Initial here if you prefer **Not** to have animals in your child's session. *Please note that as a patient of The Caring Tree or Balance for Growth, you and your child may still have brief contact with our animals and animal dander.*

Consent for Outpatient Services

I understand that during enrollment for outpatient services at The Caring Tree or Balance for Growth for assessment/treatment, complete and accurate information has been/will be provided regarding each of the following areas:

- Results of the assessment
- Treatment Alternatives
- Possible outcomes and side effects of treatment are recommended in the treatment plan.
- Treatment recommendations and benefits of the treatment recommendations.
- Approximate duration and desired outcome of treatment recommended in the treatment plan.
- The rights of receiving outpatient services, including the consumer's rights and responsibilities in the development and implementation of an individual treatment plan.
- The fees that the consumer or responsible party will be expected to pay for the proposed services.
- How to use The Caring Tree or Balance for Growth's Grievance Procedure.
- The means by which clients may obtain emergency mental health services during periods outside the normal operating hours of the clinic.
- Outpatient services discharge policy, including circumstances under which a patient may be involuntarily discharged for inability to pay or for behavior reasonably the result of mental health symptoms.
- This consent is effective for 15 months from the time the consent is given.

I have read and understand the above information, I have had an opportunity to ask questions about this information, I understand that I can have a copy of this consent form, and I consent to an assessment and/or treatment. I have the right to ask my outpatient service provider questions about the above information at any time.

Client or Parent/Legal Guardian Signature:_____ **Date:**_____

Patient Name:_____**DOB:**_____

DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
F-22538 (09/2016)

STATE OF WISCONSIN
Wisconsin Statutes
§ 51.61 (1) (o)
Administrative Rule
DHS 94.18

CONSENT TO FILM OR RECORD

Patient Name (Last, First MI)	ID Number	

By my signature below, I authorize the filming / recording as listed; and I understand that I may view the photograph or film or hear recording prior to any release. This consent may be revoked at any time by giving written notification to the facility / institution director.

Type of Filming / Recording	Date – Consent Expires
Video & Audio	**Until revoked in writing**

Name – Individual / Group Doing the Filming / Recording

The Caring Tree - Child & Family Counseling and Balance for Growth

Purpose / Reason for Filming / Recording	Resulting Materials Can Be Used By
Video security cameras are used for the safety of our clients and staff. Recordings are automatically deleted after 14 days unless needed by authorities. Audio recordings will be used as part of a note taking tool for clinical documentation and are unavailable to the clinician as they are automatically deleted once added to the clinical note.	**The Caring Tree** **Balance for Growth** **Local authorities**

I further understand that I may specify periods during which or situation in which client / patient may not be filmed or recorded. I understand that neither last names nor other identifying information will be used or made available.

Filming / Recording Limitation – Times / Situations

Video recording is limited to the common areas of the clinic. Audio recordings during session but not available to clinician as they are automatically deleted once added to the clinical note.

SIGNATURE – Patient – If Presumed Competent		Date Signed
SIGNATURE – Parent for Child (Minor) or Guardian	Relationship	Date Signed

DISTRIBUTION: Original—Patient Record

Patient Name:_____**DOB:**_____

Practicum and Internship Acknowledgement

The Caring Tree Child & Family Counseling Center is committed to providing quality counseling services. Part of this commitment is to enhance the quality of the field by allowing master's level providers and counseling students (interns) to practice and implement counseling services while under supervision. Interns providing services at the Caring Tree……..

- Are expected to follow the ethical guidelines for the Counseling profession and are required to follow the policies and procedures implemented by The Caring Tree Child & Family Counseling Center and their
- Follow and implement HIPPA standards.
- Counseling students are in their final stages of their masters education and are preparing to enter the counseling field. Counseling students have been approved by their education institution to practice their clinical skills by completing the necessary coursework and demonstrating competency in providing counseling services to clients while under direct supervision of a licensed professional.
- The intern will continue to receive guidance, evaluation and education while practicing their clinical skills. At times the intern will be accompanied in sessions by post graduate licensed professionals who can help assist in growth of clinical skills.
- Supervision of interns is conducted by a fully licensed professional counselor. At the Caring Tree this service is provided by the Clinical Director, Trena Loomans.
- In order to continue to enhance their skills. Interns may be required to record occasional sessions for supervision purposes only. These recordings are kept in accordance with HIPPA standards by being stored on password protected devices and are destroyed at the termination of therapy.
- Clients and their guardians can refuse or revoke consent at any time with the understanding that services will need to be transferred to another provider within The Caring Tree, and may cause a pause or disruption to treatment services.

