Child Intake Form

Name of Child: _____ Age: _____ Birth Date: _____ Gender: _____

Parent/Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Child's School/Daycare: _____ School Phone #: _____

Grade: _____ Teacher: _____

Please list any medications your child is currently taking, including psychotropic medications:

_____

Please describe any medical conditions or your child I should be aware of (allergies, injuries, illnesses, etc):

_____

_____

Please describe your current household composition (names, ages, and relationship of those living with your child):

_____

_____

Please describe the role, if any, faith and religion play in your family:

_____

The reason I am seeking therapy for my child is:

_____

_____

What have you already tried to correct or resolve this problem?

_____

_____

What are you most concerned about?

_____

_____

What changes would you like to see as a result of therapy?

_____

_____

Clearhope Counseling and Wellness Center

Child History

Name of Child: _____ Age: ___ Gender: _____

Is your child adopted?---------- yes no

Has your child ever been or is he/she currently in foster care?---------- yes no

Explain:_____

Has your child received any previous counseling or treatment?---------- yes no

Explain:_____

Were there any problems or complications during pregnancy or birth?------- yes no

Explain:_____

Has your child experienced any form of abuse (physical, emotional, sexual)? yes no

Explain:_____

Has your child experienced any significant trauma or losses?---------- yes no

Explain:_____

Has your child experienced any divorces or separations?---------- yes no

Explain:_____

Does your child have difficulty at school or daycare?---------- yes no

Explain:_____

Does your child generally get along with other children his/her own age?---- yes no

Does your child generally get along with adults?---------- yes no

Does your child have unusual eating patterns?---------- yes no

Explain:_____

Does your child have unusual sleeping patterns?---------- yes no

Explain:_____

Child's Family History

Current custody status:

_____

Visitation arrangements:

_____

What are your main approaches to discipline?

_____

Which approaches to discipline have shown the most success?

_____

Which family members, including extended family, suffer from any form of mental illness?

_____

Clearhope Counseling and Wellness Services

Consent to Treat a Minor

Name of minor client: _____

Date of birth: _____

This is to certify that you give permission to _____ (therapist) for the treatment of your child, _____. This treatment may include individual or group psychotherapy, counseling, and testing. This treatment may also include referrals to other professional agencies.

One of my stipulations in treating your child is that you as a parent/guardian also be involved in the therapeutic process. By signing this consent form, you are also agreeing to attend occasional sessions at which I request your presence.

In addition, you as a parent/guardian agree to the following stipulations:

- Although your child is a minor, he/she has the right to confidentiality. This confidentiality is crucial for a child to feel safe and secure in the counseling environment and a necessary ingredient for treatment success. You agree to honor this right to confidentiality. Children age 14 and older have the right to full client privilege. Parents of children younger than 14 have the right to information regarding the minor's treatment so long as it is in the best interest of the child.
- In cases of divorce or parental conflict, you agree to not request that I participate in any court proceedings, to include but not limited to, testifying, providing records, or writing letters of summary or recommendation.

**I have a legal right to ☐ sole / ☐ shared medical decision making regarding the following children:

I understand that I may revoke this authorization by submitting my request in writing to my therapist.

_____

Signature of Parent or Legal Guardian Name (please print) Date

_____ _____

Signature of Therapist Date

**In cases of joint custody or shared allocation of parental responsibility for medical decisions, a copy of the divorce decree and custody order along with signatures indicating consent from both parents are required in order to treat a minor, except in emergencies.

Clearhope Counseling and Wellness Center

Financial Agreement Form

I agree to the following financial payment and procedures.

1. To pay $120 for the initial assessment and $110 per 53-minute session thereafter.
2. To pay an hourly rate of $110 for educational services, including serving as an advocate at 504 meetings, ARD meetings, and transition meetings, plus mileage at $.545 per mile.
3. To pay an hourly rate of $110 for time spent preparing and writing any formal or legal documentation including but not limited to court letters, disability determinations, assessments, and treatment summaries. If I am required to appear in court, the $110 per hour and $.545 per mile will be incurred as a charge by the client, with a $500 retainer fee per required date of court.
4. Payment is expected at each session, unless prior arrangements have been made.
5. ***Appointments not cancelled 24 hours in advance*** may be charged a $50 cancellation fee and must be paid before the next session.
6. A $25 service charge will be added to all returned checks and must be paid at the next session.
7. Payments of fees are the full responsibility of the client. Insurance is billed as a courtesy only and does not guarantee that all fees will be covered by insurance.
8. Explanation of any alternate payment plan:
   _____
   _____
   _____

☐ ***I would like Clearhope Counseling and Wellness Center to bill my insurance.***
Initials

Insurance Information

Name of Insurance Company: _____

Insurance Company Address: _____

(City)_____ (State)_____ (Zip Code)_____

Phone Number: _____

Subscriber Name: _____ Date of Birth: _____

Place of Employment: _____

Policy ID or Social Security Number: _____

Group Number: _____

I understand the above payment procedures and I agree to this plan of payment.

Client Signature _____ Date _____

Therapist Signature _____ Date _____