



### 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 \_\_\_\_\_



**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.

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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 \$100.
- 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 \$135/ session for individuals, couples, families and /or EMDR and EFT.

**Print Name** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



### 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 minors parents are divorced or separated, the most recent copy of the custody agreement must be provided before treating the minor.

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Name of Minor	Date
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Signature of Parent or Legal Guardian	Date
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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 may 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 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 a client is a danger to themselves or someone else and they need increased 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.

## **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**

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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Counselor Signature \_\_\_\_\_ Date \_\_\_\_\_



## 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.





## Symptom & Problem List

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Complains about aches and pains | <input type="checkbox"/> Mood Swings             | <input type="checkbox"/> Overly Confident     |
| <input type="checkbox"/> Racing Heart                    |  |   |
| <input type="checkbox"/> Cannot Enjoy Life               | <input type="checkbox"/> Unusual Experiences     | <input type="checkbox"/> Stomach problems     |
| <input type="checkbox"/> Memory Problems                 | <input type="checkbox"/> Physical Numbness       | <input type="checkbox"/> Sleeping too much    |
| <input type="checkbox"/> Anxiety                         | <input type="checkbox"/> Panic Attacks           | <input type="checkbox"/> Always on Guard      |
| <input type="checkbox"/> Fatigue                         | <input type="checkbox"/> Losing Track of Time    | <input type="checkbox"/> Apathetic            |
| <input type="checkbox"/> Anger Outbursts                 | <input type="checkbox"/> Impaired Vision         | <input type="checkbox"/> Numbing Out          |
| <input type="checkbox"/> Shortness of Breath             | <input type="checkbox"/> Back Pain               | <input type="checkbox"/> Distrustful          |
| <input type="checkbox"/> Sweating                        | <input type="checkbox"/> High Risk Activities    | <input type="checkbox"/> Buying Sprees        |
| <input type="checkbox"/> Hot flashes                     | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Drug use             |
| <input type="checkbox"/> Reliving Past Events            | <input type="checkbox"/> Disturbing Memories     | <input type="checkbox"/> Family Arguments     |
| <input type="checkbox"/> No Loving Feelings              | <input type="checkbox"/> Low Self-Esteem         | <input type="checkbox"/> Often Physically ill |
| <input type="checkbox"/> Fears                           | <input type="checkbox"/> Poor Appetite           | <input type="checkbox"/> Hearing Voices       |
| <input type="checkbox"/> Chest Pains                     | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Vomiting             |
| <input type="checkbox"/> Decisions Difficult             | <input type="checkbox"/> Nightmares              | <input type="checkbox"/> Slowed Thinking      |
| <input type="checkbox"/> Racing Thoughts                 | <input type="checkbox"/> Heart Palpitations      | <input type="checkbox"/> Physical Violence    |
| <input type="checkbox"/> Clammy Hands                    | <input type="checkbox"/> Depressed               | <input type="checkbox"/> Easily Startled      |
| <input type="checkbox"/> Hard to Make Friends            | <input type="checkbox"/> Guilt Feelings          | <input type="checkbox"/> Work Problems        |
| <input type="checkbox"/> Flashbacks                      | <input type="checkbox"/> Poor Concentration      | <input type="checkbox"/> Hopeless Feelings    |
| <input type="checkbox"/> Overeating                      | <input type="checkbox"/> Blackouts/Fainting      | <input type="checkbox"/> Dizziness            |
| <input type="checkbox"/> Suicidal Thoughts               | <input type="checkbox"/> Unwanted Thoughts       | <input type="checkbox"/> Hallucinations       |
| <input type="checkbox"/> Taking Pain Killers Often       | <input type="checkbox"/> Out of Control Behavior |   |





## 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.

<u>Monthly Income</u>	<u>Session Fee</u>
\$0 - \$2,000.....	\$60
\$2,001 - \$3,000.....	\$70
\$3,001 – 5,000.....	\$80
\$5,001-Above .....	\$100



### Credit Card Agreement

Please note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to the counselor at your initial session.

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:

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

Fees for cancellation without 24 hours notice (according to a counselor's policy)

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)