If you have any questions regarding engaging in services that may be provided by an intern for either yourself or your child please contact The Caring Tree at 715-301-0667 or email at info@caringtree.us and someone will be able to provide you further information.

I, _____ (printed name), acknowledge that I am voluntarily authorizing my child, _____ (child's printed name) to engage in services with a counseling student (intern) at The Caring Tree Child & Family Counseling Center. I have read the above information and understand the purposes of treatment and factors surrounding services provided.

Printed name:_____

Signature:_____ **Date:**_____

Receipt of Privacy Notice Acknowledgment

Your signature on this form acknowledges that you have been given the option of receiving a copy of The Caring Tree or Balance for Growth's Privacy Notice, which explains how your health information will be handled in different situations. For minor children under the age of 18 who live with you, you also acknowledge that you have received this notice on their behalf.

Client or Parent/Legal Guardian Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to Patient:**_____

Patient Name:_____**DOB:**_____

The Caring Tree LLC
Telemental Health Informed Consent

The Caring Tree or Balance for Growth is offering telehealth psychotherapy sessions. Your therapist will either be providing telehealth in their office at The Caring Tree, Balance for Growth, or at their home in a secure room.

I understand and agree to receive telemental health services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document.

I understand the potential risks of telemental health, which may include the following: 1) the video connection may not work, or it may stop working during a session; 2) the video or audio transmission may not be clear; and 3) I may be asked to go to my therapist's office in person if it is determined that telemental health is not an appropriate method of treatment for me.

I recognize the benefits of telemental health, which may include the following: 1) allowing me to practice safety precautions regarding health concerns 2) reduced cost and time and commitment for treatment due to the elimination of travel; 3) ability to receive services near my home or from my home; and 4) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via videoconferencing or teleconferencing. I understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during video conferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recording my session is prohibited.

I agree to take full responsibility for the security of any communication or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to assess the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is not feasible for me.

I understand the limitations to confidentiality with my therapist include a reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My signature indicates that I agree to participate in telemental health under the conditions described in this document.

Client Name (please print): _____ **Date:** _____ **Legal**

Guardian (if applicable): _____ **Relationship**

to client: _____ **Client/Guardian**

Signature: _____ **Date:** _____

Patient Name:_____DOB:_____

Patient Bill of Rights & Responsibilities

You have the right to all of the following:

Personal Rights Initial:_____

- Be cared for in a safe and clean environment by competent healthcare professionals.
- Be free from chemical and physical restraints and involuntary seclusion unless medically necessary.
- Be free from abuse, neglect, and harassment. This includes physical, mental, emotional and financial abuse.
- Have staff make fair and reasonable decisions about your treatment and care. .
- Receive treatment in a safe, psychologically, and physically humane environment.
- Be treated with dignity. We will respect your cultural and personal values, beliefs, and preferences.
- Not have your care affected by your race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, illness, handicap or ability to pay.
- Contact with a family member or representative and your personal physician to notify them of your admission, or have a staff member do so on your behalf. You may refuse to have others contacted.

Treatment Rights Initial:_____

- Staff involved in your care will introduce themselves to you and explain what they are going to do.
- You must be provided prompt adequate treatment, rehabilitation and educational services appropriate to you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives and possible side effects and/or risks of treatment or medications.
- You have the right to refuse treatment or medication unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders that. If you have a guardian however, your guardian may consent to treatment and medications on your behalf.
- You may not be subject to electroconvulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed, in writing, of any cause of your care or treatment for which you or your relative may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.
- You have the right to formulate Advanced Directives.

Communication and Privacy Rights Initial:_____

- You may call or write to public officials or your attorney
- You may not be filmed or taped or photographed unless you agree to it.
- You may use your telephone when you wish. . .
- Your treatment information is kept confidential unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records.

Patient Responsibilities Initial:_____ The care you receive depends partially on you. Therefore, in addition to these rights, a patient also has certain responsibilities. These responsibilities are presented in the spirit of mutual trust and respect.

