Child & Adolescent Information

Date: ________________

Child's Name: _______________________________________ D.O.B.: ___________ Gender: (circle) M / F
Home Address: ______________________________ City: ____________ State: _____ Zip: _______

Parent/Guardian Name: ____________________________________ Relationship: _________________
Parent/Guardian Name: ____________________________________ Relationship: _________________

FAMILY HISTORY

Mother's Name: ________________________ Age: _____ Occupation: ________________________
Address: _____________________________ City: ________________ State: _______ Zip: _______
Primary Phone: (cell/hm/wk)__________________ Secondary Phone: (cell/hm/wk)__________________
Email: ______________________________________
Marital Status: ___Married ___Divorced ___Separated ___Widowed ___Engaged ___Live w/ partner

Father's Name: ________________________ Age: ____ Occupation: __________________________
Address: ____________________________ City: ________________ State: _______ Zip: ________
Email: ____
Primary Phone: (cell/hm/wk)__________________ Secondary Phone: (cell/hm/wk)__________________
Marital Status: ___Married ___Divorced ___Separated ___Widowed ___Engaged ___Live w/ partner

Individuals raising the child (circle all that apply):

Biological Parents	Adoptive Parents	Parent and Step-parent	Single Parent
Foster Parents	Grandparents	Relatives	Nanny

List all individuals living with child:
Name: _______________________________ Age: _____ Relationship to child: __________________
Name: _______________________________ Age: _____ Relationship to child: __________________
Name: _______________________________ Age: _____ Relationship to child: __________________
Name: _______________________________ Age: _____ Relationship to child: __________________
Name: _______________________________ Age: _____ Relationship to child: __________________

Significant individuals not living with child:
Name: _______________________________ Age: _____ Relationship to child: __________________
Name: _______________________________ Age: _____ Relationship to child: __________________

Does your child have family members with histories in any of the following areas? (check all that apply)
☐ Mental Illness ☐ Suicide (or attempts) ☐ Drug or Alcohol Abuse
☐ Abuse (verbal/emotional, physical, sexual) ☐ Domestic Violence ☐ Legal Problems
Comments:____
Is your child currently involved with legal authorities? (custody, CPS, foster care, etc.) YES NO
If yes, explain: ____
Date and nature of any anticipated court hearings: ____
Is there a possibility that therapist will be asked to provide reports or testify? ______________________

MEDICAL HISTORY

Rate Child's Physical Health: (circle) Good Fair Poor
Current Medications: ____

List any chronic health conditions or allergies: ____
Any major illnesses, injuries, hospitalizations, loss of consciousness, or physical disabilities (explain):
____
____
Does your child have a speech, hearing, or vision impairment? __________________________________

DEVELOPMENTAL HISTORY
Was your child's pregnancy planned? _____________ Celebrated? ____________________________
Any drugs, alcohol, medication taken during pregnancy? _______________________________________
Were there any complications during pregnancy (physical or emotional)? __________________________
Any problems or conditions present at birth? ____
Any physical or emotional separations between child and caretaker during first 2 years of life? _________
List the ages at which your child achieved the following developmental tasks:
Walking __________ Talking ___________ Toilet Training ___________
Does/did your child have wetting or soiling accidents? _________ If so, when? ____________________
What time does your child go to bed? _________ How many hours does your child sleep at night? _____
Where does your child sleep? ____
Does your child have sleep disturbances, nightmares, or night terrors? _____ If so, how often? _________
Have you noticed any changes in your child's eating habits or weight in the past few months? (if so, explain):____

EDUCATIONAL INFORMATION
School : ____ Grade: _________
Previous schools/years attended: ____
Any education concerns, current or previously? ____
Is your child in special education or receiving special services? (explain): _________________________
Any concerns with peers (bullying, social difficulties): ____

