Triad Counseling & Clinical Services, LLC
5587-D Garden Village Way, Greensboro, NC 27410

Client (Under 18 years old) Information Form

If parent/guardian is completing this form please answer questions from your child's perspective

Date:________________________Referred by:____

Client's Full Name:________________________Preferred Name:____________________________________

Date of Birth:_____________________Age:________Gender: ____________

Address:____City:____________State:________________

Zip:_______________

Home Phone: _______________________Cell Phone: ___________________________

Email:_____________________________________

Please indicate where you prefer to be contacted: ☐ home phone ☐ work phone ☐ cell phone ☐ email

Please indicate where we have permission to leave a message: ☐ home phone ☐ work phone ☐ cell phone ☐ email

Please indicate you have read: ☐ I understand that email and texting, while confidential, may not be secure to third-party intrusion.

Parent/ Guarantor'sName:____

Address:______________________________________City:________________________State:_____________

Zip:________________

Employer:____

Email:____

Home Phone:_______________________Cell Phone: ____________________________Work:______________________

Please indicate where you prefer to be contacted: ☐ home phone ☐ work phone ☐ cell phone ☐ email

Please indicate where we have permission to leave a message: ☐ home phone ☐ work phone ☐ cell phone ☐ email

Please indicate you have read:

☐ I understand that email and texting, while confidential, may not be secure to third-party intrusion.

Please indicate one (1) option for appointment reminders:

☐ Voice mail (_____)__________-________________ ☐ Text Message (_____)____________-__________________

☐ Email ____ ☐ No appointment reminder is needed.

Client Education/Employment

Current Grade:______________________School:____

Employment: ☐None ☐Part-time ☐Full-time Occupation: ________________________________

How long? __________

Afterschool activities (if any):____

Please list information about client's immediate family members:

Relative (mother, father, siblings)	Name	Age	Deceased (yes/no)	Current City, State	Relationship (excellent, good, fair, poor)	Physical/ Mental Illness

Any other family history of psychological/psychiatric concerns? (i.e. grandparents, aunts/uncles, etc.)____

____

Are client's parents married? ☐Yes ☐ No

If no, please indicate parents' relationship status: ☐never married ☐separated ☐divorced ☐widowed

If not, mother remarried? ☐Yes ☐No Father remarried? ☐ Yes ☐ No If yes:

Stepfather's name:______________________________ Stepmother's name:______________________________

What are the client's current living arrangements:

____

____

If there is a custody agreement who has primary custody? ☐ N/A or list below:

____

Family spiritual/religious practices, if any: ________________________________

Client's religious/spiritual preference, if any________________________________

Personal Health History

In general, client's health is: ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Client's physician:

____

Date of last physical exam:______________________________

Client's psychiatrist (if applicable):________________________________

Date of last visit:______________________________

Please indicate if the client has (a) serious medical condition(s) and age of onset:

____

____

Does the client have allergies?:________________________________

Does the client have any developmental concerns/differences?

____

____

Have any of client's medical conditions required hospitalization? ☐ No ☐ Yes Please describe below:

____

____

Has client been hospitalized for psychiatric or substance abuse issues? ☐ No ☐ Yes

Hospital/treatment center: ____________________

Location: ____________________ Dates of

Treatment: ____________________

Please list all current medications for client:

Medication	Dose	Frequency	Reason for medication

Please describe client's previous counseling history:

Dates of service	Counselor's name	Reason for services/Outcome

Current Health Information

Briefly describe your reason for/anticipated outcome in seeking counseling services at this time:

____

____

____

TO BE COMPLETED BY PARENT/GUARDIAN:

Which best describes your child?

	Never	Sometimes	Often
1. Destroys/destroyed property	1. ☐	☐	☐
2. Is/was unhappy or sad	2. ☐	☐	☐
3. Behavior causes/ed school problems	3. ☐	☐	☐
4. Has/had temper outbursts	4. ☐	☐	☐
5. Worrying prevents him/her from doing things	5. ☐	☐	☐
6. Worries/worried about almost everything	6. ☐	☐	☐
7. Has repeated unwanted thoughts	7. ☐	☐	☐
8. Engages in repeated, ritualized behaviors	8. ☐	☐	☐
9. Feels nervous and shaky (dizzy)	9. ☐	☐	☐
10. Feels worthless or inferior	10. ☐	☐	☐
11. Changes moods quickly	11. ☐	☐	☐
12. Difficulty with concentration	12. ☐	☐	☐
13. Frequent stomach or intestinal distress	13. ☐	☐	☐
14. Difficulty falling asleep	14. ☐	☐	☐
15. Difficulty staying asleep	15. ☐	☐	☐
16. Difficulty at home with siblings	16. ☐	☐	☐

