

Confidential Minor Intake

Referred By	Date		
Minor's Name	Birthdate	Age	S.S.#
Address	City		Zip
Home Phone	Cell Phone (If applicable)		
Father's Name	Birthdate	Age	S.S.#
Address	City		Zip
Home Phone	Father's employer		Work Number
Mother's Name	Birthdate	Age	S.S.#
Address	City		Zip
Home Phone	Mother's employer		Work Number

If needed, may we contact you at work? Yes No

If we contact you at home, may we say who we are? Yes No

Marital status of parents: Married Divorced Separated Single Deceased

If parents are separated or divorced, parent child is currently living with and custody arrangements _____

(documentation of custody arrangement may be requested)

Names of step parents (if applicable)

Steparent's Name	Birthdate	Age	S.S.#
Steparent's Name	Birthdate	Age	S.S.#

Sibling's Names (include all) Ages

Please note address (if different)

Name	Birthdate	S.S.#	City/State
Name	Birthdate	S.S.#	City/State
Name	Birthdate	S.S.#	City/State
Name	Birthdate	S.S.#	City/State
Name	Birthdate	S.S.#	City/State
Name	Birthdate	S.S.#	City/State

Additional Comments on Children or Parents' Marital History:

School	Teacher/School counselor	Current Grade	Current GPA
School History	Grade	Age	Dates Attended

Church affiliation (if any)	Pastor
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Minor's interests or hobbies

Is minor currently under medical treatment? Yes/No If yes, name of Doctor:

Any medication currently taking? Yes/No If yes, please list:

Please describe any current or chronic diagnosed medical conditions or disabilities

Is the minor currently involved in any legal matters, including custody disputes or insurance settlements? If so, please describe:

Previous counseling experiences:

Counselor _____ Length of counseling _____
Dates _____ Location _____

Counselor _____ Length of counseling _____
Dates _____ Location _____

Reason for seeking counseling (Describe presenting problem, including length & precipitating event, if applicable)

Goals for counseling

Please circle any appropriate answers:

Current or previous alcohol or drug abuse Eating disorders

Family member's current or previous alcohol or drug abuse

Habits minor is struggling with: _____

Anger difficulty History of sexual abuse History of physical abuse

Changes in sleep Changes in level of energy Changes in eating habits

Behavior problems Parents' arguing frequently Recent move

Recent loss of a loved one School difficulties Anxiety difficulties

Learning Disabilities History of Head Trauma

To your knowledge, has the minor ever had suicidal thoughts? If yes, please explain: _____

Brief description of child's life stressors from ages 1 to 3: _____

Give a brief history of relationships with:
Father _____

Mother _____

Brothers/Sisters _____

Children _____

Others _____

Are there additional comments you would like to tell us about the minor?

Signature of individual providing minor's information _____

PARENTAL CONSENT FOR TREATMENT OF A MINOR

I authorize _____, _____ # _____ to provide psychotherapy for the minor listed below. By signing this agreement, I am certifying that there is no custodial arrangement which prohibits this minor from receiving treatment under this authorization.

_____	_____	_____	_____
Minor's Name	Birthdate	Age	S.S.#
_____	_____	_____	_____
Address	City	Zip	
_____	_____		
Home Phone	Cell Phone (If applicable)		

_____	_____
Parent/Guardian's Name (printed)	Parent/Guardian's Signature

Date

_____	_____
Parent/Guardian's Name (printed)	Parent/Guardian's Signature

Date

Fees, Insurance and Confidentiality

THE STANDARD FEE for a psychotherapy session is \$95.00 per fifty-minute session. For those who do not have the resources to pay this fee, a sliding scale is provided. Group therapy sessions have rates that vary with the type of group. Phone sessions will be billed at your normal psychotherapy rate. Mediation and court appearances will be billed at the rate of \$95.00 per hour, regardless of your established fee for psychotherapy. Letters will be billed at your psychotherapy fee for hour(s) spent in preparation. Court reports, psychological evaluation reports, and legal reports will be billed at the rate of \$95.00 per hour spent in preparation, regardless of your established fee for psychotherapy, with a minimum charge of at least \$250.00.

