Sheltered Cove Counseling Center
6488 Spring St. Ste. 102, Douglasville, GA 30134
770-949-1595/ 770-489-7521 fax

Child/Adolescent Client Information Form

(Revised January 2009)

This Form is Completely Confidential

Today's date: _______________

Your child's name: ____
Last First Middle Initial

Parent or Legal Guardian's Name: ____
Last First Middle Initial

Child's date of birth: _______________ **Gender:** _______________

Policy Holder's Social Security #: ____

Home street address: ____

City: ____ **State:** _______**Zip:**____________________

Parent or Legal Guardian's Name of Employer:____

Address of Employer: ____

City: ____ **State:** _______**Zip:**____________________

Home Phone: ___________________________ **Work Phone:** ______________________________
Cell Phone: _______________________ **Email:** ____
Calls will be discreet, but please indicate any restrictions:____________________________________
____

Referred by: ____
- May I have your permission to thank this person for the referral?
  - **Yes** • **No**
- If referred by another clinician, would you like for us to communicate with one another?
  - **Yes** • **No**

Person(s) to notify in case of any emergency: ____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature):____________________________________

Please briefly describe your child's presenting concern(s):____________________________________
____
____

What are your/your child's goals for therapy? ____
____
____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?___________________________

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had: _______
____
____
____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _________________________
____
____

Previous psychiatric hospitalizations (Approximate dates and reasons): _______________________
____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): ____
____
____

FAMILY:

How would you describe your child's relationship with his or her mother? ____________________
____
____

How would you describe your child's relationship with his or her father? _____________________
____
____

Are the child's parents still married or did they divorce?_______________ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her?
____
____

Please describe your child's relationship with his or her grandparents: _______________________
____
____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: ______________________
____
____

How many sisters does your child have? _____Ages? ______________________________________

How many brothers does your child have? ______ Ages? ___________________________________

How would you describe your child's relationships with his or her siblings? ____________________
____
____
____

<u>SOCIAL SUPPORT, SELF-CARE, & EDUCATION:</u>

POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _________________________
____

Please briefly describe any history of abuse, neglect and/or trauma: ___________________________
____
____

Please briefly describe your child's self-care and coping skills: ________________________________
____
____

What are your child's diet, weight, and exercise/activity patterns? ______________________________
____
____

Please briefly describe your child's school performance and experience: _______________________
____
____

What are your child's hobbies, talents, and strengths? _____________________________________
____
____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

Any additional information you would like to include:

____

____

____

____

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to ***Sheltered Cove Counseling Center***. We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at ***Sheltered Cove Counseling Center***. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Theoretical Views & Client Participation

It is our belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without the therapists here at ***Sheltered Cove Counseling Center***. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit.

Confidentiality & Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our business office. Additionally, your therapist will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or

her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Please initial that you have read this page ________

Structure and Cost of Sessions

Your therapist agrees to provide psychotherapy for the fee of $120 per 50 minute intake session, $95 per 50 minute ongoing session, unless otherwise negotiated by you or your insurance carrier. Doing psychotherapy by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at $2.00 per minute. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and we will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $25 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies. As a courtesy to you, we will attempt to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If our Office is closed at the time of cancelation be sure to leave detailed message with time and date of the appointment to avoid fees. If such advance notice is not received, you will be financially responsible for the session you missed by paying a $65.00 fee. Please note that insurance companies do not reimburse for missed sessions.

In Case of an Emergency

Sheltered Cove Counseling Center is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Ridgeview Institute at 770.434.4567 or
- Peach Ford Hospital at 770.454.5589.
- Call 911.
- Go to your nearest emergency room.

Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients secret. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or

her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapist is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Please initial that you have read this page ________

Statement Regarding Ethics, Client Welfare & Safety

Sheltered Cove Counseling Center assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association and/or the American Counseling Association and/or the National Association of Social Workers. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact ___Lisa Klinger________________ at 770-949-1595..

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Please initial that you have read this page ________

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you.

____ ________________

Client Name (Please Print) **Date**

____

Client Signature

If Applicable:

____ ________________

Parent's or Legal Guardian's Name (Please Print) **Date**

____

Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

____ ________________

Therapist's Signature **Date**

No Show or Late Cancel Agreement

I understand that I will be charged a $**65.00** fee if I:

Don't show up for my appointment.

