ST LUKE'S UNITED METHODIST CHURCH | COMMUNITY COUNSELING CENTER

CHILD COUNSELING SERVICES AGREEMENT

Child's Name ____

Parent's Name: ____

Parents Marital Status: ____________________ **Previous Marriages** _______________

Child's Birth Date: ______________ **Age** ________ **Religion** _________________________

Address: ____________________________________ **City, State, ZIP**__________________________

Home Phone:________________ **Child(Mobile)** _____________**Both Parent's Phone**_______________
____

School Grade: __________ **Number of Siblings** ________**Ages** ________________**Sex**____________

Insurance Plan) ____**Authorization #**________________

Policy Holder's Name & Date of Birth ____

This is to certify that I consent on behalf of my child to counseling: _________Initial

The hourly fee for all appointments not cancelled 24 hours in advance will be charged.

I agree that information will be released to my insurance carrier for purposes of reimbursement where applicable. _____ Initial

After-Hours Emergencies: Call 911, or contact your insurance company for direction regarding the most appropriate level of care. The Community Counseling Center does not provide after hours or weekend care. _____ Initial

The regular hourly fee will be charged for children who are not picked up on time at the end of the session. _______Initial

There is a $100 charge for completing disability, FMLA and any other paperwork. It is the responsibility of the patient to pay this fee prior to completion of the form. Our policy is to allow 7-14 days for processing the form. We require that the patient information, employer information and other personal sections be completed before accepting the form. ________ Initial

____ _________________________

Parent's Signature (if client is under 18 years) Date

____

Counselor's Signature

April 2017

Health History for Children and Youth

Name: ____

Last First Initial

Date of Birth: ______________________

The following questions are designed to be of assistance in determining the needs of your child or adolescent. Please complete this questionnaire as accurately and honestly as possible.

Please print legibly.

Patient's Name ______________________________ Date of Birth ______________

Mother's Name ______________________________ Date of Birth ______________

Father's Name ______________________________ Date of Birth ______________

Step-Parent's Name___________________________ Date of Birth ______________

Step-Parent's Name___________________________ Date of Birth ______________

Sibling's Name______________ Age ______ Sibling's Name______________ Age _____

Sibling's Name______________ Age ______ Sibling's Name______________ Age _____

1.) Did someone refer you? Yes _____ No _____

If yes, who referred you? ____

What was the reason? ____

2.) Who is your Pediatrician? ____

3.) The name child's School ____

Type of Placement: Regular; LD; SL.; EH; EMH: Gifted; Special/Regular

Work history: ____

4.) Has psychological testing been completed? Yes ___ No ___ by whom? _______

Has educational testing been completed? Yes ___ No ___ by whom? _______

if yes for above, please discuss providing these test results to the Counselor. The results can be instrumental in the counseling process.

5.) Please indicate the behaviors that are a source of concern for you. Indicate **P for past** and **C for current:**

___Temper outburst
___Fire setting
___Withdrawn
___Stealing
___Day dreaming
___Nightmares
___Lying
___Fearful
___School performance
___Short attention span

___Bed wetting
___Peer issues
___Soiled pants
___Impulsive
___Drug use
___Suicide talk
___Cutting
___Alcohol use
___Head banging
___Defiant

___Cigarette smoking
___Trouble with law
___Sexual abuse
___Eating problems
___Running away
___Compulsive
___Worry/anxiety
___Sexually acting out
___Pregnancy
___Other ______

Name: ____
Date of birth: ___________________________

Medical History:

6.) List all medical hospitalizations:

Reason: ___________________________ **Dates:** ___________________________
Reason: ___________________________ **Dates:** ___________________________
Reason: ___________________________ **Dates:** ___________________________
Reason: ___________________________ **Dates:** ___________________________

7.) Chronic Illness/ head injuries:

____
____
____

8.) List of medications for medical or mental health issues (present and past):

Medication Dosage

____
____
____
____

9.) Previous Mental Health Treatment: Yes _____ No _____

Out-patient Counseling:

Counselor/ Psychiatrist Date

____
____
____

In-patient Counseling:

Counselor/Psychiatrist Facility Date

____
____
____

In-school Counseling:

Counselor/Psychologist School Grade Date

____
____

Developmental History:

10.) Who does the child/teen live with? ______________________________________
Who has legal custody? ____

PreNatal Care: Yes _____ No _____ Full Term: Yes _____ No _____
If premature, how early: ___________________________ Birth weight: lbs._____ oz. _____
Type of delivery: spontaneous __, cesarean __, with instruments __, head first___, breech ___
Was it necessary to give the infant oxygen? Yes _____ No _____
Was the infant discharged with Mother? Yes _____ No _____
Did mother use alcohol/drugs/nicotine during pregnancy? Yes _____ No _____
If yes, please explain:

____
____

Difficulty sleeping as an infant _____, Colic _____, Breast fed _____, Regular formula _____
Developmental milestones: walked ___(age), spoke full sentences ____(age), toilet trained ___(age)

Name: ____

Date of birth: ______________________________

Educational History:

11.) At what age did you child enter Day Care? __________
Did your child attend Pre-School? _________________
Please list all the schools your child has attended until present:

____
____
____
____

Please describe your child's last report card:

____
____
____
____

12.) Goals of counseling: (What would like to see happen as a result of counseling?)

