Child Counseling Place

Promoting strength, connection, and growth

Hello,

Thank you for taking the time to complete the intake paperwork. Attending therapy is an important step in helping your child cope with her/his experience. Your child's sessions will help her/him cope with thoughts, feelings, and behaviors. As therapy progresses, there may be times your child is reluctant to attend; however, the effectiveness of therapy depends on being able to tolerate short-term, painful emotions, and your child will need to attend sessions to learn to do that.

Therapy is a collaborative venture with both the client and therapist, as well as the client's caregivers. Caregivers are expected to participate in their child's treatment. Caregiver participation might include attending individual sessions with the therapist, participating in the child's individual sessions, attending family sessions, and/or completing homework assignments based on the child's sessions.

Your child's appointments are reserved only for her/him. As such, if s/he needs to cancel an appointment, please do so in a timely manner.

Counseling works best if sessions are weekly at first. As progress is made, session frequency is reduced. Bi-weekly sessions may be arranged if financial and/or scheduling burdens arise. **Appointments are offered during the day**. While daytime appointments mean missed school time for children, this is a short-term situation for long-term healing.

I am not a custody evaluator. If you are seeking counseling services for your child because of a custody dispute, you will need to seek evaluation services from someone who does custody evaluations. Additionally, any parent who has medical rights to their child will be notified if their child is seeking counseling services, regardless of the parent's involvement in that child's counseling services. As the parent or guardian seeking services, you must provide written documentation of a parent's termination of rights if you do not wish for that parent to be contacted.

Please note this practice is not capable of offering emergency services. Should an emergency arise with your child, your child should seek treatment at a local emergency center.

Welcome!

Erica L. Daniels, LPCC-S
Pediatric Mental Health Counselor

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Intake Form

PLEASE PRINT CLEARLY Today's Date ______________________

PERSONAL INFORMATION

PATIENT ____

Date of Birth ______________________ Gender __________

Address ____

City, State ____________________________Zip __________

Home Phone ____

Work Phone ____

Cell Phone ____

RESPONSIBLE PARTY ____

Responsible Party's SSN ____

Address (if different) ____

City, State ________________________________ Zip _______

Home Phone (if different) ________________________________

Work Phone (if different) ________________________________

Cell Phone (if different) ________________________________

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_______ Spouse_______ Child_______ Other _______

Relative or friend in case of emergency ____
Name Phone# Relationship

Source of referral _________________________ Reason for referral ___________________

How did you hear about Child Counseling Place? ____

FAMILY INFORMATION

NAME	M/F	AGE	DATE OF BIRTH	RELATIONSHIP TO PATIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Parents / Step-Parents/ Adoptive Parents of Patient						
1.						
2.						
3.						
4.						
Siblings / Step-Siblings /						
1.						
2.						
3.						

4.						
Others Living in Household						
1.						
2.						
3.						

MEDICAL INFORMATION

1. **Patient Name ____**

Have s/he ever been treated for emotional difficulties before (When and Where?) ____

____

Physician: Name/Practice _____________________________ Address________________________ Phone _______________________

Date of last physical exam _____________________________ Height ________________________ Weight _______________________

How is her/his general health now? ________________________ Medications? ____

Is s/he presently being treated by a physician for any physical condition? ____

Has s/he had any serious illness? (List) ____

Has s/he ever had any surgery? (List) ____

___Anger ___Anxiety ___Behavior Problems ___Changes in Appetite/Eating Habits ___Criminal Activity ___Decreased Energy ___Delusions ___Depressed Mood ___Disruption of Thought Process/Content ___Emotional/Physical/Sexual Trauma ___Excessive Crying ___Family Conflicts	___Grief ___Guilt ___Hallucinations ___Hopelessness ___Hyperactivity ___Impulsiveness ___Interpersonal Conflicts ___Irritability ___Manic ___Mood Swings ___Oppositional ___Panic Attacks	___Paranoia ___Physical Aggression ___School/Work Problems ___Self Abusive Behavior ___Sleep Disturbance ___Somatic Complaints ___Suicidal Thoughts/ Attempts ___Weight Gain ___Weight Loss ___Worthlessness ___Other (Specify)

How could your child’s life be better?

What would you like your child to accomplish through counseling (her/his goal)?

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Privacy Practices Form

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified therapist. We wish to take this opportunity to welcome you and to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
   a) Type of therapy needed (individual, group, medication referral, etc.)
   b) Frequency of therapy sessions (weekly, biweekly, etc.)
   c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 45-50 minutes. At the end of each appointment you can discuss future appointments with your therapist.

3. CANCELLATIONS: If you find you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. PAYMENTS: We greatly appreciate payment in full for each office visit when you come for your appointment. We accept cash and check. **Please make checks out to "Erica L. Daniels, PCC, LLC**".