FAMILY LIFE & RECREATION
List any major changes or losses your child or family has experienced in the past few years: ___________
____
Describe major sibling conflicts: ____
Describe major conflicts with parents: ____
Describe any conflicts between parents that may impact child: ___________________________________
____
List child's interests/hobbies/extra-curricular activities: ____
____
What type of playmates does your child prefer? (i.e. peers, older, younger, adults, all ages, imaginary, none)____
Describe how your child plays: ____

DISCIPLINE
Who disciplines your child? ____
What methods are used to discipline your child? ____
Any conflict among caregivers regarding discipline? ____
How does your child react to discipline? ____
How does your child show anger? Affection?____

How do you show anger? Affection? ____

COUNSELING INFORMATION

Please explain the reason you're seeking counseling for your child. ________________________________
____
____
____

What specific concerns do you have for your child? (i.e. anger, aggression, acting out, sadness, sexual behaviors, anxious/compulsive behaviors, eating disorder, etc.)___________________________________
____

How do you hope counseling will help with your concerns? _____________________________________
____
____

List your child's biggest strengths and weaknesses: ____
____
____

How have you explained counseling to your child? ____
____

Has your child been evaluated previously? YES NO

Psychological Evaluation: Where_______________________ When_________ Diagnosis_____________

Educational Evaluation: Where_________________________ When_________ Diagnosis_____________

Neurological Evaluation: Where________________________ When_________ Diagnosis_____________

Counseling: Where___________________________________ When________________________________

To your knowledge, has your child experienced any abuse (physical, sexual, verbal/emotional) or neglect?
____
____

Does your child have any strong fears? ____

Has your child experienced a stressful or scary event? ________

If yes, describe the event & your child's reaction: ____
____

Has your child ever engaged in or expressed thoughts of death, self-harm, or suicide? (explain)_________
____
____

Any other information you think is important for us to know:

SIGNATURE PAGE

To Remain In Your File In Kim Servent's Office

Your initials here indicate you have received a copy of Kim Servent's Notice of Privacy Policies
____

Your signature here indicates you have read, understand and accept the policies and have reviewed the risks and benefits of general verbal therapy as explained in the "PROFESSIONAL DISCLOSURE STATEMENT Therapy Policies and Services" document. My therapist has adequately answered any questions I have regarding these risks and benefits. I agree to enter verbal therapy with an understanding of the possible risks. I further understand that my therapist will explain any additional specific risks and benefits associated with any particular method, goals or objectives they may recommend.

____________________________	____________________________	____/____/20____
Client name (Print)	Signature	Today's Date

____________________________	____________________________	____/____/20____
Client name (Print)	Signature	Today's Date

I have interviewed the above named individual(s) and have answered any questions about their informed consent, confidentiality, and the risks and benefits of general verbal therapy. On the basis of my interview I have no reason to believe that he/she or they are not competent to understand the nature of verbal therapy and the potential risks and benefits that may result from it.

We have also agreed to a per session fee of $____________.

____ _____/_____/20_____
Kim Servent, MS, LPC

My signature confirms that I have legal guardianship of the above named child and have the legal right to independently consent to psychological treatment of the above named child. I have provided my therapist with copies of all current legal documents or court orders pertaining to custody or guardianship of the above named child. I understand that it is my responsibility to provide my counselor with any future documents or court orders while my child is receiving treatment with Kim Servent, MA, LPC.

Parent/Guardian's Signature:_____________________________________ Date: ___________________
Printed Name: ____

Parent/Guardian's Signature:_____________________________________ Date: ___________________
Printed Name: ____

PROFESSIONAL DISCLOSURE STATEMENT Therapy Policies and Services
Please Read Carefully

Who we are:
An out-patient treatment center ready to help people:
- Change their lives and relationships
- Learn coping skills
- Learn to balance work, family, social and spiritual lives

Qualifications:
All therapists have master's degrees or higher academic training, as well as thousands of hours of clinical experience. All therapists pledge to practice by the code of ethics of any professional licensing group by which they practice (e.g. Texas Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Master Social Worker, Licensed Psychologist, Psychiatrist, etc.), and by any professional association they are members of (e.g the American Association of Marriage and Family Therapists and American Association of Pastoral Counselors, etc.).