____
____
____
____
____

13.) Is there any other information that you believe would be helpful for the Counselor to know?

____
____
____
____
____

14.) How did you hear about St. Luke's Community Counseling Center?

______ Word of Mouth ______ Online Search (key words) ___________________

______ Print Ad ______ Worship Guide

______ Brochure at St. Luke's ______ Brochure at Event

I understand that this information is being provided to my child's Counselor only. It is my responsibility to share relevant medical information with my child's Pediatrician/Primary Care Physician.

____
Name of the person completing this questionnaire Date

____
Reviewed By Date

Patient Record of Communication

Patient Name: ____

In general, the HIPAA privacy rule gives the individual the right to request confidential communications or that a communication is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone: ______________________________________
  - ( ) O.K. to leave message with detailed information
  - ( ) Leave message with call-back number only
- Written Communication
  - ( ) O.K. to mail to my home address
  - ( ) O.K. to mail to my work/office address
  - ( ) O.K. to fax to this number: ____________________________
- Work Telephone:____
  - ( ) O.K. to leave message with detailed information
  - ( ) Leave message with call-back number only
- Other____

<u>Authorization to Disclose Information</u>
<u>To Primary Care Physician</u>

If you are an insurance client, you <u>must</u> fill out this form. If you do not want your records released to your Primary Care Physician, check the third option below, sign and print your name.

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, ____ hereby authorize ___________________________________
(Please Print Client's Name) *(Please Print Treating Counselor's Name)*

Please check any that apply:

_____ To release any applicable information to my Primary Care Physician
_____ To release medication information only to my Primary Care Physician
_____ Not to release information to my Primary Care Physician

____ ___________________________
(Client's or Client's Guardian Signature) *(Date)*

____ ___________________________
(Please Print the above Name) *(Date)*

Primary Care Physician:

Name: ____

Address: ____

____

Phone: ____

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN INDICATING THAT YOU HAVE READ AND UNDERSTAND THE NOTICE.

Understanding Your Health Record/Information

Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool in educating heath professionals;
- a source of information for public health officials charged with improving the health of the nation;
- a source of data for facility planning and marketing and
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. Privacy Rules (PR) specify that you have the right to:

- request a restriction on certain uses and disclosures of your information as provided by PR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in PR 164.524
- amend your health record as provided in PR 164.528
- obtain an accounting of disclosures of your health information as provided in PR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the Administrative Assistant at 407-876-4991 ext. 250

If you believe your privacy rights have been violated, you can file a complaint with the Director of The Community Counseling Center, or with St. Luke's Director of Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by your mental health counselor will be recorded in your record and used to determine the course of treatment that should work best for you. Your counselor will document in your record her/his expectations of your treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis.

We will use your health information for regular health operations. For example: Members of the counseling staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the counseling service we provide.

Other Uses or Disclosures

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

*Communication with Family: Counse*lors in best judgment may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

There are specific exceptions to confidentiality as provided in state and federal law, where a counselor can release information **without** your consent. These exceptions include possible threat of harm to self, harm to others, child abuse and neglect situations, aging adult abuse and neglect.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Client Rights and Responsibilities

As a client of the Community Counseling Center at St. Luke's, you have certain rights and responsibilities.

Rights

- You have the right to receive information about the services and providers available through the Community Counseling Center at St. Luke's. You also have the right to receive information related to standards of practice.
- You have the right to be treated with respect and dignity and understanding of your need for privacy.
- You have the right to an honest discussion of appropriate treatment options for your conditions regardless of cost or benefit coverage.
- You have the right to refuse treatment. If you refuse treatment, you have the right to ask your provider about the possible results of refusing.
- You have the right to receive information about your rights and responsibilities as a client. You may also make recommendations regarding the client's rights and responsibilities policies.

Responsibilities

- It is your responsibility to actively and earnestly cooperate in your treatment.
- It is your responsibility to follow program rules.
- **It is your responsibility to keep scheduled appointments Or cancel at least 24 hours in advance or pay a flat fee.**
- It is your responsibility to pay for treatment at the time services are rendered as agreed during your initial intake.
- It is your responsibility to provide full information, to your counselor, regarding any treatment you are receiving or have received including types of counseling, medications and hospitalizations.

Reasons for Discontinuing Counseling

I understand that the following are program rules and violation of any of these rules WILL result in my discharge from counseling.

- No alcohol, illegal drug possession, drug/alcohol use will be permitted on or about the Community Counseling premises.
- No violence, threats of violence or verbal abuse will be permitted on or about the Community Counseling premises.
- No weapons will be permitted on or about the Community Counseling premises.
- No act of vandalism to the property of the Community Counseling Center, its staff or patients will be permitted.
- No smoking will be permitted inside the Community Counseling Center building.
- Nonpayment of Counseling Center charges will result in termination of counseling.

I have read and understand the Notice of Health Information Practices.
I have received a copy of the Client Rights and Responsibilities and have read and understand them.
I understand the rules of the program. I understand the policy of reporting abuse or complaints.
I agree to participate and abide by the stipulations in this contract.

Client's Signature ______________________________ **Date** ______________

Parent's Signature (if client is under 18) ______________________ **Date** ______________

Counselor's Signature ______________________________ **Date** ______________