Adolescent Personal Information

Counseling We Are Seeking: Individual ☐ Family ☐ Group ☐

Parent/ Guardian Info	Employer and Status
Name: _____ Date of Birth: ___/____/____ Address: _____ City: _____Zip: _____ Home #_____ Cell #_____ Work #_____ Other #_____ On what number may we leave a confidential message: Home ☐ Cell ☐ Work ☐ Other ☐ Email: _____ Appointment reminders via: Text ☐ Email ☐ None ☐ Do you prefer contact via email? Yes ☐ No ☐ How did you hear about Heartwood Family Therapy? _____	Company _____ Address _____ City _____Zip _____ Self-Employed ☐ Retired ☐ Unemployed ☐ I am: Single ☐ Married/ Partner ☐ Separated ☐ Divorced ☐ How long (to all that apply)? _____ How many in your household? _____ Do you have children, and if so, how many children? _____ How many in the home? _____
Name: _____ Date of Birth: ___/____/____ Address: _____ City: _____Zip: _____ Home #_____ Cell #_____ Work #_____ Other #_____ On what number may we leave a confidential message: Home ☐ Cell ☐ Work ☐ Other ☐ Email: _____ Do you prefer contact via email? Yes ☐ No ☐ How did you hear about Heartwood Family Therapy? _____	Company _____ Address _____ City _____Zip _____ Self-Employed ☐ Retired ☐ Unemployed ☐ I am: Single ☐ Married/ Partner ☐ Separated ☐ Divorced ☐ How long (to all that apply)? _____ How many in your household? _____ Do you have children, and if so, how many children? _____ How many in the home? _____

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements) _____

Is ex-spouse (biological parent) aware that you are bring their children to therapy? Yes ☐ No ☐

If not, please explain. _____

If adopted, does child know of adoption? Yes ☐ No ☐ What age was child at time of the adoption? _____

Child's Info	School and Status
Name: _____	School _____
Date of Birth: ____/_____/_____	Grade _____
Interests/ Extra-Curricular Activities: _____	Grades _____
_____	Previous Grades _____

Emergency Contact Information

Notify: _____ Relationship to Client _____

Phone number_____ Alternate Number _____

Is it acceptable to use the name Heartwood Family Therapy in messages of any nature? Yes ☐ No ☐

Health and Medical

Primary Care Physician for Child/ Teen: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems or head injuries: _____

_____

Please list any current medication: _____

_____

When are you available for an appointment? (all availability- put "p" for preferred, "a" for available)

50 Minute Sessions	Mon	Tues	Wed	Thurs	Fri	Sat
8am, 9am, 10am, 11am						
12pm, 1pm, 2pm, 3pm						
4pm, 5pm, 6pm, 7pm						

Additional Info

Are you required by a court of law to receive counseling as part of a legal proceeding? Yes ☐ No ☐
Have you obtained services from Heartwood before? Yes/ No If yes, when? _____
Are you interested in group therapy? Yes/ No If yes, what kind? _____
Are any other agencies involved with your family (CPS, Child Welfare, Courts)? _____

Please describe what concerns you have regarding your child: _____

_____

_____

How long has this problem existed? _____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years? _____

_____

_____

What attempts have been made to resolve the difficulty? _____

_____

_____

Consent for Treatment of a Family or a Child

Please read carefully

This is to certify that I give permission to Heartwood Family Therapy for my family or child's participation in therapy. The names of the family members in therapy are outlined below. Additional children may be listed on the back of page 2.

Name of Child: _____ Date of Birth: _____ Age: _____

Name of Child: _____ Date of Birth: _____ Age: _____

Parent's/Legal Guardian's Name: _____ Date of Birth: _____ Age: _____

Parent's/Legal Guardian's Name: _____ Date of Birth: _____ Age: _____

I. Fees and Appointments

1. Appointments are approximately 50 minutes, and ordinarily take place one time per week or as necessary. Your family/child's specific hour is held by their counselor from week to week. If you are unable to keep an appointment, please contact your therapist directly to cancel as soon as possible.

2. During your initial appointment you will be assigned a fee for your weekly sessions. We ask that you pay at the beginning of each session on a weekly basis. Heartwood Family Therapy reserves the right to suspend therapy for services rendered and not paid for after two sessions.

3. You will be allowed to cancel four sessions within a one year period with no charge, as long as you have canceled your appointment prior to the 48 hours before the appointment. The year begins on the date of your Intake Appointment. After four canceled appointments you will be responsible for payment of missed sessions. If you are able to reschedule your appointment within five working days, it will not count as a cancellation.

