Children and Adolescent Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected and confidential information.

Personal Information

Name of Client: _____

Preferred Name: _____

Parent/Legal Guardian (if under 18): _____

Address_____

Home Phone_____ May we leave a message __Yes ___No

Cell/Work/Cell/Work/Another Phone: _____ May we leave a Message ___Yes __No

DOB: _____ Age_____ Gender Preference: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone_____

Referred By (If Any) _____

How would You Describe your Sexual Orientation?

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____

Eating Disorders	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____
Anger Issues	yes / no	_____

Mental Health Information

How would you rate your current physical Health? (Please Circle One)

Poor Unsatisfactory Satisfactory Good Very Good

Pleas List any Specific Health Problems you are currently experiencing_____
_____
_____

How would you rate your current sleeping habits (Please Circle One)?

Poor Unsatisfactory Satisfactory Good Very Good

Please List any Specific Sleep Problems you are currently experiencing:_____
_____
_____

How many times per week do you generally exercise/Participate in Extracurricular activities?_____

Please List any difficulties you experience with your appetite or eating problems:_____
_____

School Information

Current School_____Grade_____

School Contact_____

Usual Grades:_____ Has there been a change in grades in last 6months, Please
Explain:_____
_____

Does Child have an
IEP/504plan?_____PleaseExplain_____
_____

Past History of Trauma (Physical, Sexual, Emotional Abuse) Yes or No, Please
Explain:_____
_____
_____

Psychiatric History

Have you previously received any type of mental Health Services (Psychotherapy, Psychiatric Services, Etc.)? Yes or No

If Yes, previous Clinician:
_____

Are you Currently taking prescription Medication? Yes or No_____

If yes, Please
List_____
_____

Have you ever had a psychiatric hospitalization? Yes or No_____

If yes, please provide dates and
reason_____

Please Briefly Describe the problem(s) for which you are currently seeking help
with:_____
_____
_____
_____

How long has the problem(s) existed? _____

Have you sought assistance with the problem(s) before Yes or No? Please
Explain_____
_____

What else would you like me to know?_____
_____
_____

I attest that all the information I have given above is accurate and complete to the best of my knowledge.

Authorized Signature_____ Date _____

Reviewed by Clinician: _____ Date_____

THE CENTER FOR MINDFUL EXPLORATION
1111 Mooty Bridge Road, Ste A/ PO BOX 564
LAGRANGE, GA 30241

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices, effective April 1, 2016, describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. Any PHI will only be released in accordance with state and federal laws and the ethics of the counseling profession.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services.

For Payment. I may use or disclose PHI so that I can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, or reviewing services provided to you to determine medical necessity.

Other uses and disclosures permitted by HIPAA without your consent.

- Abuse and Neglect
- Emergencies
- Audits or Investigations
- National Security
- Judicial and Administrative Proceedings
- Law Enforcement
- Public Safety (Duty to Warn)
- Required by Court Order

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PHI

Right of Access to Inspect and Copy. You have the right, which may be restricted only in circumstances where there is compelling evidence that access would cause serious harm to you, to inspect and copy PHI that may be used to make decisions about your care.

Right to Add Information or Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may submit a written request to amend the information, although I am not required to agree to the amendment.

Right to a Copy of this Notice. You have the right to a copy of this notice and the right to receive any future changes in policy.

☐I have read this notice and fully understand its content.

_____ _____ _____

Client Name | Client Signature (Parent/Guardian if Under 18) | Date

The Center for Mindful Exploration, LLC
OFFICE POLICIES AND PROCEDURES

The policies and procedures of this office have been created in an effort to improve service and to minimize inconvenience to our patients. It is my hope that by familiarizing you with these policies in advance, we may prevent misunderstanding and potential confusion or other difficulties.

OFFICE HOURS: Traditional office hours are from 8:00 A.M. until 6:00 P.M. Monday through Thursday, though individual therapists may work different hours. Our phone number is 706-443-5433. We are generally in session, but you can leave your name, number and message and someone will return your call within two business days.

APPOINTMENTS: Visits are by appointment only. However, if an urgent need should arise, we will make every effort to see you that day if possible. If you are unable to wait for a call back or your need is emergent, please proceed to your nearest hospital emergency department or call 911 for any potential life-threatening event. You can also call the Georgia Crisis Line at 800-715-4225.

LETTERS AND FORMS: Our therapists do not fill out disability or FMLA forms. Recommendations for these types of forms are best suited for doctors. There is a $30 charge for any letter you request from your therapist.

