THRIVE
COUNSELING & CONSULTING, PLLC ®

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NEW CLIENT INTAKE PACKET

CHILD 0-12 YRS

CONFIDENTIAL INFORMATION

THRIVE
COUNSELING & CONSULTING, PLLC

REGISTRATION FORM

Please make sure our office staff copies your insurance/ID card

SECTION I: Patient/Client Information

Date:____________________

Name:____________________ Nickname:____________ Age:______ Gender: ______ Race:________

Address:______________________________ City:______________ State:______ Zip:________

Cell Phone: ________________ Work Phone: ________________ Other Phone: ________________

The best number to contact me (or parent) is: Home Phone Work Phone Cell Phone

Can we contact you by email? *Email address:* ______________________________

I agree that Thrive may text me for appointment coordination and reminders: *Y / N*

Date of Birth: ___ / ___ / ___ Social Security #: ____________

Check appropriate box: Minor Single Married Widowed Separated Divorced

If student, name of school: ________________________ City/State: ______________ FT / PT

Emergency Contact: ____________________ Relationship: __________ Phone: ______________

Best weekdays and times for you to schedule appointments: ______________________________

Is anyone living in your household (partners, friends, children, &/or spouses) currently receiving care at Thrive? *Y / N*

Has anyone living in your household (partners, friends, children, &/or spouses) received care at Thrive in the past? *Y / N*

SECTION II: Responsible Party – Spouse or Parent/Guardian info, If client is a child

Relationship to Patient: Self Spouse Parent Other

Name (printed): ____ SSN: ______________

Address (If different than above): ____

City: ______________ State: _____ Zip: ____________ Phone: ________________

Employer: ______________________________ Work Phone: ______________________

SECTION III: Insurance Information

Please circle one: Aetna • BCBS • Cash • Cigna • Tricare Prime • Tricare Prime Retired
Tricare Standard • Tricare Standard Retired • Other: __________

Name of Insured (Sponsor): ______________________________ DOB: ________________

Relationship to Patient: ____

Sponsor SSN: ____________ Name of Employer: ______________ Work Phone: ____________

Address of Employer: ______________________ City: ____________ State: _____ Zip: ________

Insurance Company: ________________ Group #: ________________ ID #: ______________

By providing this information, you are authorizing us to bill your insurance(s) for services provided to you for your family members.

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO *IF YES, COMPLETE THE FOLLOWING:*

Insurance Company: ________________ Group #: ____________ ID #:________________

YOU MUST inform us immediately if there are any insurance changes, or you may be responsible for payment.

Client Signature **Date** _____ / _____ / _____

Updated 6.20.19

THRIVE
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PARENT/GUARDIAN ASSESSMENT

MINOR 0-17

Child's Name: ______________________ **DOB:** ____ / ____ / ____ **Age:** ______ **Gender:** M / F

How did you hear about Thrive (check one)?

- ❑ Our website
- ❑ Referred by medical professional
- ❑ Referred by other professional
- ❑ Psychology Today
- ❑ Referred by a friend or family member
- ❑ Referred by a church: ______________________
- ❑ Social media
- ❑ Military resource
- ❑ Other ______________

Please circle ALL of the following that describe how your child has been feeling lately:

anxious • depressed • frightened • guilty • angry • ashamed • aggressive • resentful • worthless

sad • tearful • irritable • confused • extreme up • extreme down • jealous • hopeless • helpless

Describe any other feelings your child has expressed: ______________________

Briefly describe your child's problem as you understand it: ______________________

____

Does your child participate in regular exercise? ❑ Yes ❑ No

Child's hobbies: ______________________

Describe your child's current school environment: ______________________

Has your child had any changes in his/her sleeping habits? ❑ Yes ❑ No
Describe: ______________________

Has your child had any changes in eating habits? ❑ Yes ❑ No
Describe: ______________________

THOUGHTS: Please check any of the following that apply to your child:

- ❑ sometimes hears voices, even though no one nearby is talking to him/her
- ❑ sometimes wants to kill him/herself
- ❑ sometimes feels controlled by forces outside him/her
- ❑ sometimes feels that other people control his/her thoughts
- ❑ sometimes has the same thought over and over and cannot control it
- ❑ sometimes feels that someone is out to hurt or act against him/her
- ❑ sometimes unable to control his/her behavior
- ❑ sometimes wishes he/she was dead