17. Difficulty at home with parents 17.☐ ☐ ☐
18. Difficulty at school (academics) 18.☐ ☐ ☐
19. Difficulty at school (socially) 19.☐ ☐ ☐
20. Difficulty at school (behaviorally) 20.☐ ☐ ☐
21. Bullies or has bullied others 21.☐ ☐ ☐
22. Is/was bullied by others 22.☐ ☐ ☐
23. Has experienced significant weight gain 23.☐ ☐ ☐
24. Has experienced significant weight loss 24.☐ ☐ ☐
25. Restricts/has restricted eating 25.☐ ☐ ☐
26. Engages/has engaged in over-exercise 26.☐ ☐ ☐
27. Feels angry or irritable 27.☐ ☐ ☐
28. Engages in /has engaged in self-injury 28.☐ ☐ ☐
29. Has experienced suicidal thoughts 29.☐ ☐ ☐
30. Has attempted suicide 30.☐ ☐ ☐
31. Has experienced homicidal thoughts 31.☐ ☐ ☐
32. Do you think your child drinks alcohol? 32.☐ no ☐ yes
33. Do you think your child smokes pot/uses other drugs? 33.☐ no ☐ yes

34. If you answered "yes" to questions #32, how many alcoholic drinks do you think your child has had in the past week?____

35. If you answered "yes" to question #33, how many days do you think your child has used pot and/or other drugs?____

36. Does your child have a history of abuse or trauma? ☐ No ☐ Yes Please describe:
____

37. Do you have a have a history of abuse or trauma? ☐ No ☐ Yes Please describe:
____

36. In the past 6 months how often have you had to miss school/work due to the physical or mental health concerns of your child?:____

37. In the past 6 months how often has your family life been disrupted because of the physical or mental health concerns of your child?____

38. What strengths do you believe your child has?____

How do you think your child would answer the following statements?:

1. I feel good about myself. ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree
2. I can deal with my problems. ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree
3. I am able to accomplish the things I want. ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree
4. I have friends or family that I can count on. ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

Is there any additional information you think it would be helpful for your therapist to know in providing services to your child?

____

____

____

____

____

____

Please initial the following statements regarding payment, release of information, and confidentiality:

______I understand that all fees from professional services rendered are my responsibility, including services not covered by insurance. I am aware that this office files my insurance as a courtesy, and services must be paid when rendered.

________I am aware that I am financial responsible to pay in full for sessions not canceled within a 24 hour window.

______I hereby authorize Triad Counseling and Clinical Services, LLC to release any information necessary to process insurance claims concerning my diagnosis and treatment, and I authorize payment of medical/psychological benefits to Triad Counseling and Clinical Services, LLC.

______I understand that Triad Counseling and Clinical Services, LLC, is ethically and legal required to report to legal authorities information I give about ongoing abuse of children, disabled, and elderly persons and imminent physical danger I present to myself or others because of psychological factors.

____

Parent/Guardian on behalf of client   Date

Release of Information
Scheduling or Billing

You can authorize the release your private health information to others for scheduling or billing purposes. Keep in mind that we cannot discuss your records without your written consent. Please complete the section below if you would like to allow access to your records.

☐ I **do not authorize** access to my private health information (PHI) at this time.

OR

☐ I **authorize** access to my private health information (PHI) to the following individual,
Name:_______________________________, Relationship:__________________________, in the following forms and purposes only:

______Scheduling (making, changing, or verifying appointments)

______Billing (accessing verbal and written detailing in regards to payments, session dates, and general billing inquires, including allowing others to make payments on my behalf)

____   __________________________

Parent/Guardian signature   Date

CONSENT FOR RELEASE OF MENTAL HEALTH INFORMATION

This form is used to be able to discuss or release information to you (or your child's) primary care doctor only, in order to coordinate treatment.

