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

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

_____ _____
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 $120.00 per fifty-minute session. For those who do not have the resources to pay this fee, a sliding scale will be 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 $200.00 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 $120.00 per hour spent in preparation, regardless of your established fee for psychotherapy, with a minimum charge of at least $250.00.

EMERGENCY OR URGENT NEEDS – Selah Counseling Services does provide phone counseling for emergency or urgent needs that may occur during your time of being a client here. Please note Emergency or Urgent Calls will be billed at your regular hourly rate. Depending on your insurance plan, these fees may not be paid by your insurance provider and will therefore be billed in total to the responsible party.

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 Superbill (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.

SOCIAL MEDIA POLICY for our therapists and clients – As professional therapists, we do not accept friend or contact requests from current or former clients on any social networking site. We believe adding clients could compromise your confidentiality and our respective privacy. Please do not contact your therapists through a Social Networking site (Twitter, Facebook, LinkedIn, etc.) These sites are not secure and we may not read them in a timely manner for your needs. The best way to reach us is by phone unless otherwise directed by your therapist.

EMAIL POLICY for our therapists and clients – We prefer using email only to arrange or modify appointments. Please do not email regarding content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate content, please be aware all emails are retained in the logs of your and our service providers. These logs are, in theory, available to be read by the system administrator of the internet service provider. Also, these emails received and responded to will become part of your legal record.

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that we have provided. Selah Counseling Services' Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Selah Counseling Services' Notice of Privacy Practices is subject to change. If we change the notice, you may obtain a copy of the revised notice from our office by contacting the Executive Director at (530)268-1355 x1.

If you have any questions about our Notice of Privacy Practices, please contact our Executive Director at: 10091 Streeter Road, Suite 1, Auburn, CA 95602 (530) 268-1355 x1.

I acknowledge receipt of the Notice of Privacy Practices of Selah Counseling Services.

Signature: _____ Date:_____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We made good faith attempts to obtain the patient(s) acknowledgement of his or her receipt of the Notice of Privacy Practices, including _____. However, because of _____, we were unable to obtain the patient's acknowledgement.

Signature of Provider: _____ Date:_____