HEARTSTRINGS COUNSELING
A NON-PROFIT AGENCY

New Minor Client Intake Form

Date_____ Referred By:_____

Minor's Name _____ Date of Birth _____

Street Address _____ City _____ Zip _____

School _____ Grade _____ Family Gross Income _____

Parent(s)/Guardian(s) Name(s) _____ Cell Phone _____ Home Phone _____

Work Phone _____ Email Address _____

Emergency Contact (Besides Guardian/Parents) _____ Relationship to Minor _____

Address _____ Phone _____

Adults With Whom Minor Lives With:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Siblings:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

6135 King Rd., Suite B, Loomis, CA 95650
Phone: 916-676-7405 Fax: 916-471-0559
www.heartstringscounseling.org

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Medical History:

Have you taken, or are you now taking, any prescription medications for mental health issues

☐ Yes ☐ No

What prescriptions?_____

For how long?_____

Prescribed by whom and for what conditions?_____

Please give a brief summary of the **specific reason** you are seeking counseling at this time. Be assured this information is confidential and will be used only for the purpose of assigning you to the appropriate counselor.

_____

_____

_____

_____

_____

_____

I give permission to Heartstrings Counseling to send me emails, announcements and updates regarding additional services and products related to mental health.

☐ Yes ☐ No

I would like biblical principles incorporated into my counseling sessions.

☐ Yes ☐ No ☐ I don't know

I would like to request a handicap accessible room and I cannot walk upstairs.

☐ Yes ☐ No

Choose your payment option below:

☐ **I am ABLE to pay the reduced clinical counseling fee of $90.**

☐ **I am UNABLE to pay the above fee and wish to use for the SLIDING FEE SCALE (based on my monthly income).**

☐ **I would like to be referred to a licensed Marriage and Family Therapist for $100/ session for individuals and $120/session for couples, families and /or EMDR.**

Print Name _____

Signature _____ **Date** _____

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Consent to Treat a Minor

The undersigned is the responsible parent or legal guardian and hereby authorizes Heartstrings Counseling and its staff to provide counseling to the minor stated below. Also, the parent or legal guardian understands that while a therapy session is a 50-minute-long hour, some young children benefit from shorter sessions. In either case, the parent or legal guardian recognizes that the transportation to and from, and the supervision of the children before and after session are the sole responsibility of the parent or guardian. If the minor's parents are divorced or separated, the most recent copy of the custody agreement must be provided before treating the minor.

_____ _____

Name of Minor Date

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Signature of Parent or Legal Guardian Date

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Informed Consent

Confidentiality

What is revealed in this setting is protected by professional and ethical standards. All material is confidential and not released without your written consent except information related to suspected child abuse, elder abuse, dependent abuse, threatened homicide or suicide.

Electronic Communication & Confidentiality

Most counselors are willing to maintain contact with you via text, email, or other electronic means. Although we cannot be certain that this information will not be intercepted, we will do our part to protect your confidentiality.

____ **Please initial here** if you understand the risks of communicating with your counselor by electronic means, and still wish to do so. Your initials indicate you understand the risk, and consent to electronic communication with your counselor.

Counselors

Counseling is provided by counselors who are in training to become Licensed Marriage and Family Therapists (LMFT). They are supervised by Darla Gale, LMFT #92413, a licensed therapist. During these supervision meetings, your information may be discussed between counselors and with the supervisor in an effort to gain understanding and build skill and knowledge related to marriage and family therapy. The Supervisor may, at times, record your session for the purpose of training and education only. We value your confidentiality and will make every effort to only share unidentifiable information. The supervisor reach out to you to check on your experience with your therapist to ensure the best possible treatment.

____ **Please initial here** to acknowledge you understand.

Counseling Services

Heartstrings Counseling is a safe environment open to all members of the community. We strive to encourage positive change and personal growth that will brace and sustain the heart. Furthermore, we provide each client with the option of integrating Biblical principles into the treatment plan. As a client of Heartstrings Counseling you are not required to bring these principles into session; however, you may if interested.

