



CHILD INTAKE FORM (Birth to 6 years of age) (Please Print)

Patient Name: _____ Date of Birth _____ Date: _____

PARENT/GUARDIAN INFORMATION			
Parent/Guardian Name:		Relationship to Patient:	
Street Address:		Suite/Apartment Number:	
City:	State:	ZIP Code:	May We Send Mail Here: <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address or Post Office Box:			
City:	State:	ZIP Code:	May We Send Mail Here: <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone:	()	May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mobile Phone:	()	May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Phone:	()	May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:	()	May We Send Email Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
PARENT EMERGENCY CONTACT			
Name:		Relationship:	
Home Phone: ()		Mobile Phone: ()	
PARENT EMPLOYMENT INFORMATION			
Employer:		Length of Employment:	
Occupation:		Average Hours Worked Per Week:	
Annual Combined Household Income :	<input type="checkbox"/> Below \$80,000 <input type="checkbox"/> \$80,001 to \$90,000 <input type="checkbox"/> \$90,001 to \$100,000 <input type="checkbox"/> \$100,001 to \$110,000 <input type="checkbox"/> \$110,001 to \$120,000 <input type="checkbox"/> \$120,001 to \$130,000 <input type="checkbox"/> \$130,001 to \$140,000 <input type="checkbox"/> \$140,001 to \$150,000 <input type="checkbox"/> Above \$150,000		
PARENT EDUCATION INFORMATION			
(Circle) Last Year of School Completed: 9 10 11 12 GED		College: 1 2 3 4	Other: _____
Are You Currently in School? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, What School: _____	
PARENT RELATIONAL INFORMATION			
Current Status:			
<input type="checkbox"/> Single	<input type="checkbox"/> Dating	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced*
<input type="checkbox"/> Engaged	<input type="checkbox"/> Living together	<input type="checkbox"/> Separated*	<input type="checkbox"/> Widowed
*Divorced or Separated, please provide copy of Custody Agreement			

I hereby give Milestone Counseling and its' staff permission to provide counseling services for the patient mentioned above:
Signature of parent or legal guardian: _____

Signature: _____ Date: _____



PATIENT INFORMATION

Patient's Age: _____ School _____ Grade: _____

S.S. # _____ (insurance clients only) Patient's primary language _____

Has patient received counseling from a Pastor, Psychiatrist, or other counselor? Yes No

If yes, Who: _____ When: _____

What was the previous chief complaint or diagnosis: _____

Physician's Name: _____ Date of last physical exam: _____

Patient's Immunizations up to date: Yes No

Significant past medical conditions and years _____

Current medical conditions (include any known allergies or dietary concerns) _____

Medications/dosage patient is currently taking and for what reason: _____

Severity of Problem: Crisis Severe Moderate Mild

Briefly describe major reasons for coming to counseling and what you hope to accomplish: _____



**Child Comprehensive Psychosocial Assessment
Family Information:**

Family	Name	Age	Educ.	Occupation	At Home
Dad					
Mom					
Stepdad					
Stepmom					
Bro/Sis					
Bro/Sis					
Bro/Sis					

Has your child ever lived with anyone else? Yes No

If so, who? _____

Is your child adopted? Yes No If yes, at what age? _____

Has your child ever experienced a trauma? Yes No

If yes, Briefly describe _____

Briefly describe the family dynamic (include cultural communication patterns, current environmental conditions and/or stressors): _____

A. Your Child's Development:

Please provide history of mother's pregnancy. Any complications during birth? _____

Developmental Milestones:

Please list the approximate age at which your child:

Approx age:	Milestone Description:	Yes/No	If no, Briefly explain:
2 Months	Smiled at the sound of your voice and followed you with their eyes as you moved around a room.		
3 Months	Raised head and chest when lying on stomach; Grasped objects; Smiled at other people.		
4 Months	Babbled, laughs, and tries to imitate sounds; holds head steady.		
6 Months	Rolled from back to stomach and stomach to back; Moved objects from hand to hand.		