Please list your Therapy Goals for your child:

____

____

____

Parent/Guardian Signature: ______________________ **Date:** _____ / _____ / _____

Updated: 1.29.20

THRIVE
COUNSELING & CONSULTING, PLLC

NEW CLIENT SIGNATURE PAGE

MINOR 0-17

NAME: ____ **DOB (mm/dd/yy):** _____ / _____ / _____

1. The information provided on the registration is true to the best of my knowledge.
2. By my signature, I authorize Thrive Counseling & Consulting, PLLC therapists to treat myself or the above-named minor. In the event that the minor client changes therapists, I understand that I must sign a new and specific Release of Information to any new therapist to be authorized access to the minor's progress notes and clinical file.
3. I hereby acknowledge that I have received, read, and understood Thrive Counseling & Consulting, PLLC's Client Handbook, which includes: Client Rights & Responsibilities Policy, Social Media & Client Communication Policy, Notice of Privacy Practices (HIPAA), and Office Information & General Policies. I understand that if I have any questions regarding the notice of my privacy rights or any other policies in the handbook, I can contact the owners of Thrive Counseling & Consulting, PLLC.
4. I understand that if I refuse treatment for the minor client, my therapist shall determine whether treatment in some other modality is possible. If I refuse treatment via other modalities, the minor client may be discharged from services.

Parent/Guardian Signature *Parent/Guardian Printed Name* *Date*

❑ Client refuses to acknowledge receipt of Notice of Privacy Practices *Staff Member Signature*

Thrive Counseling & Consulting, PLLC seeks to help each client achieve their goals. If you don't understand the following, please discuss with your therapist or with administrative staff before you sign.

1. Thrive Counseling & Consulting, PLLC is the corporation that does business.
2. Each individual therapist is either a contractor or employee of the above corporation
3. It is our intention at Thrive Counseling & Consulting, PLLC that you get the help that you need. It is therefore important that your therapist is a good fit for you and your minor. **Please let your therapist know exactly what your expectations are and what changes you are looking for. Do this during your first session. If you believe at some point that it is not a good fit for your minor, we encourage you to speak to the therapist first to see if adjustments can be made.** If you discover it is still not a good fit, please ask your therapist for a referral to another therapist at Thrive Counseling & Consulting, PLLC who may be a better fit for your minor.

I have read & understood the above.

Parent/Guardian Signature *Date*

Name of Minor's Primary Care Physician/Clinic: ____

(If the minor does not have a PCM, or you do not want us to communicate with their PCM, write "None" and sign)

Parent/Guardian Signature *Date*

Please sign under ONLY ONE of these choices:

SELF-PAY CLIENTS ONLY: I attest that:

a. I do not have insurance coverage; OR
b. I have insurance coverage but choose not to use it, and in doing so I am waiving any right to reimbursement; OR
c. I have insurance coverage, but understand that my services are not covered by the plan.
d. I agree to pay the rate as disclosed in my therapist's professional disclosure.

Parent/Guardian Signature *Date*

INSURANCE CLIENTS ONLY: I authorize any insurance benefits to be paid directly to Thrive Counseling & Consulting, PLLC, or any of its contract therapists who provide services to me or my family members. I understand that I am financially responsible for any balance. I also authorize Thrive Counseling & Consulting, PLLC (or the entities listed above) and/or my insurance company to release information required to process my claims.

Parent/Guardian Signature *Date*

THRIVE
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CONSENT FOR PSYCHOLOGICAL TREATMENT OF A MINOR (0-17 YRS)

Referred by *(Self/Agency/Doctor/Clinician)*: ______________________________

Parent/Guardian/Step-parent Full Name: ______________________________

Child's Full Name: ______________________________

Child's Birthdate (MM/DD/YY): ________ / ________ / ________ **Grade in School:** ______________

Home Address where Child Lives: ______________________________

Home Phone: ______________ **OK to call here?** *Yes No* **OK to leave voice messages?** *Yes No*

Biological Father's Full Name: ______________________________

Home # ______________ Cell # ______________ Email: ______________

Biological Mother's Full Name: ______________________________

Home # ______________ Cell # ______________ Email: ______________

(CHECK ONE) **Step-parent's Legal Guardian's Full Name:** ______________________________