Please check here to indicate if you would you like Biblical principles to be included in your counseling sessions? ☐ Yes ☐ No ☐ I Don't Know
* Please note that you can change this selection, verbally or in writing, at any time.

Fees and Payment

Your fee is based on a sliding fee scale according to your average monthly income and ability to pay. Payment of fees will be due at each session. Cash, check, credit cards, and health savings cards are accepted. There is a $15 fee for any returned checks. The only form of insurance that is accepted at Heartstrings Counseling is the state Victims of Crime Compensation Program. However, if for some reason the program does not pay for the services provided, each client will be responsible for the payments. If a client is using the Victims of Crime Compensation Program and doesn't show for a scheduled appointment or

doesn't give the therapist a 24-hour cancellation notice, the full session fee will need to be paid out of pocket. At times, a fee may be waived, based on our ability to receive grants or in an unlikely event of a crisis where client is a danger to themselves or someone else and they need increase sessions, or at the discretion of the Supervisor.

Cancellations

Cancellations must be made 24 hours in advance. If an appointment is canceled or missed without 24 hours of notice, you will be charged your usual fee for that missed session.

Client Litigation

Heartstrings Counseling will NOT voluntarily participate in any litigation, or custody dispute in which client and another individual, or entity, are parties. Heartstrings Counseling has a policy of not communicating with clients' attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in client's legal matters. Heartstrings Counseling will generally not provide records or testimony unless compelled to do so. Should the therapist at Heartstrings Counseling be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving client, client agrees to reimburse Heartstrings Counseling for any time spent for preparation, travel, or other time in which therapist at Heartstrings Counseling has made themselves available for such an appearance at an hourly rate of $90/hr due to the complexities of such case.

Your Counseling Experience

Your therapy session is a 50-minute hour. Counseling is a unique and highly individualized experience. It is an opportunity to learn about yourself, your relationships, and the world around you. Most people seeking counseling are hoping for improvement in at least one area of their life and this is definitely possible through dedication and consistent counseling sessions. Although you may want immediate relief, it is common for symptoms to get worse before they get better. Remember that it may have taken time for your struggles to develop, and it may also take time for you to begin to feel better.

Counseling involves change, which may feel threatening, not only to you, but also to those people close to you. The prospect of giving up old habits, no matter how destructive or painful, can often make you feel very vulnerable. At the same time, counseling can aid you in discovering tools and techniques, which can be utilized to improve the quality of your life and relationships. As the person involved in this process, you have the right to ask your counselor questions about his/her professional experience, background and theoretical orientation.

Please ask for any clarification needed for the above

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Counselor Signature Date

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HIPAA Notice of Privacy Practice

1. This notice describes how medical information about you may be used and disclosed electronically. Please review it carefully.

2. We have a legal duty to safeguard your protected health information (PHI) when we transmit information electronically. We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you regarding your past, present, or future health or condition, the provision of health care to you, or the payment of this health care.

We must provide you with this Notice about our privacy practices, and such Notice must explain how, when and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of our practice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.

By signing this notice you acknowledge we may use your PHI, but may not disclose your PHI without further written authorization by you. We do not keep separate treatment notes and psychotherapy notes; all of our notes are treatment notes and can be found in the client file. Your PHI will not be disclosed for marketing purposes. Your PHI will not be sold without your authorization. You will not be contacted for fundraising purposes. If you pay for any service out-of-pocket, then you have the right to restrict disclosures of PHI to health plans from that service. If there is a breach of your unsecured PHI, you will receive notification.

However, we reserve the right to change the terms of this Notice and privacy policies at any time. Any changes will apply to PHI on file with us already. Before we make any important changes to our policies, we will promptly change this Notice and post a new copy of it in our office. You can also request a copy of this Notice from us, or you can view a copy of it in our office.

Please sign this Notice, stating that you acknowledge receipt of this Notice of Heartstrings Counseling.

I _____ was or _____ was not offered a copy of this notice.

Signature: _____ Date: _____

Signature: _____ Date: _____

_____ Initial here if you decline to receive a copy if this notice.

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CANCELLATION POLICY

Cancellations must be made 24 hours in advance.

If an appointment is cancelled or missed without 24 hours of notice, you will be charged your usual fee for that missed session.

