CHILD INTAKE FORM (age 6 to 12)

(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: ❑ Yes ❑ No
Mailing Address or Post Office Box:			
City:	State:	ZIP Code:	May We Send Mail Here: ❑ Yes ❑ No

Home Phone:	( )	May We Leave a Message Here: ❑ Yes ❑ No
Mobile Phone:	( )	May We Leave a Message Here: ❑ Yes ❑ No
Work Phone:	( )	May We Leave a Message Here: ❑ Yes ❑ No
Email Address:	( )	May We Send Email Here: ❑ Yes ❑ 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 :

❑ Below $80,000 ❑ $80,001 to $90,000 ❑ $90,001 to $100,000

❑ $100,001 to $110,000 ❑ $110,001 to $120,000 ❑ $120,001 to $130,000

❑ $130,001 to $140,000 ❑ $140,001 to $150,000 ❑ 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? ❑ Yes ❑ No	If Yes, What School:	

PARENT RELATIONAL INFORMATION
Current Status:
❑ Single ❑ Dating ❑ Married ❑ Divorced*
❑ Engaged ❑ Living together ❑ Separated* ❑ 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: _____

MILESTONE
COUNSELING

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/Adolescent 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? _____

_____

Please list the approximate age at which your child:

	Age	Problems
Walked	_____	❑ Yes ❑ No
Talked	_____	❑ Yes ❑ No
Toilet Trained	_____	❑ Yes ❑ No
Puberty/1st Menstruation	_____	❑ N/A ❑Yes ❑ No
Sexually Active	_____	❑ N/A ❑Yes ❑ No

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? Tobacco products? ❑ 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

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 experience any of the following:

Soiling or lack of bowel control? ❑ Yes ❑ No

_____

Urinary problems? ❑ Yes ❑ No

_____

Seizures or Convulsions? ❑ Yes ❑ No

_____

Eye/Ear Problems? ❑ Yes ❑ No

_____

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? / 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 compete 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 I 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: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ 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.

.