What we offer:
We offer a variety of programs: individual, couple, family, group psychotherapy, play therapy for children – delivered by therapists using different approaches. All therapists have been extensively trained and receive on-going supervision and education.

Your role in therapy is to:
- Make a commitment for change and/or growth
- Take responsibility for your own life
- Set goals for therapy
- Give feedback to your therapist
- Work on your own goals between sessions

Your therapist's role is to:
- Decide if his or her skills meet your need
- Facilitate your reaching your goals
- Help identify community and other psychotherapeutic resources

Our limitations:
- We are an out-patient treatment center, we cannot provide intense daily client monitoring. Further, we are unable to help clients who:
- Continue to be under the influence of illicit drugs (including alcohol)
- Misuse or refuse to use prescribed medication
- Require intense supervision
- Consistently disturb other clients or staff
- Endanger other clients or self
- Willingly destroy our property

INFORMED CONSENT

Confidentiality: Your relationship with Kim Servent is important and confidential. Information cannot be released regarding your counseling without your written permission unless disclosure is required by state law. Some examples are: 1) suspected abuse of a child, elderly or disabled person or elder abuse; 2) if you are involved in a legal case, your therapist may be required by law to release your records to attorneys or judges; 3) if you are dangerously close to harming yourself or others your counselor may notify medical or law enforcement personnel; 4) you disclose sexual contact with another mental health professional; or 5) you direct your therapist to release your records. If you see your therapist in public, they will protect your confidentiality by acknowledging you only if you approach them first.

Counseling Relationship: While you work together with your therapist, your sessions may be very intimate psychologically, but please remember this is a professional relationship rather than a social one. Please do not invite any counselor to social gatherings, ask them to write references for you, or ask them to relate to you in any way other than the professional context of your counseling sessions. You will be best served if your sessions concentrate exclusively on your concerns.

Your in-person contact with your therapist will be limited to your counseling. You may leave messages for your counselor at 214-550-2907 and they will return your call as soon as possible. <u>If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room.</u>

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you. (See "The Counseling Process Below)

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end your counseling relationship at any time. However, we ask that you participate in a termination session with your therapist. If you have concerns or problems with your counseling relationship or if you have questions about Kim Servent's policies we hope that you will talk directly with your counselor. If your counselor is not able to resolve your concerns, you may report your complaints to the Texas Department of Health, 512-834-6658.

Sessions: Sessions are generally scheduled for 45 - 50 minutes. The appointment you schedule is reserved for you. You will be billed for missed appointments and cancellations of less than 24 hours notice. Unforeseen emergency situations may be taken into account.

Referrals: If for any reason your therapist feels your treatment is beyond their scope of expertise, they will immediately provide a referral to another therapist or facility/group/practice. You will be responsible for contacting and evaluating those referrals and /or alternatives. Certain aspects of treatment may require evaluation through psychological testing or medication. In such cases, a referral to a psychiatrist or medical doctor may be made.

Fees: Your fee will be negotiate in advance of treatment confidentially with your therapist. If the fee represents a hardship to you, please let your therapist know and they will work with you on a sliding scale

as needed. The fee for each session will be due and must be paid by the conclusion of each session. Visa, Mastercard, AMEX, Discover Card, Cash or personal checks made out to Kim Servent are acceptable for payment.

Insurance: Kim Servent does not file for reimbursement from health insurance companies but you may request the required information be given in order for you to follow up with your insurance provider. If you become involved in litigation that requires your therapist's participation, and due to the complexity and difficulties of legal involvement, Kim Servent will charge $250 per hour for preparation for, travel to, and/or attendance at any legal proceedings.