4. If you miss an appointment and have not contacted your counselor prior to the missed appointment, it will not be considered one of your four cancellations and you will be charged for that "no show" appointment.

5. Fees can be paid via cash, check or credit card. Payment is expected at each session unless other arrangements have been made in advanced. There will be a $35.00 service fee for any returned checks, and no more checks will be accepted.

6. You can and should discuss any concerns regarding your financial status with your counselor especially if your financial situation should change or improve. Additionally, once per year your fee will be reevaluated and if it is determined you are able to pay more, your fee may be adjusted

II. Confidentiality

1. Communication between you and your family/child's counselor is both privileged and confidential. This means that without your written permission the counselor cannot discuss your family/child's case orally or in writing.

2. Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:

a. If there is a reason to believe there is an occurrence of child, elder or dependent adult abuse or neglect.
b. If there is reason to believe that your child or a member of your family has serious intent to harm themselves, someone else, or property by a violent act they may commit.
c. If you introduce a family member's emotional condition into a legal proceeding your counselor is subpoenaed or court ordered to give testimony

3. Client Rights and Responsibilities

1. You have the right to end your family/child's therapy at any time, for whatever reason, without any obligation except for fees already incurred.

2. You have the right to question any aspect of your family/child's treatment with your counselor and to expect that we will work with you to meet your needs for adjunctive or alternative treatment.

3. If your child sees a counselor individually, you have the right to expect that their counselor, as requested, will communicate with you about your child's therapy. However, as the establishment of trust between your child and their counselor is important for a successful therapeutic outcome, we ask you to keep in mind your child's need for privacy.

4. You realize that if your child is seen in therapy, both parents may be asked to participate in the treatment. This may involve family treatment, parent meetings between you and your child's therapist, or individual therapy for each parent. Your therapist may share information regarding issues that arise in the course of the therapy with either parent.

5. You have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, which would greatly compromise the therapeutic relationship.

6. Heartwood Family Therapy does not provide psychological testing, acting as a witness in court cases, or report writing of any kind (except for providing evidence of attendance, upon request). You agree that you will not request any of these services from Heartwood Family Therapy.

7. Therapy involves a partnership between therapist and client. Your family's therapist will contribute knowledge, skills, and a willingness to do his/her best. The determination of success, however, is largely dependent upon your commitment to your family's personal growth and care. Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to Heartwood Family Therapy to provide counseling services and that this contract is binding for all future sessions you may have with this practice.

Parent/ Guardian Signature_____Date: _____

Parent/ Guardian Signature_____Date: _____

Client/Child Signature_____ Date: _____

Symptom Assessment

(If client is a teen, please have them fill this out. If a child, please assist them in filling out)

Please give as accurate account as you can and if you have any questions or concerns, please discuss them with your therapist.

I am experiencing…	Never	Seldom	Often	Always	For How Long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Avoiding people/places associated with trauma					
Nightmares about traumatic experiences					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					

I am feeling…	Never	Seldom	Often	Always	For How Long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self esteem					

I notice…	Never	Seldom	Often	Always	For How Long?
I am angry, irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I have…	Never	Seldom	Often	Always	For How Long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					

I have…	Never	Seldom	Often	Always	For How Long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

Symptom Assessment pg. 2

I use the following…	Never	Seldom	Often	Always	For How Long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

My eating involves…	Never	Seldom	Often	Always	For How Long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					

School and Self-Care	Never	Seldom	Often	Always	For How Long?
I can't go to sleep before 10pm					
I have problems with grades					
I have problems taking a shower					
I fall asleep in school					
I have to draw or talk during class					
I have a hard time getting out of bed					

Family History

Have *you* ever been hospitalized for a psychiatric illness? Yes ☐ No ☐

Has a *close relative* ever been hospitalized for a psychiatric illness? Yes ☐ No ☐

Does anyone in your family have a mental illness? Yes ☐ No ☐

Has anyone in your family every attempted or committed suicide? Yes ☐ No ☐

Does anyone in your family have a substance abuse problem? Yes ☐ No ☐

Have you ever been arrested? Yes ☐ No ☐

Current Assessment

On a scale of 1-10, with 1 being poor and 10 being excellent, please rate the following:

How are you doing on your job? _____

How well are you doing in your marital/ significant other relationship? _____

How well are you doing in your family relationship? _____

How well are you doing in relationships with people outside your family? _____

Please rate your current physical health? _____

Please rate your mood/ happiness level as of today? _____

CREDIT CARD AGREEMENT

Please note: Clients are **required** to have a credit card on file in order to secure the initial appointment. Clients will be charged for cancellation if therapist is not notified within 48 hours.