Approx age:	Milestone Description:	Yes/No	If no, Briefly explain:
7 Months	Responded to own name; Found partially hidden objects.		
9 Months	Sat without support, crawled, babbled "mama" and "dada".		
12 Months	Walked with or without support; Said at least one word; Enjoyed imitating people.		
18 Months	Walked independently; drank from a cup; said at least 15 words; pointed to body parts.		
2 Years	Ran and jumped; Spoke in two-word sentences; Followed simple instructions; Began make-believe play.		
3 Years	Climbed well; Spoke in multiword sentences; Sorted objects by shape and color.		
4 Years	Played well with people outside the family; Drew circles and square; Rode a tricycle		
5 Years	Tells name and address, Jumps, hops, and skips Gets dressed, Counts 10 or more objects		

B. Biological Family History: (biological unknown Yes)

Has anyone in your immediate family ever had any of the following problems?

1. Epilepsy or Diabetes? Yes No If Yes, who? _____
2. Significant Medical Problems? Yes No If Yes, who? _____
3. Mental Illness Requiring Hospitalization? Yes No If Yes, who? _____
4. Counseling for Emotional Problems? Yes No If Yes, who? _____
5. Current or past use of alcohol/drugs? Yes No If Yes, who? _____
6. Suicidal Behavior? Yes No If Yes, who? _____

C. Your Child's Behavior:

1. Does he/she get along well w/others? Yes No Sometimes
2. Does your child follow instructions? Yes No Sometimes
3. Is your child appropriate with pets? Yes No Sometimes
4. Does your child have self-control? Yes No Sometimes
5. Has your child ever set a fire? Yes No Sometimes
6. Does your child cry easily? Yes No Sometimes
7. Has your child ever used alcohol or other drugs? Yes No Sometimes
8. Has your child ever experienced problems with the law? Yes No
9. Has your child ever talked about, threatened or tried to harm himself or herself? Yes No
10. Has your child ever threatened to or harmed others? Yes No
11. Has your child ever used tobacco products? Yes No



D. Your Child's Education:

1. What school is your child attending?

2. In what grade is your child? _____
1. Has your child attended a special education program? Yes No
2. Has your child repeated, skipped or had any interruptions in his/her education? Yes No
3. How many days has he/she missed this year? _____

E. S. N.A.P.:

1. What are your child's Strengths? _____
2. What are your child's Needs? _____
3. What are your child's Abilities? _____
4. What are your child's specialties, if any? _____

F. Barriers to Treatment: What issues could inhibit progress towards treatment? _____

G. Spiritual/Cultural:

What spiritual, cultural or ethnic considerations should we be aware of: _____

H. Health:

Has your child experienced any of the following: If Yes, briefly explain?

Soiling or lack of bowel control? Yes No

Urinary problems? Yes No

Seizures or Convulsions? Yes No

Eye/Ear Problems? Yes No



H. Health (Cont.):

Complications from high fever? Yes No

Persistent Headaches? Yes No

**Persistent Stomach Aches/Nausea
Or Vomiting?** Yes No

Sleeping Problems? Yes No

Physical, Sexual or Emotional Abuse? Yes No

Poor Appetite? Yes No

Significant Weight Loss or Gain? Yes No

Frequent Colds/Respiratory Yes No

Self-Injury, Rocking, Head Banging? Yes No

Coma or Unconsciousness Yes No

Serious Injury Resulting from Accidents Yes No

Parent or Guardian's Signature

Date



FINANCIAL POLICY

Payment Policy:

We are committed to providing you with the best possible care. Payment for service (including co-payments) are **due at the time of service.**

It is essential that you complete these forms in their entirety and provide Milestone Counseling with all the necessary information regarding ALL your insurance providers.