Home # ______________ Cell # ______________ Email: ______________

EMERGENCY CONTACT: In the case of an emergency involving this minor, I give permission to the clinician to contact:

Name: ______________ **Relationship:** ______________ **Phone:** ______________

1. **My relationship with this child is as:** .... *Biological Parent Step-parent Legal Guardian Other*
2. **If you are the step-parent of this child, do you have any written authorization to seek care for this child?** .... *Yes No N/A*
3. **Are you the parent of this child through adoption?** .... *Yes No N/A*
4. **Were you ever married to the biological parent of this child?** .... *Yes No N/A*
5. **Are you currently divorced, separated, or in custody litigation with the other biological parent of this child?** .... *Yes No N/A*
6. **Are you authorized by a custody, guardian, or separation agreement/decree to seek treatment for this child?** *If yes, see COURT DECREES below* .... *Yes No N/A*
7. **Are both biological parents alive?** .... *Yes No N/A*
8. **Is one biological parent not involved in this child's life?** .... *Yes No N/A*
9. **Does the minor have regular contact with both biological parents?** .... *Yes No N/A*
10. **If step-parent, is the biological parent currently deployed or outside of the country?** .... *Yes No N/A*
11. **Is there any domestic violence occurring in the home between parents, step-parents, or other family members living in the home?** .... *Yes No N/A*
12. **Are you a step-parent who will be bringing the child and paying for services?** .... *Yes No N/A*
13. **Will you agree to update the minor's paperwork if legal changes occur in the relationships affecting this child?** .... *Yes No N/A*

COURT DECREES:

Civilian (Non-Military) Consumer: *If you answered yes to question #6—please provide a copy of the North Carolina court decree.*

Military/Federal Employee: *If you answered yes to question #6—please provide a copy of the appropriate state court's decree.*

NOTE: *Joint custody and care authorization must be specifically stipulated on the court decree for one parent/legal guardian to authorize the Consent to Treat for their child.*

PLEASE PROVIDE US WITH A COPY OF YOUR CURRENT COURT CUSTODY AGREEMENT.

NOTE: *If someone other than the biological parent or legal guardian (i.e. step-parent) is bringing a child to counseling, they must provide a current Notarized Power of Attorney (POA) from the biological parent that allows you at a minimum to give consent for care and pay for services of the minor client.* ***Unless specifically stated in the POA, a step-parent will not have access to the child's medical records.***

PLEASE PROVIDE US WITH A COPY OF YOUR NOTARIZED POWER OF ATTORNEY.

Child's current medication(s) and dosage *(If none, state "none")*: ____

If child is on medication, please provide the doctor's name, address, and phone number: ______________________________

____

PLEASE COMPLETE A RELASE OF INFORMATION BETWEEN THRIVE AND YOUR CHILD'S DOCTOR.

Does this child have any acute medical conditions or any immediate life-threating conditions?........................ *Yes* *No*

If "yes", please list: ____

FOR PARENT(S)/LEGAL GUARDIAN(S) ONLY

I/we, ____, as the biological parent(s) or legal guardian(s), request that ____ (name of clinician) provide psychological assessment and/or treatment to ______________________________ (name of child), a minor child/adolescent. This form is to document consent for assessment and treatment as well as an agreement to the conditions of the assessment and/or treatment. I understand that the clinician's primary responsibility is my child's best interest and he/she may decide to involve me in my child's evaluation and/or treatment at his/her sole discretion. **I understand that the clinician is NOT agreeing to be an expert witness or to testify on my behalf or any other individual's behalf at dispositions, court proceedings, or other legal proceedings. I understand that the clinician DOES NOT agree to meet with me, my attorney, or any other party or attorney in custodial or divorce proceedings. My signature below means that I have read, understood, and agree to abide by the above statement:**

____

SIGNATURE OF PARENT/LEGAL GUARDIAN 1 | *SIGNATURE OF PARENT/LEGAL GUARDIAN 2* | *DATE*

____

SIGNATURE OF MINOR CLIENT | *SIGNATURE OF CLINICIAN* | *DATE*

FOR STEP-PARENT ONLY

I, ______________________________________, as the step-parent and in accordance with my Power of Attorney, request that ____ (name of clinician) provide psychological assessment and/or treatment to ____ (name of child), a minor child/adolescent. I understand that the clinician's primary responsibility is the child's best interest and that he/she will not involve me in the child's evaluation and/or treatment unless specifically stated in my Power of Attorney and at his/her sole discretion. **I understand that the clinician IS NOT agreeing to be an expert witness or to testify on my behalf or on the behalf of the POA signer at dispositions, court proceedings, or other legal proceedings. I understand that the therapist DOES NOT agree to meet with me, the POA signer, my attorney, or any other party or attorney in custodial or divorce proceedings. Further, I agree and understand that I will only have access to the child's records if it is specifically stated in my Power of Attorney by the parent/legal guardian. My signature below means that I have read, understood, and agree to abide by the above statement:**