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with most insurance plans; however, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Child Counseling Place ultimately are your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

6. CONFIDENTIALITY: Information regarding the specific nature of your counseling or psychotherapy is maintained at Child Counseling Place and the Electronic Health Record Database we use and is considered confidential within the office unless specified by you in writing; however, each therapist at this office reserves the right to use specialty consultation with other therapists at the office as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.
   a. **Child Custody Matters**: No one affiliated with Child Counseling Place is a child custody evaluator or can make decisions regarding custody. The Ohio Counselor, Social Worker, Marriage and Family Therapist Board is the regulatory body for providers at this practice. The CSWMFT Board, in accordance with the Ohio Revised Code, mandates counselors inform all parents with parental rights their child is receiving services, regardless of the parent's involvement with that child or that child's therapy unless a court has determined the parent should not have access to records related to the child.

☐ Yes ☐ No I acknowledge that I have read and understand all the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

☐ Yes ☐ No I have received a copy of the Privacy Practices Form.

Patient:____

Signature of Guardian or Adult Patient:_______________________________________Date: _______

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Privacy Practices Form

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4. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. If you do not pay in full at the time of service. We accept cash and check. **Please make checks out to "Erica L. Daniels, PCC, LLC**".

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with most insurance plans; however, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Child Counseling Place ultimately are your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

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   a. **Child Custody Matters**: No one affiliated with Child Counseling Place is a child custody evaluator or can make decisions regarding custody. The Ohio Counselor, Social Worker, Marriage and Family Therapist Board is the regulatory body for providers at this practice. The CSWMFT Board, in accordance with the Ohio Revised Code, mandates counselors inform all parents with parental rights their child is receiving services, regardless of the parent's involvement with that child or that child's therapy unless a court has determined the parent should not have access to records related to the child.

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Patient:____

Signature of Guardian or Adult Patient:___________________________________Date: _______

CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS

CLIENTS RIGHTS, RESPONSIBILITIES, AND CONFIDENTIALITY POLICY

(CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS)

Erica L. Daniels, PCC, LLC is a private, outpatient practice that includes assessment and therapy for individuals and families. **The practice is not equipped to provide intensive or emergency services, and a referral for these services will be made if necessary.**

CLIENT RIGHTS

To be treated with respect and dignity at all times. This includes being included in all facets of the planning of treatment. You have the right to ask questions at any time, and you may refuse to participate in any intervention suggested. You have the right to be fully informed regarding the estimate of the approximate length of treatment to meet the goals.

To be fully informed about your provider's qualifications, training, and experience. Please see your therapist's Professional Disclosure Sheet.

To understand any issue related to the therapy process. If you have any questions or concerns, please do not hesitate to discuss them with your therapist.

To discontinue treatment at any time. Ideally, therapy terminates at a point agreed upon by both client and therapist; however, the final decision about termination rests with the client. Should you decide to discontinue before your therapist thinks you are ready, your therapist may request a final session to discuss progress and areas of continuing concern.

CLIENT RESPONSIBLITIES

To arrive on time for therapy sessions, and to cancel appointments 24 hours in advance. Your appointment time is reserved exclusively for you; canceling is needed at least 24 hours in advance in order to avoid being charged a $40 fee. This charge cannot be billed to your insurance because they do not pay for missed or late-cancelled sessions. Extenuating or emergency circumstances most likely will result in the charge being waived.

To pay for the services at the time they are received. Fees are due at the time of services. Some fees may not be covered by insurance (e.g., phone calls over 15 minutes, consultation with other professionals, preparation of written reports, or others). If you have insurance coverage, you must pay that portion not covered by your insurance at the time of services, including any deductible and/or copay amounts. Erica L. Daniels, PCC participates in some insurance plans, and you may call your plan to confirm whether she participates in its network. You may opt to pay your bill in full and submit your own insurance claim, or you may opt to use your therapist as an out-of-network provider if your therapist does not accept your plan (please confirm this with your plan before services begin). Accounts 30 days overdue will be subject to a late fee. If your account is 90 days overdue, you will be referred to collections. You will be responsible for all fees associated with collections, attorney costs, and court costs.

Limits of Confidentiality

Under most circumstances, communications between you and your provider are, by law, confidential, and may not be disclosed without permission. In a few special circumstances, information may be disclosed without your permission. For example, a judge may order disclosure of information if you are involved in legal proceedings or if your treatment is court-ordered. Circumstances that pose a significant, imminent threat of harm to you or someone else also may be disclosed without your permission. Disclosure of child abuse, abuse of the elderly, and abuse of disabled adults is required by law, and can be disclosed without your permission.