The patient and family are responsible:

- To provide accurate and complete information concerning his or her present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- For reporting perceived risks in his or her care and unexpected changes in his or her condition to the responsible practitioner.
- For following the treatment plan established by his or her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- For keeping appointments and for notifying the center when he or she is unable to do so.
- For his or her actions should he or she refuse treatment or not follow his or her therapist’s orders.
- For ensuring that the financial obligations of his or her care are fulfilled as promptly as possible.
- For following the organization’s policies and procedures.
- For being considerate of the rates of other patients/clients and staff.
- For being respectful of his or her personal property and that of other persons.
- For asking questions about the patient’s condition, treatments, procedures, lab and other diagnostic test results.
- For asking questions when they do not understand what they have been told about the patient’s care or what they are expected to do.
- For immediately reporting any concerns or errors they may observe.

You have the right to address any concerns, complaints, file a grievance or learn more about the grievance procedure used by The Caring Tree or Balance for Growth. Please contact the Clinical Supervisor/Compliance Officer, Trena Loomans, 715-301-0667. You may also choose to communicate concerns directly to the state of Wisconsin Department of Health Services, Division of Quality Assurance, PO Box 2969 Madison, WI 53701-2969, or call 608-265-8481.

Patient Name:_____**DOB:**_____

Health Questionnaire

Please identify concerns below. Circle all that apply.

Emotional Distress	**Functional Problems**	**Safety Concerns**
Depression Sadness Moodiness Anger Anxiety Panic Attacks Worries Ruminates Tearful Cries easily Withdrawn Defiant Irritable/on edge Rage Perfectionist Unmotivated Fearful Phobias Recent death/loss Nightmares Parent' Divorce Recent move New School Change in family system Psychotic-like symptoms	Poor Hygiene Irresponsible Employment Concentration Mobility Physical Pain/Injury High or Low energy Poor Grades Poor Organization Hearing Concerns Trouble Listening Speech Concerns Social Relationships Memory Concerns Lack of Coordination Fine Motor Skills Sleep Problems Sensory Problems Eating/Food Concerns Adjusting to changes Time Management Money Management Learning Problems Cognitive Problems Problems with Play Problems Socializing	Alcohol Drug use Lying Stealing Physical Aggression Verbal Aggression Impulsive Truancy concerns Elopement Breaking the Law Suicidal Homicidal Self Injurious Behaviors Problems recognizing danger **Other/Not Listed concerns:** _____ __ _____ __ _____ __ _____ __

Developmental History

Mother's age at time of child's birth:_____

Was this patient possibly exposed to alcohol or other substances during the mother's pregnancy? Yes or No **Were there any complications or concerns during the pregnancy for the mother?** Yes or No (If yes please identify or elaborate on condition including treatment if required):_____

_____

Length of pregnancy: Full Term or Premature born at how many weeks?_____ **Was Labor induced?** Yes or No **Mode of Delivery** (circle from the following)**:** Vaginal Cesarean Emergency Cesarean

Place of Birth?_____ **Number of days the patient was hospitalized after birth?**_____

Were there any complications during or immediately after delivery? Yes or No

(If yes please identify or elaborate condition including treatment if required):_____

_____

Are there any developmental concerns? Yes or No (If yes, please describe):_____

_____

Is the patient toilet trained? Yes or No **Circle all that apply:** Daytime Wetting Nighttime Wetting Bowel Incontinence

Puberty: No Yes, started at age:_____ If female, first menstruation age:_____

Cares for self (i.e. bathing, dressing, and grooming): Yes No With Help

Other notes:_____

Medical History

Name of Primary Care Physician & Clinic:_____

Patient Name:_____**DOB:**_____

Date of last physical exam:_____

Medical Diagnoses:_____

Has the patient been medically hospitalized? Yes or No

(If yes please provide: date, procedure, and any complications):_____

_____

Has the patient ever experienced the following medical concerns? Check all that apply

High or unexplained fever
Head Injury
Concussion
Loss of consciousness
Tics of abnormal body movements
Thyroid or endocrine issues
Strep throat
Chronic ear or sinus infections. Were Tubes required? Yes or No
Seizure Type: Partial Partial Complex Generalized
Diabetes or Blood sugar issues
Meningitis or Encephalitis
Bronchitis or pneumonia
Upper respiratory issues/asthma
Allergies
Other congenital conditions:_____
Lead or other toxin exposure