____

SIGNATURE OF STEP-PARENT 1 | *SIGNATURE OF STEP-PARENT 2* | *DATE*

____

SIGNATURE OF MINOR CLIENT | *SIGNATURE OF CLINICIAN* | *DATE*

OFFICE USE ONLY

Child can be seen with only one parent's consent?.. *Yes* *No*

Justification:____

Child's family is a Military Family or Federal Employee Family?... *Yes* *No*

Parent provided the following documents:

- ❑ Court Custody Decree from _______________ (ST)
- ❑ Separation agreement that specifies having permission to seek counseling for child

Step-parent provided a Power of Attorney that specifies:

- ❑ Permission to consent to treatment for child
- ❑ Permission to pay for treatment as necessary
- ❑ Permission to access child's medical records and discuss child as directed by clinician

Reason child needs both biological parents'/legal guardians' signatures: ____________________________________

____

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CHILD STATEMENT OF CONFIDENTIALITY

(AGES 0-12)

Minors do not have the legal status to enter into a written agreement of informed consent regarding the counseling process, the risks and benefits of counseling, and the limits of confidentiality. Therefore, having signed the clinician's Professional Disclosure Statement regarding counseling services, I/we, ______________________________ **(parent[s]/legal guardian[s] name[s])**, the parent(s)/legal guardian(s) of ______________________________ **(name of minor)**, give my permission for him/her to receive counseling services/treatments/assessments for the purposes of:

1. ______________________________

2. ______________________________

Minors DO NOT have legal right to confidentiality. However, to ensure the integrity of the counseling process and to provide the minor with an atmosphere of trust with the clinician, confidentiality should be provided to the minor to the greatest extent possible. Regardless of the age of the client, confidentiality CANNOT be maintained under the circumstances explained in the standard limits of confidentiality shared on the informed consent form. I/we agree that these limits have been fully explained by the clinician to the minor in my presence.

Additionally, as the parent(s)/legal guardian(s), I/we wish to place limits on confidentiality based on the areas I/we have initialed below. This means that **should any of the topics initialed below arise, I/we desire to be informed of such by the clinician.** Therefore, the clinician may not give assurance of confidentiality to the minor in areas that have been initialed. By initialing certain issues below, I/we acknowledge the possible impact this may have on my minor's ability to feel free to discuss his/her feelings and thoughts, thereby limiting the effectiveness of the counseling process. If I/we do not initial a specific topic, and should such topic arise during therapy with the minor, the clinician will attempt to bring the minor to a point where he/she can inform me of the issue. The clinician will attempt to gain permission from the minor to inform me/us of the issue(s) as well. I/we understand that any disclosure that falls under the limits of confidentiality discussed in the therapist's Professional Disclosure Statement, regardless of my indication below, will be reported to me/us immediately.

- ❑ Illegal drug use
- ❑ Drinking and driving
- ❑ Having a gun or other weapon
- ❑ Tobacco use
- ❑ Getting a girl pregnant
- ❑ Planning to run away
- ❑ Alcohol use
- ❑ Being pregnant
- ❑ Lying about where he/she goes
- ❑ Having an STD
- ❑ Suicidal ideation
- ❑ Sneaking out of home or school
- ❑ Sexual behavior
- ❑ Sexual identity and/or orientation
- ❑ Other: __________

My/Our signature(s) below means that I/we have read, have understood, and agree with the above statement:

SIGNATURE OF PARENT/GUARDIAN 1 *DATE* *SIGNATURE OF PARENT/GUARDIAN 2* *DATE*

I have discussed above statement with the signing adult(s). My observations lead me to believe that the signing adult(s) is/are fully authorized and competent to give informed consent for the minor client's counseling.

SIGNATURE OF CLINICIAN *DATE*