_____ _____

Printed Name Date

_____ _____

Client Signature

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Symptom & Problem List

Please check all that you have experienced in the last 90 days

- ☐ No energy
- ☐ Cannot Enjoy Life
- ☐ Memory Problems
- ☐ Anxiety
- ☐ Fatigue
- ☐ Anger Outbursts
- ☐ Shortness of Breath
- ☐ Sweating
- ☐ Hot flashes
- ☐ Reliving Past Events
- ☐ No Loving Feelings
- ☐ Fears
- ☐ Chest Pains
- ☐ Decisions Difficult
- ☐ Racing Thoughts
- ☐ Clammy Hands
- ☐ Hard to Make Friends
- ☐ Flashbacks
- ☐ Overeating
- ☐ Suicidal Thoughts
- ☐ Taking Pain Killers Often
- ☐ Mood Swings
- ☐ Unusual Experiences
- ☐ Physical Numbness
- ☐ Panic Attacks
- ☐ Losing Track of Time
- ☐ Impaired Vision
- ☐ Back Pain
- ☐ High Risk Activities
- ☐ Insomnia
- ☐ Disturbing Memories
- ☐ Low Self-Esteem
- ☐ Poor Appetite
- ☐ Headaches
- ☐ Nightmares
- ☐ Heart Palpitations
- ☐ Depressed
- ☐ Guilt Feelings
- ☐ Poor Concentration
- ☐ Blackouts/Fainting
- ☐ Unwanted Thoughts
- ☐ Out of Control Behavior
- ☐ Overly Confident
- ☐ Distractible
- ☐ Sexual Indiscretion
- ☐ Socially Withdraw
- ☐ Eating Disorder
- ☐ Alcohol Use
- ☐ Seeing things
- ☐ Excess Energy
- ☐ Unsure of Reality
- ☐ Wishing to Die
- ☐ Confusion
- ☐ Weight Change
- ☐ Impaired Hearing
- ☐ Muscle Spasms
- ☐ Tremors
- ☐ Unsure of Identity
- ☐ Seizures
- ☐ Sporadic Dieting
- ☐ Sexual Difficulty
- ☐ Hypertension
- ☐ Racing Heart
- ☐ Stomach problems
- ☐ Sleeping too much
- ☐ Always on Guard
- ☐ Apathetic
- ☐ Numbing Out
- ☐ Distrustful
- ☐ Buying Sprees
- ☐ Drug use
- ☐ Family Arguments
- ☐ Often Physically ill
- ☐ Hearing Voices
- ☐ Vomiting
- ☐ Slowed Thinking
- ☐ Physical Violence
- ☐ Easily Startled
- ☐ Work Problems
- ☐ Hopeless Feelings
- ☐ Dizziness
- ☐ Hallucinations

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Sliding Fee Schedule

Session fees are determined by your monthly income and ability to pay.

Monthly income includes all forms of household income

(such as pension, disability, unemployment, stipends, commission, salary, etc.)

Dependent session fees are determined by the monthly income of the guardians of the child.

Payment of fees will be due at each session in either cash, check, or credit card. As a reminder, cancellations must be made 24 hours in advance. If an appointment is cancelled or missed without 24 hours of notice, you will be charged for the missed session.

Monthly Income	Session Fee
$0 - $2,000	$60
$2,001 - $3,000	$70
$3,001 – 4,000	$80
$4,001-Above	$90

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Third Party Credit Card Agreement

I, _____, authorize the credit card below to be used for any and all counseling sessions for _____.

CC Type: MC Visa Amex Other_____

Name as shown on card_____

CC Number_____

CC Expiration Date_____

3-digit security code on back of the card_____

Billing Zip Code associated with the card_____

This card may be charged for:

__X__ Regular session fees (at your request, as a convenience to you)

__X__ Fees for cancellation without_24__hours notice (according to a counselor's policy)

__X__ Delinquent session fees (fees more than 30 days overdue)

"I _____ (print name) have read and understand the terms of providing my credit card to Heartstrings Counseling. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered.

_____ (signature) _____(date)

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