ADOLESENT INTAKE FORM

Today's Date:____________

To be completed by parent or legal guardian.

Identification

Client Name (include middle initial): ______________________________________ Date of Birth: ____________________ Age: _____

Preferred Name: ____________________ Person Completing Form: __________________ Relationship to Client: __________________

Gender: ❑ Female ❑ Male ❑ Other

Parent/Guardian Home street address: ____ Apt.: _____________

City: ____ State: __________ Zip: _____________________

Parent/Guardian Phone Number: _______________________________ Other Phone: _________________________

Parent/Guardian Email Address: ____

*Please note that email is not a secure form of communication.

Your contact preference: ❑**Phone** If Unavailable can we leave a voicemail? ❑ Yes ❑ No (we do not contact clients via text message)

❑Email ____

Calls or e-mails will be discreet, but please indicate any restrictions: ____

Religious Affiliation: ___________________________________

Is the minor enrolled in school? ❑Yes ❑No

School: ____ Grade: _________________________________

Emergency Information: If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____________________________________ Phone: ___________________ Relationship: _________________________

Address: ____

Your Medical Care: From whom or where do you get your medical care?

Clinic/doctor's name: _____________________________________ Phone: __________________

Referral: How did you find me?

Name: ____

Insurance Information: If you do **not** have insurance, or do not plan on using it check here ❑

If you plan on using any insurance plan, please complete and sign the insurance information sheet contained in this packet.

If you have an insurance card, please give it to my secretary to copy.

Is a pre-authorization required? ❑ Yes ❑ No Do you have a pre-authorization #? ________________________________

If you do not have insurance, the cash pay price is $90.00 for an initial assessment and $75.00 for subsequent sessions.

Chief Concern

Please describe the main difficulty that has brought you to see me: ______________________________

____

Do you have any medical problems we should be aware of?

____

Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When ________ From whom ____________ For what ______________ With what results ________________

____

____

2. Have any members of your family been diagnosed with a mental health issue?

❑ No ❑ Yes If yes, please state who and the diagnosis

____

____

Legal history

1. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain: __________________

____

2. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes If yes, please explain:

____

3. Are there any other legal involvements I should know about? ______________________________

Timpanogos Counseling does not provide civil or criminal court related treatment. If your appointment is related to an issue involving any court or legal proceedings, this must be disclosed to the therapist in your initial visit.

Pre-Therapy Check List

Allan Roe, Ph.D.

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Name ______________________________ Date ___________________________

Underline all issues that you have had, and **circle** issues that are presently of concern to you.

- Abused by boyfriend
- Abused by girlfriend
- Abused by parent
- Abused by spouse
- ADD or ADHD
- Affair of mine
- Affair of spouse
- Afraid of people
- Alcohol
- Amphetamines
- Anger
- Anorexia
- Anxiety
- Arguments
- Arrested
- Bankruptcy
- Being hit
- Being neglected
- Bipolar disorder
- Borderline personality
- Boyfriend problem
- Bulimia
- Chat rooms
- Child in trouble
- Child support problems
- Children disobeying
- Co-worker problems
- Cocaine
- Communication problems
- Compulsions
- Controlled by someone
- Criminal
- Criticized
- Depression
- Dieting
- Discouraged
- Dissociative disorder
- Divorce recovery
- Drug/medication abuse
- Eating disorder
- Emotionally abused
- Ex-spouse problems
- Fears
- Financial disagreements
- Financial problems
- Forgiving myself
- Forgiving someone
- Gambling
- Girlfriend problem
- Going to court
- Grief
- Guilt feelings
- Had surgery
- Hallucinations
- Hospitalized
- Identity, who I really am
- Impulsive
- In-law problems
- Jealousy
- Learning problems
- Legal problems
- Lies I told
- Lies told to me
- Lonely
- Lost self-respect
- Low self-esteem
- Made a big mistake
- Manic depressive
- Manipulated by someone
- Marriage problems
- Medical problem
- Medication problem
- Moody
- Multiple personality
- My anger
- My weight
- Need divorce decision
- Need evaluation for court
- Need long term therapy
- Need report for court
- Nightmares
- Not assertive enough
- Not having a job
- Obsessions
- Obsessive compulsive
- On welfare
- Pain pill abuse
- Panic attacks
- Paranoid
- Parent-child problem
- Parenting
- Parents' disagreements
- Parents' divorce
- Physical handicap
- Physically abused
- Pornography
- Posttraumatic stress
- Problem with a parent
- Psychotic
- Relationship problem
- Religious problem
- Schizophrenia
- School problems
- Self-critical
- Separated
- Sexual addiction, mine
- Sexual addiction, other's
- Sexual problem
- Sexually abused
- Sleep problems
- Sleeping pill abuse
- Someone else's anger
- Spouse has a secret life
- Spouse is too controlling
- Spouse's sexual addiction
- Step family problems
- Stress
- Suicidal
- Suspicions
- Tempted easily
- Too dependent
- Too sensitive
- Trust issues
- Under achiever
- Unhappy at home
- Unpaid bills
- Verbally abused
- Violence
- Wasteful spending
- Work related problem
- Working with a lawyer
- Worry