Our fees:

- Your Sessions are _____ per hour per fee schedule and policies
- Groups are \$ _____ per hour.
- Additional counselor Service: Treatment Summary Requests, Professional Letters, Emails or Phone/Conference calls, if requested, will be billed in 15minute increments at the your therapeutic rate listed above.
- Administrative Services by staff: Letters from the front office, insurance forms, authorization requests will be billed a \$15 per 15 minutes of billable services with a \$15 minimum.
- Court Appearances and Depositions are billed door to door at \$300 per hour with a minimum \$1000 retainer.
- Returned checks are subject to a \$30 fee.
- No-show fees are charged for appointments canceled or broken without 24 hours advance notice unless there is an emergency or illness. The no-show fee is equivalent to your normal session fee.
- Insurance clients who accrue 3 no call/late call (less than 24 hours notice) or no shows for appointments may have services terminated.
- In the event there are changes to the client's insurance plan(s), co-pays, deductibles, and/or charges not paid by insurance are the responsibility of the client. A credit/debit card authorization form will be provided to pay for these charges.

Policy on Insurance Reimbursement:

If you have Insurance that provides coverage for mental health counseling, we can help you receive your maximum allowable benefits.

We will be happy to provide you with a receipt to forward to your insurance company. You are responsible for generating the claim and mailing it to the insurance company and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.

Rate Calculation Policy:

- Mandated counseling is subject to a \$20 per hour surcharge, couples & family counseling a \$10 per hour surcharge, below \$50,000 household income, & a \$20 per hour surcharge, above \$60,000 household income.
- Mediation services are billed at \$140.00 per hour.
- Late evening appointments, 6 p.m. & later, will be subject to a \$20 per hour surcharge
- Fees listed are for one clinical one hour. Longer sessions are calculated by .5 hour increments
- Hourly fees are calculated and based on previous year's total household income and/or support from all sources including, but not limited to, hourly wages, salaries, bonuses, investment income, Social Security, disability, retirement income, child support, alimony, welfare, unemployment compensation, food stamps, public or private childcare assistance, company vehicle, public or private housing assistance, board, etc.
- Proof of income may be required. All financial information kept confidential.
- Discounts for multiple clients or weekly sessions, from the same family, may be arranged on a case by case basis.

Signature _____ Date _____



Informed Consent & Release of Liability

This form is to document that I (please print) _____ give my consent and

permission for Milestone Counseling to provide mental health therapy services to myself and/or

(please print) _____, who is my child or for whom I am legal guardian, custodian, or legal Power of Attorney.

I understand the following:

- Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
- Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
- This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend and evening hours.
- Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. The therapist will make reasonable efforts to resolve these situations before breaking confidentiality.
- I am financially responsible for this treatment and any portion of the fees not reimbursed or covered by insurance are payable by me.
- I have been informed that for the protection of clients and therapists, all sessions with persons under the age of 18 may be videotaped.
- I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.
- I acknowledge that I have the right to request a printed copy of the Milestone Counseling Client Handbook.
- I have read and received the Office Policies & General Information Agreement for Psychotherapy Services and I agree to the policies. I have also received a copy of the HIPAA Notice of Privacy Practices. I have discussed any concerns about the policies with the therapist prior to signing this consent.

Signature: _____ Date: _____



NOTICE OF PRIVACY PRACTICES

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIP AA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIP AA provides penalties for covered entities that misuse personal health information. As required by HIP AA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative

order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

- You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
 - The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
 - The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
 - The right to request an amendment to your PROTECTED HEALTH INFORMATION.
 - The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate for filing a complaint.

For more information about our Privacy Practices, please contact:
The Privacy Officer of Milestone Counseling
205 Hatteras Ave.
Clermont Fl. 34711
352-348-8858

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C 20201
877.696.6775 (toll-free)

KEEP FOR YOUR RECORDS

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.

This authorization can be used to settle any outstanding balances due, co-payments, deductibles, fees and/or charges not provided by insurance.

For your convenience, this form can be used to pay for sessions in advance, out of office appointments and/or to create a payment plan. This form will remain on file until completion of therapy and payments have been fully processed.

Credit Card Information			
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover <input type="checkbox"/> AMEX
	<input type="checkbox"/> Other _____		
Cardholder Name (as shown on card): _____			
Card Number: _____			
Expiration Date (mm/yy): _____			
Cardholder ZIP Code (from credit card billing address): _____			

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.