<u>CHILD</u> Application for Services

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

Client's Name: _____Today's Date: _____

Parent or Legal Guardian: _____

Parent or Legal Guardian: _____

Medicaid DCN number (if applicable): _____

Guardian's Social Security Number: _____

Relationship to Child: _____

Address: _____

_____

Phone: (Home) _____ Phone (Work) _____

Phone: (Cell) _____

Emergency Contact Name: _____ Phone: _____

Client's Date of Birth: _____ Age: _____ Gender: _____

Client's Ethnicity: _____

Client's Employer (or School): _____Occupation: _____

Guardian's Occupation: _____

Who referred you to this office? _____

Briefly describe your reasons for requesting services: _____

_____

List any previous mental health services you have received: _____

_____

Please list any medications the child is taking: _____

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.

APPOINTMENTS AND CANCELLATION POLICY:

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. 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.

CONTACTING US:

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 voice mail 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 911or 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.

CONFIDENTIALITY

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.**

PROFESSIONAL FEES:

The standard fee for a 38-52 minute session is $115. The standard fee for a 53-60 minute session is $135. Our fee for psychological evaluations is $150 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.

BILLING AND PAYMENTS:

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.

INSURANCE REIMBURSEMENT:

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.

CLIENT'S RIGHTS:

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.

CONSENT TO TREAT:

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.

_____

Client's Name (Please Print)

_____ _____

Client's Signature Date

CHILD DEVELOPMENTAL HISTORY

Please complete the following questionnaire as thoroughly as possible. If more space is needed, use the back of any page. Your answers will help your therapist assess your history more quickly, so that the time during your session can focus more on your specific concerns.

Child's Name: _____ Today's Date: _____
Form Completed By: _____Relationship to Child: _____

Presenting Circumstances

Who referred you to our office? _____

Current Caregiver: _____Relationship to Child: _____
Occupation: _____

Current Caregiver: _____ Relationship to Child: _____
Occupation: _____

Other Individuals Currently Living in the Home:
Name: _____ Age: _____ Relationship to Child: _____
Name: _____ Age: _____ Relationship to Child: _____
Name: _____ Age: _____ Relationship to Child: _____
Name: _____ Age: _____ Relationship to Child: _____

Please list others whom you feel have a significant impact on the child's life:
_____
_____

Names and ages of biological parents and siblings if not already listed:
_____
_____

Grade in school: _____ Name of School: _____
Overall Academic Performance: _____ Below Average _____ Average _____ Above Average
Has the child ever used special educational services? _____ Yes _____ No
Why were the services needed? _____
Is the child still receiving special services? _____ Yes _____ No
Please list any school behavior problems (detention, suspension, etc.):
_____
_____
_____

Please check all of the following that are of concern and are related to why the child is being brought to our office:

_____ Aggressive, angry feelings, temper
_____ Behavior problems
_____ Thoughts about hurting him/herself
_____ Difficulty making decisions
_____ Anxiety
_____ Medical problems
_____ Lack of self-confidence
_____ Poor concentration
_____ Nervous habits
_____ Crying spells
_____ Use of alcohol or drugs
_____ School problems
_____ Eating problems/Stomach trouble
_____ Family problems
_____ Sexual Concerns
_____ Memory problems
_____ Headaches
_____ Religious/Spiritual concerns
_____ Sleep difficulties
_____ Fidgety/restless, can't sit still
_____ Feelings of sadness or hopelessness
_____ Guilt feelings
_____ Problems with energy levels
_____ Bedwetting

When did these problems first appear? _____

Briefly describe your goals for therapy. What benefits do you hope your child will gain from therapy? What behaviors and/or feelings would you like to see improved?

_____
_____
_____
_____

Medical/Mental Health History

Please list any previous counseling, psychiatric care, mental health hospitalizations, or substance abuse treatment you child has had.

Doctor/Therapist/Hospital	Dates	Reason for Treatment

Please list all medications your child is currently taking.

Medication	Dose	When Taken	For What Condition

What psychiatric medications has your child taken in the past? _____

Please list any chronic health conditions. _____

Has your child had any significant medical problems, accidents, injuries, surgeries, or hospitalizations? If yes, briefly describe: _____
_____
_____
_____

Is your child allergic to any medications? If yes, which medication and what type of reaction did he/she have?

_____
_____

Who is your child's primary care physician?_____
Who is your child's psychiatrist (or clinician who prescribes psychiatric medications)?
_____

Substance Use History

Nicotine: _____ Yes _____ No _____ Yes, but in the past
If yes:
What type? _____ Cigarettes _____ Cigars _____ Chewing Tobacco _____ Pipe
Amount used per day: _____
How long has the child been using tobacco? _____
Any related health problems? _____

Alcohol: _____ Yes _____ No _____ Yes, but in the past
If Yes:
What type of alcohol? _____
How frequently? _____ Rare _____ Occasional _____ Moderate _____ Frequent
How much does the child typically drink at a time? _____
Type of alcohol use: _____ Social _____ Recreational _____ Problematic _____ Dependent
Pattern of use: _____ Daily _____ On weekends _____ Only at social events

Most recent use of alcohol: _____
Longest period of sobriety: _____
Any related health problems? _____
Any previous treatment for alcohol abuse? If yes, when and where?
_____
_____

Drugs: _____ Yes _____ No _____ Yes, but in the past
If yes:
What type(s)? _____
Amount typically used: _____
How frequently? _____ Rare _____ Occasional _____ Moderate _____ Frequent
How long has/did the child use? _____
Method (e.g., smoked, snorted, injected, etc.) _____
Most recent use of drugs: _____
Longest period of sobriety: _____ When was this? _____
Any related health problems? _____
Any previous treatment for drug abuse? If yes, when and where? _____
_____
_____

Family/Social/Legal/Educational History

Has the child experienced any traumatic events? (Death of close relative, sexual, physical, or emotional abuse, neglect, witness to violence, etc.)? If yes, please state the child's age at the time and describe the circumstances:
_____
_____
_____

Has the child ever been placed outside of the home (foster care, residential treatment, living with relatives, etc.)? If yes, please describe: _____
_____
_____
Has your child ever been involved with the criminal justice system? If yes, briefly describe:
_____
_____

Please list the types of leisure activities your child most enjoys:
_____
_____

Who does your child rely on for emotional support? _____ family _____ friends _____ no one
_____ teachers _____ neighbors _____ other (_____)

Religious affiliation: _____

Please list any groups or agencies you are involved with that may help your child with his/her problems (e.g., church groups, Alateen, Children's Division, Department of Mental Health, etc.):
_____
_____
_____

Feel free to make any additional comments that you feel are important to share about this child:
_____
_____
_____
_____
_____
_____

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: _____