Other issues you need to deal with

____

Underline all medications that you have used and **circle** medications that you are now using.

- Adderall
- Ativan
- Celexia
- Clozaril
- Concerta
- Cymbalta
- Darvocet
- Darvon
- Depakote
- Effexor
- Eskalith
- Geodon
- Haldol
- Klonopin
- Lexapro
- Librium
- Lithium
- Lithobid
- Lortab
- Loxitane
- Luvox
- Moban
- Navane
- OxyContin
- Pain prescription
- Paxil
- Percocet
- Percodan
- Prozac
- Remeron
- Resperdal
- Ritalin
- Serentil
- Seroquel
- Serzone
- Sinequan
- Sleeping pills
- Stadol
- Stelazine
- Strattera
- Surmontil
- Thorazine
- Tranxene
- Valium
- Vicodan
- Welbutrin
- Xanax
- Zoloft
- Zyprexa

______________________ _

______________________ _

Other

____

____

____

____

Consent for Treatment

Psychotherapy is a working cooperative relationship between you and your counselor. Each member of this cooperative relationship has certain responsibilities. Your counselor will contribute their knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration, participation, and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of treatment, your commitment may increase the likelihood of a satisfactory experiences.

The follow provides information on Timpanogos Counseling's policies. Please read and sign at the bottom.

How Treatment Can Help

Therapy is most helpful in assisting individuals when the client is taking responsibility. This includes the following: 1 – Being committed to change; 2 – Attending all of your scheduled appointments; 3 – Following through with assignments/tasks given to you by your therapist. You decide the nature of the changes you wish to make.

Most individuals experience improvement and healing over the concerns that brought them to therapy; however, throughout the course of therapy, you may at times feel worse than when you started. This is because participating in therapy may involve discomfort, including remembering and discussing unpleasant and painful events, feelings, and experiences. This is normal and should be anticipated.

Timpanogos Counseling strives to give their clients the best possible care. Due to this policy, there are disorders, diagnoses, and methods of therapy, that therapists at Timpanogos Counseling are not trained in. These include, but are not limited to: personality disorders, substance abuse, Schizophrenia or other psychotic disorders, neurological disorders, perpetrators of domestic violence/sexual assault/child abuse, marriage/couples counseling, and court involved counseling. In the event that a therapist is not trained in a specific area or diagnosis, the client will be provided with names of providers that are trained in these areas.

Confidentiality

We commit to keeping complete confidentiality, unless we learn of situations where we are required by law to report. Those situations include:

1. Intendances of actual or suspected physical, sexual, or emotional abuse, or neglect of child, elderly or disabled individual.

