

# Child Application for Services

(Please complete all sections that are applicable to your child)

**Child's Legal Name:** \_\_\_\_\_

**Child's Preferred Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Address 1:** \_\_\_\_\_

**Address 2:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Child's phone:** \_\_\_\_\_ **May we leave messages? Yes No**

## Parent/Guardian Information

**Contact Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Mobile Phone:** \_\_\_\_\_ **May we leave messages? Yes No**

**Home Phone:** \_\_\_\_\_ **May we leave messages? Yes No**

**Contact's Email Address:** \_\_\_\_\_

(Your email address is not required. If you provide your email address you are giving our office permission to send you a link to our client portal and to email you automated appointment reminders. This email address will be linked to the client's portal)

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**Contact Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Mobile Phone:** \_\_\_\_\_ **May we leave messages? Yes No**

**Home Phone:** \_\_\_\_\_ **May we leave messages? Yes No**

**Contact's Email Address:** \_\_\_\_\_

(Your email address is not required. If you provide your email address you are giving our office permission to send you automated appointment reminders)

## **Intake Information:**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Please check all of the following that concern you and are related to why you came to our office:**

- |   |  |
|---|--|
| <input type="checkbox"/> Aggressive, angry feelings, temper | <input type="checkbox"/> Eating problems/Stomach trouble     |
| <input type="checkbox"/> Relationship problems              | <input type="checkbox"/> Family problems                     |
| <input type="checkbox"/> Thoughts about hurting myself      | <input type="checkbox"/> Sexual Concerns                     |
| <input type="checkbox"/> Difficulty making decisions        | <input type="checkbox"/> Memory Problems                     |
| <input type="checkbox"/> Anxiety                            | <input type="checkbox"/> Headaches                           |
| <input type="checkbox"/> Medical problems                   | <input type="checkbox"/> Religious/spiritual concerns        |
| <input type="checkbox"/> Lack of self-confidence            | <input type="checkbox"/> Sleep difficulties                  |
| <input type="checkbox"/> Poor concentration                 | <input type="checkbox"/> Fidgety/restless, can't sit still   |
| <input type="checkbox"/> Nervous habits                     | <input type="checkbox"/> Feelings of sadness or hopelessness |
| <input type="checkbox"/> Crying spells                      | <input type="checkbox"/> Guilt feelings                      |
| <input type="checkbox"/> Use of alcohol or drugs            | <input type="checkbox"/> Problems with energy levels         |
| <input type="checkbox"/> Financial problems                 | <input type="checkbox"/> Preoccupation with gambling         |

**Please briefly describe the symptoms that you checked above:**

**Do you currently have thoughts of self-harm or thoughts of suicide?**

**History of present problem:**

When did your symptoms begin? \_\_\_\_\_

How often do you experience your symptoms? \_\_\_\_\_

**Please list any previous counseling, psychiatric care, mental health hospitalizations, or substance abuse treatment.**

Doctor/Therapist /Hospital Treatment	Dates	Reason for

**Do you feel safe in your current environment? If no, why not?**

**Do you have any history of being violent? (Please describe)**

## Trauma History

Have you experienced any verbal, emotional, sexual, or physical abuse? \_\_\_\_\_

Have you experienced any other traumatic event? \_\_\_\_\_

If yes, please briefly describe:

## Family psychiatric history:

Has anyone in your family been diagnosed with a psychological disorder? \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

## Medical conditions and history:

Current medical conditions: \_\_\_\_\_

Past medical conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Other treatments: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

## Medications: (Please bring a full list to your appointment if you take numerous medications)

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Purpose: \_\_\_\_\_

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Prescribing physician: \_\_\_\_\_

**Substance use:**

Alcohol:	How Often:	Last use:
Marijuana:	How Often:	Last use:
Smoking/vaping:	How Often:	Last use:
Other:	How Often:	Last use:
Other:	How Often:	Last use:

Have you ever received treatment for substance abuse? \_\_\_\_\_

If yes, where was the treatment and when?

**Family history:**

Who lives in your home?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Who were you raised by?

\_\_\_\_\_ Parents \_\_\_\_\_ Grandparents \_\_\_\_\_ Adoptive Parents \_\_\_\_\_ Foster Parents

\_\_\_\_\_ Other Relative      Other: \_\_\_\_\_

How many siblings do you have? \_\_\_\_\_ Half Siblings? \_\_\_\_\_ Step Siblings?

\_\_\_\_\_

Were your parents in a committed relationship with each other?

What was your childhood like?

**Social history:**

Who do you rely on for emotional support?

\_\_\_\_\_ Family    \_\_\_\_\_ Friends    \_\_\_\_\_ Coworkers    \_\_\_\_\_ Neighbors  
\_\_\_\_\_ Religious/Spiritual Leader    \_\_\_\_\_ No One

Any religious affiliation?

**Education/Occupational history:**

What is your highest level of education?

\_\_\_\_\_ Some High School    \_\_\_\_\_ High School    \_\_\_\_\_ Some College  
\_\_\_\_\_ College Graduate    \_\_\_\_\_ Masters    \_\_\_\_\_ Doctorate

Are you currently employed? \_\_\_\_\_

Who is your employer? \_\_\_\_\_

How long have you been in this position? \_\_\_\_\_

What kind of jobs have you held in the past?