TREATMENT EXPECTATIONS: Many things affect the success of treatment. The severity of the problem, the match between the clinician and patient, and the motivation of the patient, among other factors affect the length of treatment. We can discuss your feelings about your treatment and whether it is meeting your needs at any time.

Typically, the decision to terminate therapy is made by mutual consent of clinician and patient. In the event that you decide to discontinue treatment without notifying your clinician, it is assumed and formally agreed upon that the therapeutic relationship terminates 30 days after your last visit.

CONSENT TO TREAT: I give consent to Susan. Marshall, LPC / LaShannon Epps, LPC to provide any mental health/substance abuse care deemed necessary to accurately diagnose and treat my condition.

FEES: Appointments are generally 55 minutes. Initial appointments are $125 and follow-up appointments are $100. If you need to cancel an appointment, YOU MUST CANCEL BY 5PM THE PREVIOUS BUSINESS DAY. This allows us time to schedule another patient for that period. A CANCELLATION CHARGE OF $50 WILL BE MADE FOR MISSED APPOINTMENTS WITHOUT NOTICE BY 5PM THE PREVIOUS DAY. Your appointment time was reserved for you and may not be able to be refilled on such short notice. Payment in full is required at the time of service unless other arrangements have been made in advance. A $35 service charge will be made for all returned checks.

A copy of this form is available for your records

I have fully read, understand, and agree to the above policies and consent.

Patient/Guardian Signature _____ Date_____

Printed Name of Patient or Guardian:_____

Social Security Number _____ Date of Birth _____

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AUTHORIZATION FOR RELEASE OF INFORMATION PRIMARY CARE PHYSICIAN OR PSYCHIATRIST

(REQUIRED BY INSURANCE)

I, _____, give full authorization to provide/exchange information regarding my mental health information to/with:

_____
Name (Primary Care Provider or Psychiatrist)

_____
Phone Number

_____
Street Address

_____
City, State, Zip Code

for the purpose(s) of:

coordination of care

_____

_____

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed.

I have been informed that I may revoke this authorization by written communication at any time.

I certify that this form has been fully explained to me and that I understand its contents.

_____ _____
Signature of Client or Legal Guardian Date of Authorization

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AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING

I, _____, give full authorization to provide/exchange information regarding my mental health information to/with:

_____
Name of Insurance Provider

_____ _____
Insurance ID # Group #

_____ _____
Name of Primary Insured Primary Insured's Date of Birth

for the purpose(s) of: Billing

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed. I have been informed that I may revoke this authorization at any time.
I certify that this form has been fully explained to me and that I understand its contents.
INSURANCE POLICIES: Please be aware that some insurance companies require the insured patient to contact them in advance of any scheduled visit to obtain pre-authorization for services. You are solely responsible for meeting this or any other obligation of your contract with your insurance company prior to the time of your visit. Your insurance co-payments and deductible fees are required in full at the time of service.
Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, I will be happy to file a claim for your visit on your behalf**. The ultimate responsibility for payment, however, remains with you.** Accordingly, any account balance over thirty (30) days old will be billed directly to you. Should your account have to be collected through a collection agency or an attorney, you shall also be responsible for all reasonable attorney's fees and all costs of collection. Please be aware that all unpaid balances will be referred to a collection agency if you fail to fulfill your financial obligations

_____ _____
Signature of Client or Legal Guardian Date of Authorization

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AUTHORIZATION FOR RELEASE OF INFORMATION EMERGENCY CONTACT/ OTHER

I, _____, give full authorization to provide/exchange information regarding my mental health information to/with:

_____ Relationship: _____
Name

_____
Phone Number

_____
Street Address

_____
City, State, Zip Code

____I DO NOT want any information released to my significant others, but I realize if my safety is at risk this desire may not be applicable.

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed.

I have been informed that I may revoke this authorization by written communication to Susan Marshall, LPC at any time.

I certify that this form has been fully explained to me and that I understand its contents.

_____ _____
Signature of Client or Legal Guardian Date of Authorization

The Center for Mindful Exploration
Contact Sheet

Patient Name: _____

DOB: _____

Social Security #: _____

Please indicate how you would like to be reminded of your upcoming appointment

Circle:
Phone or Text

Please provide the **phone number** for your reminder:

_____

Please provide your **email address**:

_____

☐ Check here if you would like to access the patient portal.

☐ Check here if you'd like to be added to our email list for updates on classes, workshops and retreats.

I hereby give authorization for the aforementioned means of contacting to remind me.

_____ _____

Patient's (or legal guardian) Signature Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX☐ Other

Cardholder Name (as shown on card):_____

Card Number: _____

Expiration Date (mm/yy): _____

CVV: _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize The Center For Mindful Exploration to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date