Electronic Communications

Erica L. Daniels, PCC, LLC cannot ensure the confidentiality of any form of communication sent through electronic media, including text messages. You are advised that any e-mail sent to a therapist via computer in a work-place environment is legally accessible by an employer. If you prefer to communicate via e-mail or text messaging regarding scheduling or cancellations, the therapist will do so. While the therapist will try to return messages in a timely manner, the therapist cannot guarantee immediate response, and requests that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Risk of using e-mail/texting: The transmission of client information by e-mail and/or texting has a number of risks that clients should consider prior to using e-mail/texting in therapy. These include, but are not limited to, the following:

- E-mail/text messages can be circulated, forwarded, or stored in electronic files.
- E-mail/text messages can be immediately broadcast worldwide and received by many intended and unintended recipients.
- Senders easily can misaddress e-mail and text messages.
- E-mail/text messaging is easier to forge than handwritten or signed documents.
- Backup copies may exist even after the sender and/or recipient has deleted her/his copy.
- E-mail/text messages can be intercepted, altered, forwarded, or used without detection or authorization
- E-mail/text messages can be used as evidence in court.
- E-mail/text messages can be lost in transmission.

Conditions for the use of e-mail/texts: Erica L. Daniels uses reasonable means to protect the security and confidentiality of e-mails and texts they send and receive; however, because of the above outlined risks, they cannot guarantee the security and confidentiality of information sent through e-mails or texts. Erica L. Daniels, PCC, LLC is not liable for improper disclosure of confidential information that is not caused by their intentional misconduct. Erica L. Daniels, PCC, LLC may choose not to use electronic communication to correspond with clients. Clients must acknowledge and consent to the following conditions:

- **This practice is not equipped to handle emergency situations. Clients should not e-mail or text Erica L. Daniels in emergency situations, but, instead, should contact 9-1-1 and/or seek emergency centers such as a local hospital, urgent care, emergency response center, etc.**
- If clients choose to use e-mail/text, they are aware that Erica L. Daniels, PCC, LLC cannot guarantee that e-mails/texts will be received and responded to within a certain period.
- When at all possible, complex or sensitive situations are encouraged to be reserved for discussion during session rather than through e-mail/text.
- Any e-mail/text sent or received is subject to being printed out and stored in the client's medical record.
- Erica L. Daniels, PCC, LLC will not forward a client's identifiable e-mails/texts to outside parties without the client's written consent, except as authorized by law and explained in the Privacy Policy.
- Clients should use their best judgment when considering the use of e-mail/texts for communication of sensitive medical information. Erica L. Daniels, PCC will not be responsible for the content of messages.
- Erica L. Daniels, PCC, LLC is not liable for breaches of confidentiality caused by the client or any third party when using e-mail/texting.
- The client is responsible to follow up and/or schedule an appointment if necessary.

Appointment Reminders: Erica L. Daniels, PCC may use an appointment reminder system that operates through either phone calls, e-mail, or texting. This system is an optional and beneficial tool for clients to use to remember upcoming appointments with their therapist. Information sent through appointment reminders is minimal. Clients may choose to opt in or out of this appointment reminder system at any time by speaking with their therapist.

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CLIENTS RIGHTS, RESPONSIBILITIES, AND CONFIDENTIALITY POLICY

Acknowledgement of Receipt of Rights

Client Name: ____ **D.O.B.**: __________________________

I hereby acknowledge that I have received and been given an opportunity to read a copy of the Client Rights, Responsibilities, and Confidentiality Policy for Erica L. Daniels, PCC, LLC. I have read, understood, and agree to abide by the above guidelines regarding my client rights and responsibilities as a client, and understand the limits of confidentiality specified in the above guidelines. I understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any services rendered by Erica L. Daniels, PCC. I understand I may contact Erica L. Daniels, PCC, LLC if I have any questions regarding my rights.

____

Signature of Client Date

____

Signature of Parent, Guardian, or Personal Representative Date

____

(*If you are signing as a personal representative of an individual, please describe your legal authority to act on behalf of this individual (e.g., power of attorney, healthcare surrogate, etc.).)

______ Initial for client refusal of acknowledgement or agreement of receipt

____

Signature of Provider Date

****

I give permission for Erica L. Daniels, PCC, LLC to send me appointment reminders through:
(Check all that apply)

_____ Phone: My preferred phone number is: ____

_____ E-mail: My e-mail address is ____

_____ Text Messages: My cell phone number is ____

____

Signature of Client, Parent, Guardian, or Personal Representative Date

****

E-Newsletter Opt-In

Child Counseling Place offers a monthly e-newsletter with information about children's mental health, mental health, health, parenting, and Child Counseling Place news. If you would like to receive these e-newsletters, please write your e-mail address below. You can opt out of receiving the e-newsletters at any time by clicking on the opt-out link in the newsletter.

_____ Yes, please add my information to your newsletter database.

Name: ____

E-mail: ____

____ _________________

Signature Date