Have you served in the military? \_\_\_\_\_

If yes, which branch? \_\_\_\_\_ Dates of Service \_\_\_\_\_ Type of Discharge \_\_\_\_\_

Please briefly describe your time in the military, including whether or not you were in active combat:

**Legal history:**

Have you ever been involved in the criminal justice system? \_\_\_\_\_

If yes, please briefly describe:

Are there any pending charges against you?

# Family Life Counseling and Psychological Services, LLC

4142 Keaton Crossing Blvd, Suite 101, O'Fallon, MO 63368

Phone: (636) 300-9333 Fax (636) 300-8761

## Outpatient Services Contract

Welcome to Family Life Counseling and Psychological Services. We are pleased to have the opportunity to work with you. This document contains important information about our professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

The length of time of the appointment varies based on the services provided. Psychological evaluations generally take three to four hours of your time. While most are completed in one day, a second appointment may be necessary, particularly with children who tire easily. Therapy sessions are generally scheduled for 45 minutes or 55 minutes, one time a week, although some sessions may be longer or more frequent. **Because the appointment time is reserved for you, it is necessary to charge our full rate for appointments that are not cancelled 24 hours in advance. This includes office visits, court appearances, depositions, DFS evaluations etc. Cancellation of Court ordered psychological evaluations require 7 days' notice. Court ordered evaluations cancelled with less than 7 days' notice will be billed for four hours at our regular evaluation rate.** However, no fee is charged for late cancellations due to inclement weather.

We are often not immediately available by telephone. While we are generally in the office Monday through Friday, we probably will not answer the phone when we are with a client. When we are unavailable, the phone is answered by our receptionist or voicemail that we monitor frequently. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. In case of emergency, call 911 or go to your local emergency room and ask for the psychologist on call or call Behavioral Health Response at 1-800-811-4760. After business hours, for urgent but non-emergency matters, you may call our office manager, David, on his cell phone at 314-276-7566. He will contact the therapist on call for the evening.

In general, law protects the privacy of all communications between a client and a psychologist or counselor, and we can only release information about our work to others with your written permission. However, there are a few exceptions:

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, if we believe that a child, elderly person, or person with a disability is being abused, we must file a report with the appropriate state agency.

If we believe that a client is threatening serious bodily harm to another, or to himself/herself, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

Information subpoenaed in a legal proceeding might not be regarded by the court as confidential.

We may occasionally find it helpful to consult other professionals about a case. The consultant is also legally bound to keep the information confidential.

Please read our Notice of Privacy Practices.

The standard fee for a 38-52 minute session is \$125. The standard fee for a 53-60 minute session is \$145. Our fee for court ordered psychological evaluations is \$200 per hour. In addition to our appointments, we charge this amount for other professional services you may need. For example, the fee for psychological evaluations also includes test scoring, interpretation, and preparation of the report. Brief telephone conversations to discuss changes in appointment times are free of charge. Phone calls over five minutes in length are billed in five-minute increments, prorated at your session rate.

If you become involved in legal proceedings that may require our participation, you will be expected to pay for our professional time even if we are called to testify by another party. Because of the complexity of legal involvement, we charge \$200.00 per hour for preparation, travel, and attendance at any legal proceeding. We charge this same fee for all matters that we determine as legal in nature including, divorce mediation, responding to subpoenas, phone calls, letters and faxes to attorneys, disruption of practice, etc.

**Your co-pay is due at the time of your session.** Payment for psychological evaluations is due in full before the results of the evaluation will be made available. You are responsible for all collection fees incurred as a result of late or non-payment including the hiring of a collection agency or use of small claims court. All invoices over 90 days old are automatically turned over to collections and currently incur a 35% collection charge. A bounced check fee of \$25 will be charged for all returned checks.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We can provide you with a detailed receipt for you to submit to your insurance company for reimbursement. We will also be happy to submit an insurance claim for you. However, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions.

At any time, you may question and/or refuse any procedures or services or gain whatever information you wish to know about the process and course of therapy and testing. We encourage you to ask us questions concerning the services provided. You are never obligated to continue services at any time.

By signing below, I consent for a therapist of Family Life Counseling and Psychological Services, LLC to provide evaluation and/or treatment services for (client's name) \_\_\_\_\_ . I understand that I may terminate services at any time without penalty. I understand and agree to all of the policies and procedures noted on page one and page two of the Family Life Counseling and Psychological Services, LLC Outpatient Services Contract and I have received and read a copy of Family Life Counseling and Psychological Services' Notice of Privacy Practices. I give permission for the office to provide information necessary to my insurance company in order to file a claim.

\_\_\_\_\_  
Client's Name or Guardian's Name (Please type or print)

\_\_\_\_\_  
Client's Signature or Guardian's Signature

\_\_\_\_\_  
Date

## Child Therapy Contract

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information in this contract is in addition to the information contained in the Outpatient Services Contract.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision. However, I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining the trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" in which they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be protecting your child's privacy by waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent unless mandated by law. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what general issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. Please let me know what behaviors you expect me to report to you. However, be aware that your child is unlikely to utilize therapy to discuss his/her decisions in areas that will be reported to you.

Although my responsibility to your child may require my involvement in conflicts between the two parents, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither parent will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability.

By signing this contract, you agree to the following:

- If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.
- You are waiving your right to access to your child's treatment records.
- I will inform you if your child does not attend the treatment sessions.
- At the end of treatment, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary, to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.
- As a mandated reporter, I will report any suspected physical or sexual abuse of a child to the state child abuse/neglect hotline.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements, visitation, etc. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.
- This Child Therapy Contract is a two-page document. I have read and agreed to both pages.

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_