2. Instances where there is a reason to believe that a client intends to harm oneself.

3. Instances where there is reason to believe that a client is in imminent danger of committing violence to another person, we may warn the intended victim and notify the proper authorities

4. Instances where there is a valid court order, issued by a judge, ordering the release of protected information.

Timpanogos Counseling cannot release any confidential information without a signed release of information form, except where required by law. I hold harmless Timpanogos Counseling, for the fulfillment of the legal responsibilities as stated above.

Appointments

Typical therapy sessions last 50-55 minutes. EMDR sessions can vary from 50 to 90 minutes. The frequency of appointments will be determined with your therapist. If you are more than 15 minutes late, your therapist may cancel and reschedule the appointment. The missed session fee will apply.

If a session needs to be extended beyond the normal 50-55 minutes, there is an extended session fee of $25. Timpanogos Counseling does provide EMDR; which may extend a session to 90 minutes. Extended session fee is in addition to co-pays or co-insurance.

If it is necessary to cancel a scheduled appointment, a 24-hour notice is required. If an appointment is missed or you fail to cancel at least 24 hours in advance, except in an emergency situation, you will be charged a **$50.00** late cancellation fee. **This fee will be charged to the client or legal guardian only**. Payment of the missed session will be required prior to attending a future session. If you have a re-occurring appointment and fail to provide notice on 2 occasions, your future sessions will be canceled and you will no longer be able to schedule on a re-occurring basis.

Therapist Availability and Communication

Your therapist is often not immediately available to speak with you. You may leave your therapist a message and they will return your call as soon as possible. Therapists check voice messages during normal business hours. Messages left outside of normal business hours will be picked up on the next business day.

Electronic communication, (email, text, or any form of communication over the internet), is a convenient way to communicate with your therapist. These are not secure forms of communication and there for complete confidentiality cannot be guaranteed. Furthermore, therapists will not communicate with clients via social media. By signing this document, you acknowledge that if you contact your therapist through electronic means, your information may not be completely secure, and that Timpanogos Counseling is not responsible for a breach in patient privacy. Therapists at Timpanogos Counseling **do not** communicate with clients via text message.

Court or Legal Matters

Services provided through Timpanogos Counseling are not to be utilized for testimony, custody disputes, disability, or any other form of court evaluations. If you are in need of these services, you will be referred to the appropriate provider. As matter of policy, therapists at Timpanogos Counseling do not testify in civil or criminal court proceedings.
If necessary, a written summary of treatment can be provided to the client or he/she's legal counsel. A signed release of information is required prior to providing the written summary. A fee of $50 will be assessed for this and must be paid prior to the written summary being provided.

Supervision of Children

Children must have adult supervision at all times in the office. Timpanogos Counseling is not response for children or adolescents left unattended. Minors must be picked up following their appointments on time.
Due to the nature of the therapeutic environment and process, children are not allowed in sessions. If it is necessary to bring a child with you, please bring another adult to provide supervision. You may be asked to reschedule your appointment if you bring your child into a therapy session.

____________________________________ ______________________________
Signature of client or guardian Date

____
Print of client or guardian

Financial Agreement

By signing this document, the patient or legal guardian, agrees to the following:

I understand that as a client or legal guardian I am responsible for payment of all charges. Payment is expected at the time services are rendered. This includes self-pay, co-pays, and co-insurance amounts. In the event that another payor may be paying for services a $25.00 co-pay is expected at the time of service. Exceptions to this policy include, but are not limited to claims processed through Crime Victims Reparations, non-health insurance companies, and religious organizations.

Although I have requested this office to bill my insurance company on my behalf, I clearly understand it is still my responsibility to make sure the bill is paid in a reasonable time. I understand there are times when Timpanogos Counseling might have been told by my insurance company that my services are covered and later find out they are not. If, for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. If a client accrues a cumulative balance of $400 or more, all future appointments will be cancelled. Insurance balances will not be included unless we have received denials for payment or amount is applied to a deductible. Client may once again schedule appointments when the balance(s) are paid in full.