CC Type: MC ☐ Visa ☐ Amex ☐ Other _____

Name as shown on card _____

CC Number _____

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 48 hours notice (according to Heartwood Policy)
- Delinquent session fees (fees more than 30 days overdue)

Agreement:

"I _____ (print name) have read and understand the terms of providing my credit card to Julia Miller, LMFT. 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)

INFORMED CONSENT AGREEMENT

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell me immediately. I will make every effort to remedy the situation or provide you with names of other therapists should you prefer a referral. Psychotherapy has been shown to have benefits for those who undertake it. It often leads to reduction of feelings of distress, and to better relationships and resolution of specific problems. The objective is to find more peace, joy, and healthier relationships.

CONFIDENTIALITY:

As part of the counseling process, we are bound by ethical responsibilities to keep confidential the information shared during the sessions and I will not release any information without your written permission. There are important exceptions to the confidentiality of the counseling relationship. We are required by law to reveal certain information under the following circumstances:

a) Disclosure of serious intent to do harm to self or others

b) Disclosure of child abuse or my suspicion of child abuse, elder abuse, or dependent adult abuse

c) If a court of law orders the release of specific information, or if you introduce your emotional condition into a legal proceeding

APPOINTMENTS:

The length of a usual appointment is 50 minutes, except for the initial session, which may take up to an hour. Appointments are usually scheduled weekly and on a regular basis until you have accomplished the majority of your goals and other arrangements are made.

CANCELLATIONS AND MISSED APPOINTMENTS:

Cancellation of appointments must be made at least 48 hours in advance. A credit card number will be taken at the onset of your counseling. Late cancellations will be charged at the regular hourly fee to your credit card. If you have a true emergency (such as a visit to the ER) your credit card will not be charged.

PAYMENT:

Payment is expected at each session unless other arrangements have been made in advance. You are responsible for payment for all services rendered either by debit card, credit card, check or cash. All checks and credit cards will be paid to Heartwood Family Therapy.

CHECKS/OVERDUE ACCOUNTS:

There is a thirty-five dollar ($35.00) service charge for all checks returned by the bank.

TELEPHONE, TEXT AND EMAIL POLICY:

Generally we ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. We encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, our schedules does not permit us to talk on the phone, respond to lengthy texts or answer lengthy emails in between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, we will wait to discuss the content in our next scheduled session. If telephone calls are necessary for a client emergency, please allow for 24 hours to call you back. If there is a more urgent emergency, please call 911. *Please be advised that our scheduling software will text/email you a generic appointment reminder unless otherwise advised.

INSURANCE:

Some staff accept a number of insurances, please discuss this prior to your appointment. You are responsible for any amount left unpaid by your insurance.

PHYSICAL EXAMINATION:

We strongly recommend that each client obtain a thorough physical exam prior to commencing This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

EMERGENCIES:

Counseling services are available only during scheduled office hours. In a crisis, you may utilize the Sacramento County Mental Health Crisis Service (phone: 916-875-1000)

If you have any questions about Heartwood Family Therapy policies or about psychotherapy, please ask before signing below. Your signature indicates that you have read the policies and agree to enter therapy under these conditions. Further, it indicates your understanding that we may terminate therapy if you do not comply with the policies or if we feel you are not benefiting from treatment.

Client/Parent Signature_____

Date:_____

Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of this *Financial Policy* is important to our professional relationship. Please ask if you have any questions about my fees, financial policy, or your responsibility.

All patients must complete our ***Patient Information, Consent to Treat, Informed Consent, and Financial Policy*** forms before being treated.

REGARDING INSURANCE: Insurance is a contract between you and your insurance carrier. **We strongly encourage you to contact your insurance carrier to determine what coverage they provide for mental health therapy.** We cannot guarantee what your insurance carrier will pay; you will be responsible for any claims unpaid by the insurance. For those therapists who accept insurance, we file claims as a courtesy to patients. You must provide all necessary information for us to assist you with your billing. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc., other then to supply factual information as necessary. You are responsible for the timely payment of your account. For those who do not accept insurance, we work on a sliding scale and can provide a "super bill" for possible reimbursement by your insurance.

PRIVACY POLICY: It is our policy to provide only information that the insurance deems necessary to service your account. This may include diagnoses, treatment plans and progress updates as necessary. We will endeavor to keep your confidence as secure as we are able, and will inform you if more information is necessary in order for the insurance company to service your account.

We accept payment by **cash, check, Visa or MasterCard**.

I understand and accept the conditions of this financial policy, and authorize Heartwood Family Therapy to bill my insurance on my behalf, if applicable.

Signature: _____

Date: _____