Was hospitalization required for any of the above concerns: Yes or No

Please list age of onset for each concern, date of any hospitalization, and any treatment or procedures required to address concern:_____

_____

_____

Current Medications	Dose (mg, mL or IU).	Frequency Prescribed	Frequency taken currently	Date Started	Prescribed for….. (Reason)

Has the client had past medications that produced ineffective or negative reactions? Yes or No (If Yes, please list the name of medication, dose, frequency prescribed, date started and discontinued and what it was prescribed for)._____

_____

_____

Current Medical Conditions/Illnesses:

Auditory Conditions: No Concerns Conductive Impairment Sensory-Neural Impairment Hearing Devices used Vision Conditions: No Concerns Nearsighted Farsighted Uses Glasses Uses Contacts Legally Blind Other:_____ Speech Conditions: No Concerns Speaks Words but no sentences Words difficult to understand Stutters

(If any of the above are circled) **Is the client receiving services to treat circled above conditions outside of the primary**

Patient Name:_____**DOB:**_____

provider? Yes or No (If yes, please list clinic and name of treating providers): _____

_____

Sleep Duration (in hours) **per night:**_____

Sleep Concerns: Check all that apply

No Concerns
Requires Naps
Midnight Awakenings
Early Awakenings

Psychiatric Hospitalization(s):

Difficulty Falling asleep
Nightmares; Frequency:_____
Other:_____

Eating Concerns: Check all that apply

No concerns
Obsessed with food; age of onset:_____
Increased appetite; since when?_____
Decreased appetite; since when?_____
Drooling
Food falls from mouth

Gags
Eats limited types of food
Has taste or texture sensitivity
Weight Gain; Amount & time frame:_____
Weight loss; Amount & time frame:_____

Psychiatric History:

1. When and where?_____
2. When and where?_____

Has the client been diagnosed previously with any type of developmental conditions?

ADHD/ADD

Date of Diagnosis:_____ Type:_____ By Whom:_____

Autism Spectrum Disorder (circle one): Autism PDD NOS

Date of Diagnosis:_____ Type:_____ By Whom:_____

Learning Disability

Date of Diagnosis:_____ Type:_____ By Whom:_____

Cognitive Impairment (circle one): Mild Moderate Severe

Date of Diagnosis:_____ Type:_____ By Whom:_____

Speech Impairments (circle one): Receptive Expressive Mixed

Date of Diagnosis:_____ Type:_____ By Whom:_____

Other Mental Health Diagnoses:

Date of Diagnosis:_____ Type:_____ By Whom:_____

Allied Health Professionals:

Past mental health professional(s) (Psychologist, Psychiatrist, Neurologist, or other). Please include name, time frame and dates of treatment: _____

_____

Has the patient ever had psychological or neurological testing? Yes or No

(If yes, by whom and when):_____

Current mental health professional(s) (Psychologist, Psychiatrist, Neurologist, or other). Please include name, time frame and dates of treatment:_____

_____

Patient Name:_____**DOB:**_____

Does the patient have a case manager? Yes or No (if yes please list name and through whom - social services or NCHCC):

_____

SUBSTANCE ABUSE

Please indicate any substance used currently or in the past by client or parents:

Individual	Time used	Alcohol Marijuana	Ecstasy	Inhalants	Other, Specify:
Client	**Past**				
Client	**Current**				
Mother	**Past**				
Mother	**Current**				
Father	**Past**				
Father	**Current**				

FAMILY DYNAMICS

Current Living Situation(s): Please check all that apply

Biological parents: Married
Biological parents: Cohabitating Biological parents: Divorced
Biological parents: Separated
Biological mother & step-parent/partner
Biological father & step-parent/partner
Foster or adoptive parents
With visitations
Without visitations
Other:_____

Family and other household members. List all immediate family members and any person who lives in the household.

Relationship	Name	Living in home Y/N	Age	Quality of Relationship: Good	Quality of Relationship: Fair	Quality of Relationship: Poor
Mother						
Father						

Patient Name:_____**DOB:**_____

FAMILY HISTORY

Please check any following if there is a family history. (Please include relationship(s) to the patient).