I understand that Timpanogos Counseling utilizes the services of Mental Health Management, for billing purposes and to forward insurance claims either electronically through the computer or by regular mail to my insurance company where it will be reviewed by any insurance company staff assigned to review claims. I understand my insurance company will obtain information listed on the insurance claim about my diagnosis and the dates of my mental health treatment sessions. By my signature below, I give permission to release all necessary information to my insurance company to determine eligibility and to process my insurance claim.

I understand that my insurance company will only cover sessions that are 50-55 minutes in length. If a session needs to be extended beyond that, I understand that I am responsible for an extended session fee of $25. Timpanogos Counseling does provide EMDR; which may extend a session to 90 minutes. I understand I am responsible for the extended session. Extended session fee is in addition to co-pays or co-insurance.

I understand Timpanogos Counseling will not be responsible for any split in cost of services due to a custody/parenting agreement. Because I have signed this financial agreement, I understand I am responsible for the entire bill.

I am aware that I need to contact Timpanogos Counseling if I will not be at my scheduled appointment. I understand that if I do not call at least 24 hours in advance to cancel, I will be billed $50.00. This must be paid prior to my next appointment. Exceptions to this policy includes the event of an emergency or sudden illness.

I understand that there is a $25.00 returned check fee. Furthermore, if my account is referred to collections or small claims court, I understand I am responsible for any additional fees that may apply.

I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion.

___________________________________ ______________________

Signature of Client or Guardian Date

____

Print Name

Insurance Information

If you have your insurance card, please give it to the secretary to make a copy. Then only fill in the top section, the responsible party section (if different from the client), and sign at the bottom.

Client Name:			Gender: ☐Male ☐Female
Home Address:			
City:	State:	Zip:	Email:
Home Phone:	Cell Phone:		Other:
Date of Birth:	Social Security #:		Is client a minor? ☐Yes ☐No
Emergency Contact:		Contact Phone #:	Relationship to Client:

Primary Insurance:			Policyholder Name:
Company Address:			Policy Holder Date of Birth:
City:	State:	Zip	Subscriber I.D. #:
Company Phone:			Group #:
Employer:			Social Security #:

Secondary Insurance:			Policyholder Name:
Company Address:			Policy Holder Date of Birth:
City:	State:	Zip	Subscriber I.D. #:
Company Phone:			Group #:
Employer:			Social Security #:

Responsible Party

Information about the person responsible for paying the patient portion of the bill (leave blank if same as client).

Responsible Party:			Relationship to Client:
Address:			Home Phone:
City:	State:	Zip	Cell Phone:

I give this office permission to release any information obtained during examinations or treatment of this client that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I understand that Mental Health Management Inc. will be utilized in all billing procedures**. I understand that I am responsible for all charges, regardless of insurance coverage**. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Bonnie Hatch, LCSW.

Signature:____ Date:____________________________

Print Name: ____

Important Information Regarding Insurance Coverage

Insurance coverage varies from insurance company and policy type. The following is information intended to provide clarification on common insurance practices.

DEDUCTIBLES

Most insurance companies and policies require a deductible be paid before the insurance company will reimburse for services. This is an out of pocket expense for the client. Deductible amounts vary across insurance companies and policies. If you have a secondary insurance, a separate deductible may apply for that insurance and policy.

CO-PAY/CO-INSURANCE

Most insurance companies require a co-pay or co-insurance be paid by a client at the time services are rendered. <u>This applies after any applicable deductible has been met.</u>
<u>Co-Pay</u> refers to a fixed dollar amount the insurance requires a client to pay.
<u>Co-Insurance</u> refers to a percentage amount that the client is required to pay.
Co-pays and Co-Insurance vary across insurance companies and policies.

As insurance coverage varies, any specific questions regarding deductibles, co-pays/co-insurance, etc. should be directed to your insurance company.

You may use an HSA or Flex Spending account to pay for services.

I acknowledge that I understand the information above, and that I am responsible for any and all amounts not covered by the insurance company.

________________________________ ________________________________

Print Name (client or legal guardian) Date

____

Signature (client or legal guardian)