The Counseling Process: Most clients enter counseling because they are in some pain and the pain of not changing their behavior or certain aspects of their life is greater than the pain of change.

Potential benefits of therapy:

- ✓Improved understanding of self and others. The objective viewpoint of the therapist helps many clients better understand their own feelings and behavior as well as those of others.
- ✓Progress toward defined goals and objectives. In therapy, the clients and therapist work together to set specific goals and objectives. A way is usually identified to measure progress toward those goals. Most clients can clearly identify the changes in feelings and behavior that they make through therapy.
- ✓Greater sense of control over moods and behavior. As clients measure progress and identify the tools used to make headway, they often gain feelings of power over moods and behavior.
- ✓Improved self-esteem. With greater self-control, clients often improve their self-concept. Confronting and managing one's difficulties often leads to improved self-esteem.
- ✓Improved self-assertion. Many clients increase their ability to assert themselves. As self-esteem and feelings of self-control improve, they feel more able to stand up for their own rights without infringing on the rights of others.
- ✓Improved relationships with others. By reducing unwanted behaviors and increasing more desirable behaviors, clients often improve relationships with family members or co-workers or friends.
- ✓Improved capacity for independence. Before therapy many clients may have depended on others for their sense of well-being. Therapy may lead to an increased ability to meet one's own needs.

Potential risks of therapy

- Lack of progress. Some clients do not appear to improve in therapy. For example, depression or anxiety may become worse. Your therapist will monitor your progress with you to determine if this happens and to plan alternatives should this occur.
- Upsetting insight. Therapy may lead to insight into your own behavior or the behavior of others that is upsetting. Your therapist will monitor your feelings with you and discuss these concerns if they arise.
- Feelings of distress. Discussing personal concerns can be upsetting by itself. Clients may experience feelings of sadness, anger, anxiety, or depression in talking about their personal or family difficulties. Clients may also have bad dreams or nightmares as a result of talking about concerns. Part of therapy often involved learning to handle such feelings more effectively when they occur. Your therapist will work with you to develop coping strategies for these feelings if they arise.
- Change in relationships. Although behaviors and moods may change in a way that the client desires, others may not like the changes and may not adjust to the changes the client makes. Improvements in client's self-esteem, self-assertion, or sense of self-control may negatively affect others. Verbal therapy can lead to conflict in marriage or other family relationships. Your therapist will work closely with you to try to anticipate such problems in therapy. However, we cannot anticipate all interpersonal conflicts that may result from therapy.

Please NOTE: This page is for your records and will be returned to you. Complete ONLY if you want this back for your records.

Your initials here indicate you have received a copy of Kim Servent's Notice of Privacy Policies

____

Your signature here indicates you have read, understand and accept the above policies and have reviewed the risks and benefits of general verbal therapy as explained in this document. My therapist has adequately answered any questions I have regarding these risks and benefits. I agree to enter verbal therapy with an understanding of the possible risks. I further understand that my therapist will explain any additional specific risks and benefits associated with any particular method, goals or objectives they may recommend.

______________________________	______________________________	_____/_____/20_____
Client name (Print)	Signature	Today's Date

______________________________	______________________________	_____/_____/20_____
Client name (Print)	Signature	Today's Date

I have interviewed the above named individual(s) and have answered any questions about the risks and benefits of general verbal therapy. On the basis of my interview I have no reason to believe that he/she or they are not competent to understand the nature of verbal therapy and the potential risks and benefits that may result from it.

We have also agreed to a per session fee of $____________.

______________________________	______________________________	_____/_____/20_____
Kim Servent, MA, LPC	Signature	Today's Date

NOTICE OF KIM SERVENT'S PRIVACY PRACTICES
PLEASE REVIEW IT CAREFULLY.