Attention:_____
Learning Difficulties:_____
School Problems:_____
Behavior Problems:_____
Depression:_____
Anxiety:_____
PTSD:_____
Drug/Alcohol Abuse:_____
Legal Issues:_____
Hallucination/Delusions:_____
Bipolar/Depression:_____
Eating:_____
Epilepsy:_____
Mental Retardation:_____
Dementia or Alzheimers:_____
Traumatic Brain Injury:_____
Autism:_____
Heart or Lung Problems:_____
Speech/Language Problems:_____
Genetic Disorders:_____

SIGNIFICANT TRAUMA

Please check any trauma that the patient has or is suspected to have experienced

Injured or in an accident
Physical Abuse (victim or perpetrator)
Sexual Abuse (victim or perpetrator)
Emotional Abuse (victim or perpetrator)
Neglect
Removed from home

Please describe nature of trauma and age of patient at time of incident:_____

_____

_____

SOCIAL RELATIONSHIP

How would you describe the patient in social situations: (Please circle appropriate descriptor).
Friendly Socially Awkward Socially unaware Shy Withdrawn Disinterested **Any of the following concerns for the patient in social situations:** (Please check all that apply)

Demanding
Socially inappropriate
Socially anxious
Withdrawn

adjustment to the following:
Used to have more friends Has few friends
No friends
Not interested in friends

How would you describe the child's

Social Demands (including at school, group activities, sharing and playing with other peers):_____

_____

Losses/Separation (deaths, moves, etc):_____

_____

Patient Name:_____**DOB:**_____

Extracurricular Activities/religious participation:_____

_____

DISCIPLINE

Please circle the following words that best describe parenting style used in household

Parent/Guardian ( ) Parent/Guardian ( ) Firm Loose Laid-back Firm Loose Laid-back Yells Avoids Fun Yells Avoids Fun

Hovers Harsh Talks too much Hovers Harsh Talks too much Conflictual Calm Conflictual Calm

Forms of Discipline: Please check all that apply

Spanking
Time outs
Yelling/Screaming
Taking things away
Praise
Other:_____

How does the child respond to discipline?_____

ACADEMIC

Current school:_____ **Started School at what age?**_____ **Current grade:**_____

Participated in: Title I Reading Developmental Kindergarten Early Childhood Education Birth to 3 **Has the child utilized special education services?** Yes or No (If yes….): IEP or 504 Plan *Please specify below all classifications that have been used and circle current classifications.*

Cognitively impaired
Emotionally impaired
Hearing impaired
Visually impaired
Other health impairment

Was the client ever:

Severe multiple impairment
Speech and Language impairment Learning disabled
Physical disability

Academic Performance: Please check all that apply

Consistently above average (A's, B's)
Consistently average (B's, C's)
Consistently below average (C's, D's)
Consistently below average to failing (D's, F's)
Previously strong grades, recent deterioration
Previously weak grades, recent improvement

Dropped out of school; at what age and grade?_____
Graduated from high school
Obtained GED
Obtained Special Education Certificate

Held back-what grades?_____
Suspended- For what and for how long?_____
Expelled-From what grade and why?_____
Home Schooled-When and why?_____

EMPLOYMENT HISTORY: Yes or No due to age

Has the client ever been employed? Yes or No

Was the client successful at the job? Yes or No (if no please provide details):_____

_____

Has the client ever had employment terminated? Yes or No (if yes please provide details):_____

_____

Jobs held:_____

Patient Name:_____**DOB:**_____

Any household chores the client engages in:_____

_____

LEGAL

Please detail any contacts the client has had with the courts, police, etc:_____

_____

_____

PERSONAL INFORMATION:

Describe the child's positive characteristics: Please select all that apply

Happy	Optimistic Funny	Faithful
Intelligent Confident Persistent	Honest	Determined
Adventurous Considerate	Loyal	Patient
Sensitive	Devoted	Responsible
Active	Loving Cooperative Helpful	
Shy	Ambitious	

What are some of the child's strengths (what are they good at)**?**_____

_____

What are some of the child's hobbies/interests?_____

_____

ANY ADDITIONAL INFORMATION

Please list any additional information you would like to let the provider know.

_____

_____

_____

_____

Who completed this form?_____ **Today's Date:**_____

Parent/Guardian printed name:_____

Parent/Guardian Signature:_____ **Today's Date:**_____

Therapist Review Signature:_____ **Today's Date:**_____

Thank you

Please return the completed packet to the clinic.

Patient Name:_____**DOB:**_____

Notice of The Caring Tree or Balance for Growth's Policies and Practices to Protect The Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information Please review it carefully.

