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

Community Counseling Center at St. Luke's

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:

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 know9

_____
_____
_____
_____
_____
_____

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_____

Authorization For Release Of Information

Section A: Must be completed for ALL authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. Both spouses in a marital counseling situation must sign the records release form to release information. All patients age 12 years and over must sign the records release form to release information.

Client name: _____
First Middle Last
SS Number: _____

Persons/organizations providing the information: _____
Persons/organizations receiving the information: _____
Address _____ City _____ St. _____ Zip_____

Specific description of information (including dates):
_____ Speak with _____
_____ Release my counseling records (check all that apply)
_____ Release my child's counseling records (check all that apply)
_____ Write a letter
_____ Fax my records (Fax #: _____)

Release the following:
☐ Assessment ☐ Diagnosis
☐ Progress Update
☐ Psychosocial Evaluation
☐ Treatment modality/summary
☐ Treatment motivation
☐ Demographic information

Section B: Must be completed only if a health plan or health care provider has requested the information

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure?

   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes____No_____**

2. The client or the client's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials: _____**
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials: _____**

Section C: Must be completed for ALL authorizations

The client or the client's representative must read and initial the following statements:

I. I understand that this authorization will expire on __ __ / __ __ / __ __ __ __ (DD/MMIYEAR) **Initials: _____**
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. **Initials: _____**

(Form MUST be completed before signing.)

_____ _____
Signature of Client or Client's Representative **Date**

_____ _____
Printed Name of Client's Representative **Relationship to Client**

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION * You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.***

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** _____

Revised Jan 2010

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.