Cancel or reschedule my appointment with less than a 24 hour notice.

If our Office is closed at the time of cancelation be sure to leave detailed message with time and date of the appointment to avoid fees

Sheltered Cove Counseling Center
6488 Spring Street
Douglasville GA 30134
(770) 949-1595

Credit Card Payment Authorization Form

Sign and complete this form to authorize **Sheltered Cove Counseling Center** to make a debit to your credit card listed below.
By signing this form you give us permission to debit your account for the amount indicated below.

Please complete the information below:

I ______________________________ authorize **Sheltered Cove Counseling Center** to charge my credit card.
(full name)

account indicated below for $**65.00.** This payment is for reasons indicated above
(amount)

Billing Address ______________________________ Phone# __________________________

City, State, Zip ______________________________ Email __________________________

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name ____

Account Number ____

Expiration Date _____________

SIGNATURE ____ DATE _____________________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the reasons described above, for the amount indicated above only, I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company.

Effective 04/14/2003
Notice of Sheltered Cove Counseling Center Inc. Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (*PHI*), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  – Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have
kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- Health Oversight Activities – If I am the subject of an inquiry by the Georgia Composite Board of Licensed Professional Counselors, I may be required to disclose protected health information regarding you in proceedings before the Board.

- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice via U.S. regular mail.

V. **Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Lisa Klinger, Compliance Officer at 770-949-1595.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to the attention of your therapist's name c/o Lisa Klinger, Compliance Officer at Sheltered Cove Counseling Center, Inc. at 6488 Spring St., Suite 102, Douglasville, GA 30134.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by U.S. Regular Mail.

Print Client Name: ____

____ ______________

Signature   Date
Patient (18 Years and older) / Legal Guardian

____

Print Name

_______ I would like a copy.   ________ I decline a copy of this document.

SHELTERED COVE COUNSELING CENTER, INC.
PAYMENT AGREEMENT

RESPONSIBLE PARTY INFORMATION

All payments (deductible, co-pay, or self-pay rate) will be made ***each visit*** before services are rendered. I am aware that payments may be rendered via Cash, Check or Credit Card I will be charged a fee of $25.00 for NSF checks. This fee and the past due amount is due upon request for payment.

24-Hour Cancellation Policy: 24-hour notice is required. If our Office is closed at the time of cancelation be sure to leave detailed message with time and date of the appointment to avoid fees. If I do not cancel 24 hours in advance, I will be charged a $65.00 late cancellation fee. Charges are due upon request for payment.

Missed Appointment Charge: I will be charged a $65.00 fee for a Missed Appointment. I am responsible for notifying SCCC. Charges are due upon request for payment.

I am aware that I am responsible for notifying SCCC of any changes in my mailing address, telephone numbers and employment.

I will notify SCCC of my decision to file insurance, know my benefits, and verify pre-certification requirements 24 hours prior to my next scheduled appointment. Proof of insurance will be provided at the time of service, or I will be required to pay the session fee at the time of visit. I will be responsible for paying my full balance should my insurance default on payment for any reason. Authorization is granted by my signature below to Sheltered Cove Counseling Center, Inc. to release to authorized representatives of my insurance company, their agents or third party payers, confidential information including copies of records as these records may be requested or necessary for the completion of claim processing and/or authorizations for future treatment. I hereby release Sheltered Cove Counseling Center, Inc. from all legal responsibility or liability that may arise from the release of such records.

If your counselor is subpoenaed to court on your behalf, the charge will be a minimum of $300.00 (two hours including travel) and $150.00 for each hour thereafter. If court is canceled or postponed or it is decided that your counselor's testimony is not needed without a 48 hour notice you will be charged a $65.00 fee for each hour you have booked.

I am aware that in the event of default of payment on this account, my account may be turned over to an outside collection agency or legal representative for collection. Any additional costs incurred by SCCC to collect the outstanding balance will become my responsibility.

My signature below authorizes payment directly to Sheltered Cove Counseling Center, Inc. of the insurance benefits otherwise payable to me, but not to exceed the balance due of the charges for my treatment.

-Signed: ______________________________________ ***Date:*** _________________

Rev. 02/03/2012