If you wish for information to be release to the primary care doctor only, please fill in the name of that doctor, check by the authorization line and sign and date the form.

If you DO NOT wish for information to be released to the primary care doctor, check by the decline line and sign and date the form.

Patient Name:________________________________ Date of Birth:______mo_____day______year

Mental Health Provider Name: ____

Primary Care Physician Name: ____

Primary Care Physician Address: ______________________________ ____________________
Street City, State

Primary Care Physician Phone: (____)_________-________________

____ I authorize the release of relevant treatment information to the provider named above. I understand that these records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. My consent may be revoked at any time, and expires one year from the date signed.

____ I decline the release of treatment information to my Primary Care Physician.

______________________________ ____________________
Signature of Patient or Legal Guardian Date

____
Relationship to Patient

5587-D Garden Village Way, Greensboro, NC 27410
232 Woodrow Avenue High Point, NC 27262

CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & ACKKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information" or PHI), excluding psychotherapy notes, by Triad Counseling and Clinical Services, LLC (Provider) in order to carry out treatment, payment, or health care operations (TPO). My specific authorization must be obtained for disclosure of my PHI, including summary of psychotherapy notes, for purposes other than TPO, except in special situations. I have reviewed the Notice of Privacy Practices for a more complete description of the potential disclosures of such information.

I have the right to inspect and obtain a copy of my medical/mental health records, although I understand the Provider has the right to deny such request under certain circumstances. I have the right to have a denial to inspect reviewed by a "reviewing official." A reasonable fee may be charged for providing a copy of my records. I have the right to request amendments to the information in my medical/mental health records, although I understand the Provider has the right to deny such request. I have the right to request an accounting of disclosures of my PHI for purposes other than TOP and those for which I provided authorization. I may submit a written privacy complaint to 5587 D Garden Village Way, Greensboro, NC 27410 or to the U.S. Secretary of the Department of Health and Human Services, without any action being taken by the Provider against me without any change in my treatment.

Provider reserves the right to change the terms of its Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed, I may obtain a copy of the revised Notice by requesting a copy.

I retain the right to request that the Provider further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Provider is not required to agree to such requested restrictions; however, if the Provider does agree to requested restriction(s), such restrictions are then binding on the Provider.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Provider in writing. The revocation shall be effective *except* to the extent that the Provider has already taken action in reliance on the Consent.

The Provider may refuse to treat me if I (or authorized representative) do not sign the Consent portion of this form (except to the extent that the Provider is required by law to treat individuals). If I (or authorized representative) sign the Consent portion and then revoke Consent, the Provider has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Provider is required by law to treat individuals).

I _____ HAVE HAD AN OPPORTUNITY TO REVIEW THE PROVIDER'S NOTICE OF PRIVACY PRACTICES.

I _____ **CONSENT** TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

OR

I _____ **DO NOT CONSENT** TO THE RELEASE FOR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_______________________ _______________________ ___________

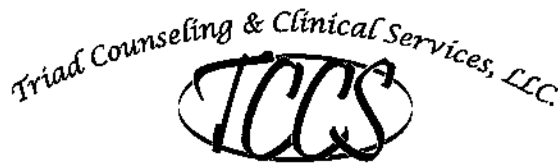
Please Print Name | Client's Signature (or authorized representative) | Date

Representative's Authority to act on behalf of the Patient: _______________________

For office staff use only:
Acknowledgement of Privacy Practices was not obtained because: _______________________

____

12/15 HIPPA
12/21/15



I ______________________________ authorize Triad Counseling & Clinical Services, PLLC to charge my credit card at the full rate for missed and late cancelled sessions. I understand that 24 hours notice is required for cancelling and rescheduling of all sessions.

Card Type:

{ } American Express
{ } MasterCard
{ } Visa
{ } Discover
{ } Other ________________________

Card Number: ______________________________

Expiration Date: ______________________________

Security Code: ______________________________

Name as it appears on card: ______________________________

Card Billing Address:

____

____

____

I verify that my credit card information, provided above, is accurate to the best of my knowledge. I understand that I am responsible for the entire amount owed. I also understand by signing this form that if no funds are available and alternate payment is not arranged, my balance will be sent to the collection agency.

____
Printed Name

______________________________ ______________
Authorized Signature of card holder Date

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