FEE PAYMENTS are presented ahead of the session, unless prior arrangements are made with the therapist. Also, there are additional charges for psychological testing and for copying of records.

REGARDING INSURANCE: For those individuals with HMO's, the CO-payment will be made before the start of each session. For all other insurance plans, payment will be made in full before each appointment and a submittal form will be given to you so you may bill your insurance company for reimbursement, unless other arrangements are made.

YOUR APPOINTMENT TIME reserves a psychotherapist's time for you. Missed sessions will be billed at your full fee unless the appointment has been canceled 24 hours in advance of the scheduled time. A missed session will not be rescheduled automatically. You must call to reinstate appointments, or mention during canceling that you wish another appointment.

OUR PURPOSE is to provide excellence of service to each of our clients. Still, the success of therapy does not just depend on the skill of the therapist. Many other factors, such as the client's openness to working with difficult material, help to determine the outcome of therapy. If you have any questions regarding your progress in therapy at any point during therapy, please communicate this with your therapist.

CONFIDENTIALITY is a basic policy. Information and records regarding clients are kept confidential unless a signed, written consent form is obtained to release records. The court and legislature have determined that confidentiality cannot override the obligation of a therapist to report child abuse, elder abuse, or threats to harm oneself or others.

I UNDERSTAND AND AGREE TO THE ABOVE. MY FEE IS _____. IT IS MY RESPONSIBILITY TO NOTIFY SELAH COUNSELING SERVICES AT LEAST 24 HOURS PRIOR TO MISSING A SCHEDULED APPOINTMENT. I AGREE TO PAY THE FULL FEE FOR EACH MISSED SESSION I CANCEL WITHOUT GIVING PROPER NOTICE.

SIGNED

DATE

SLIDING SCALE FEE PAYMENT SCHEDULE

For those individuals and couples who are unable to afford the full hourly fee of \$95.00 and/or do not have the resources to pay such a fee, we offer a sliding scale. Your fee will be established during your initial intake session with your therapist if our administrator has not already done so prior to your initial session. Client payment is based on total gross income for both husband and wife added together.

Husband's Gross Yearly Income: \$ _____

Wife's Gross Yearly Income: \$ _____

TOTAL YEARLY INCOME: \$ _____

AMOUNT CLIENT PAYS BASED ON NET INCOME

\$60,000 and above = \$95.00/hr
\$55,000 - \$59,999 = \$90.00/hr
\$50,000 - \$54,999 = \$85.00/hr
\$45,000 - \$49,999 = \$80.00/hr
\$40,000 - \$44,999 = \$75.00/hr
\$35,000 - \$39,999 = \$70.00/hr
\$30,000 - \$34,999 = \$65.00/hr
\$25,000 - \$29,999 = \$60.00/hr
\$20,000 - \$24,999 = \$55.00/hr
\$19,999 and below = \$50.00/hr

If these fees need to be discussed, let's discuss them. Our chief concern is that you get the help that you need. We will do our best to work with you.

Agreed Upon Rate \$ _____

To the best of my knowledge the foregoing is true and I agree to be responsible for payment of the fee, less any amount covered by insurance.

Signature: _____ Date: _____

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and me/us _____. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written that name here

_____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others to arrange payment for your treatment, or for other business or government functions.

By signing this form you are agreeing to let me use your information here and share it with the others as mentioned above. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Privacy Officer, Kate Pieper, LMFT, or by calling her at (530) 268-1355.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it in writing. We will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

Signature of client (or personal representative)

Date

Printed name of client (or personal representative)

Relationship to client

Description of personal representative's authority

Signature of authorized representative of this office or practice

Date of NPP _____ Copy given to the client/parent/personal representative