This statement gives you advice required by law. This Notice is effective as of April 14, 2003 and applies to health information Kim Servent receives about you. Any reference to Kim Servent in this document also refers to and includes the counselor you work with in Kim Servent's offices. You may receive similar notices about your medical information and how other practitioners handle it.

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). This statement is not a consent or an authorization form. We will not use this form to release or use your health-care information in any manner that is not permitted by the Privacy Regulations.

This Notice is for clients of Kim Servent. As a client of Kim Servent, you are entitled to receive this Notice of Kim Servent's privacy procedures with respect to your health information that Kim Servent creates or receives (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how we will use or disclose your PHI, your privacy rights with respect to PHI, our duties with respect to your PHI, your right to file a complaint with us or with the Secretary of the United States Health and Human Services ("HHS"), and our office to contact for further information about our privacy practices.

We may make the following uses and disclosures of your PHI:

We may use or disclose your PHI to obtain payment.

We may use or disclose your PHI for purposes of treating you. For example, if your doctor or other healthcare provider who is also treating you requests information on what treatment you are currently receiving, we will provide that information. In addition, we may also disclose your PHI to anyone on our staff involved in your treatment plan/program or in connection with Kim Servent's operations.

Kim Servent may also be required to disclose or use your PHI for certain other purposes. These purposes include uses or disclosures that are required by law. For example, if we are required to disclose your PHI to comply with a court order, or as relating to workers' compensation.

Kim Servent will disclose your PHI if you authorize the disclosure in writing. If you authorize the disclosure, we will give you a copy of any authorization you sign. We will make any other use or disclosure of your PHI only with your written authorization. You may revoke that authorization in writing. However, your revocation cannot be effective to the extent that we have already taken any action relying on your authorization for disclosure.

Your PHI may be used so that Kim Servent, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you.

Rights You May Exercise –You Have the Right to Request:

1. access to your PHI and to inspect and copy your PHI under the policies and procedures we have established.
2. amendment to your PHI under the policies and procedures we have established.
3. accounting of any disclosures we make of your PHI, other than those for payment, treatment, and health-care operations.
4. obtain a paper copy of this Notice of Privacy Practices.

5. to inspect a copy of your PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings. Psychotherapy notes are separately filed notes about your conversations with your mental-health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment.

Other Uses or Disclosures of Protected Health Information

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if: the information is directly relevant to the family or friend's involvement with your care or payment for that care; and you have either agreed to the disclosure or have been given an opportunity to object but have not objected.

Use and disclosure of your PHI is allowed without your authorization or any opportunity to agree or object when required by law.

Rights of Individuals

You may request that we restrict uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to restrict uses and disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request.

We require that you or your personal representative complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following: Kim Servent, 6116 North Central Expressway, Suite 500, Dallas, Texas 75206, 214-550-2907.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as we have it. "Designated Record Set" includes your medical records and billing records that are maintained for payment, billing, and case or medical-management record systems maintained by or for us. We will charge you a reasonable fee per page for making these copies.

If we deny you access to your PHI, we will give you or your personal representative a letter telling you why. We will also tell you how to request a review and how to complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend

You have the right to ask us to amend your PHI or a record about you in a designated record set for as long as your PHI is maintained in the designated record set. You or your personal representative must complete an amendment-request form and give us a reason why we should amend your PHI.

You have the right to file a complaint with us or with the Secretary of the United States Health and Human Services if you believe that your privacy rights have been violated. Your written complaint should describe the violation and when it occurred. We will not retaliate against you for filing a complaint.

You may also file a complaint with the Office of Civil Rights of the Department of Health and Human Services at 200 Independence Avenue S.W., Room 515F, HHH Building, Washington, DC 20201, or at the appropriate regional office of the Office of Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. If you would like to receive further information, you should contact Kim Servent, 6116 Central Expressway, Suite 500, Dallas, Texas 75206, 214-550-2907.

This Notice will first be in effect on April 14, 2003 and shall remain in effect until you are notified of any changes, modifications or amendments.