1. Uses and disclosures for treatment, payment, and healthcare operations. The Caring Tree or Balance for Growth may use or disclose your protected health information ("PHI") for treatment and payment purposes without your informed consent or authorization. Other uses require authorization. Typically, we will ask for informed consent or authorization to communicate with other treatment providers in order for you to be aware of communication which may occur. *To help clarify these terms, here are some definitions. "PHI" refers to information in your health record that could identify you. "Treatment and payment" treatment is when the center provides, coordinates, or manages your health treatment, including working with you directly on your goals or consulting with another healthcare provider, such as your family physician or another psychologist. "Payment" is when we obtain reimbursement for your healthcare. Examples of payment or when we disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage. "Use" applies only to activities within our clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. "Disclosure" applies to activities outside of the clinic such as releasing, transferring, or providing access to information about you to other parties. "Informed consent" and "authorization" are written forms that you sign permitting use to release specific information about you to specific recipients.* **2. Uses and disclosures requiring authorization.** We may use or disclose PHI for purposes outside of treatment and payment when your appropriate consent or authorization is obtained. In those instances, we will obtain a Release of Information from you before releasing the information. We will also need to obtain an authorization before releasing your psychotherapy progress notes. *"Psychotherapy progress notes" are notes we have made about our conversation during a private, group, joint or family counseling session.* You may revoke an authorization at any time in the manner selected on the ROI form, or in writing. You may not revoke an authorization to the extent that 1. We have relied on that authorization; or 2. If the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

3. Uses and disclosures with neither consent nor authorization. We may use or disclose PHI without your consent or authorization in the following circumstances: **Serious threat to health or safety:** if we have reason to believe using our professional care and skill that you may cause harm to yourself or another, we must warn the third-party or may include instituting commitment proceedings. **Child abuse:** if we have reasonable cause to suspect a child seen in the course of my professional duties has been abused or neglected, or have a reason to believe that he or she has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, we must report this to the relevant county department, child welfare agency, police or sheriff department. **Adult and Domestic abuse:** If we believe that another person has been abused or neglected we may report such information to the relevant county department or state official of the long-term care ombudsman. **Health oversight:** If the Wisconsin Department of Health Services requests that we release records to them for an investigation or audit, we must comply with such a request. **Judicial or administrative proceedings:** If the patient is involved in a court proceeding and a request is made for information about his or her diagnosis and treatment in the record such information is privileged under state law and we will not release the information without written authorization from the patient or his or her guardian or legally appointed representative, or a court order. The privilege does not apply when the patient is being evaluated for a third-party or where the evaluation is court ordered. You will be informed in advance if this is the case. **Worker's compensation:** If a patient files a Worker's Compensation claim to the patient's employer or its insurer, we may be required to testify. There may be additional disclosures of PHI that we are required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common. **4. Patient Rights and Therapist's Duties. Right in Receive Confidential Communications by Alternative Means and At Alternative Locations-** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, if you did not want a family member to know that you're being seen here we can send your bill to a different address. **Right to Inspect and Copy-** You have the right to records used to make decisions about you for as long as the PHI is maintained in the record. **Right to Amend-**You have the right to request an amendment of PHI for as long as the PHI is in the record. **Right to Accounting-** In most cases you have the right to receive an accounting of disclosures of PHI regarding you. **Right to a Paper Copy-** You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically. *Contact info@caringtree.us to find out how to request there.*

5. Therapists Duties Regarding PHI. Therapists are required by law to maintain the privacy of PHI and to protect patients with a notice of his or her legal duties and privacy practices. *The Caring Tree or Balance for Growth reserves the right to change the privacy policies and practices described in this notice and unless we notify you of such changes, we are required to abide by the terms currently in effect. If we revise the policies and procedures we will inform you at your next appointment. However, if the change is one that would af effect your treatment or handling of your PHI prior to your next visit.*

6. Questions/Complaints. If you have questions about this notice or disagree with a decision made about access to your records or if you have concerns about your privacy rights you may contact Trena Loomans at The Caring Tree, or at 715-301-0667. Patients can bring their concerns to the Clinic Manager or the Clinical Supervisor, Dr. Trena Loomans.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to 227400 Rib Mountain Dr, Suite D, Wausau, WI 54401. You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The Caring Tree or Balance for Growth will not retaliate against a patient for exercising his or her right to file a complaint. **Keep this page for your records.**