THRIVE
COUNSELING & CONSULTING, PLLC®

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NEW CLIENT INTAKE PACKET

CHILD 13-17 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
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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*

Updated 1.30.20

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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ADOLESCENT STATEMENT OF CONFIDENTIALITY & CONSENT TO TREAT

(13-17 YEARS)

Your Rights & My Policies

WHAT TO EXPECT

The purpose of meeting with a clinician (a therapist or counselor) is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life, like school and personal relationships. You may be here because you wanted to talk with a clinician about these problems. Or, you may be here because your parent, guardian, doctor, or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you, and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and safe, and have more trust in their clinician. Privacy, also called **confidentiality**, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I'm required by law or by guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

CONFIDENTIALITY CANNOT BE MAINTAINED WHEN:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe that you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person whom you intend to harm.
- You tell me you are being abused physically, sexually, or emotionally, or that you have been abused in the past. In this situation, I am required by law to report the abuse to the North Carolina Department of Health and Human Social Services.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.
- I'm a provisionally licensed clinician who is required to have supervision as a part of my working toward full licensure. I will disclose your information to my supervisor specifically and only for supervision-related discussion.

COMMUNICATING WITH YOUR PARENT(S) OR GUARDIAN(S):

Except for situations such as those mentioned above, I will not tell your parent(s) or guardian(s) specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent(s)/guardian(s) would not approve of, or would be upset by, but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in danger, I will communicate this information to your parent(s)/guardian(s).

If you need hypothetical examples of these behaviors or activities, we can discuss this during our first intake session so that you will know what the boundaries are for our therapeutic relationship. Please feel free to ask me any questions.

Please understand, even if I have agreed to keep information confidential, my first duty is to protect you. I want to assist you in facilitating a healthy relationship with your parent(s)/guardian(s) and good personal boundaries. I believe that your parent(s)/guardian(s) should be informed of extreme or excessive risk-taking behavior that is going on in your life. In these situations, I will encourage you to tell your parent(s) or guardian(s) and will help you find the best way to tell them. Also, when meeting with your parent(s)/guardian(s), I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

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ADOLESCENT STATEMENT OF CONFIDENTIALITY & CONSENT TO TREAT

(13-17 YEARS)

COMMUNICATING WITH OTHER ADULTS:

SCHOOL: I will not share any information with your school unless I have your permission and permission from your parent(s)/guardian(s). Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission, but both I and your parent(s)/guardian(s) believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

DOCTORS: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or clinician. I will get your written permission and permission from your parent(s)/guardian(s) in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk of serious and immediate physical/medical harm.

ADOLESCENT THERAPY CLIENT:

Signing below indicates that you have reviewed the information described above, understand the limits to confidentiality, **and consent (agree) to treatment**. If you have any questions as we progress with therapy, you can ask your clinician at any time.

PRINTED NAME OF MINOR

MINOR'S SIGNATURE *DATE*

PARENT(S)/GUARDIAN(S): Check boxes and sign below indicating your agreement to respect your adolescent's privacy.

- ❑ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates abut general progress, and/or may be asked to participate in therapy sessions or parent/guardian's update sessions as needed.
- ❑ Although I know I may or may not have the legal right to request written records/session notes since my child is a minor, I agree **NOT** to request these records in order to respect the confidentiality of my adolescent's treatment.
- ❑ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the clinician's professional judgment as guided by NC law, ethical considerations, and confidential collaboration/consultation with other professionals.

PARENT/GUARDIAN SIGNATURE *DATE*

PARENT/GUARDIAN SIGNATURE *DATE*

CLINICIAN SIGNATURE *DATE*