New Perspective Counseling Services
Child/Teen Intake Form

Welcome to New Perspective Counseling Services. We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us to better understand your situation as well as potential solutions in helping you get your life back on track.

CHILD'S INFORMATION

Child's Full Name: _____ Nick Name: _____

Date of Birth: _____ Age: _____ Sex: ☐Female ☐Male Grade Level: _____

In an emergency, who do we call? Contact Name: _____ Contact Phone: _____

PARENT/GUARDIAN INFORMATION

Mother's Name: _____Date of Birth: _____ SSN: _____

Street Address: _____ City/State:_____ Zip Code: _____

Home Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Email Address: _____ Is it okay to e-mail? ☐ Yes ☐ No

Religious Affiliation (if any): _____ Relationship Status: ☐ Single ☐ Engaged ☐ Married

☐ Re-Married ☐ Separated ☐ Divorced ☐ Same-Sex Partners ☐ Widowed

Father's Name: _____Date of Birth: _____ SSN: _____

Street Address: _____ City/State:_____ Zip Code: _____

Home Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Email Address: _____ Is it okay to e-mail? ☐ Yes ☐ No

Religious Affiliation (if any): _____Relationship Status: ☐ Single ☐ Engaged ☐ Married

☐ Re-Married ☐ Separated ☐ Divorced ☐ Same-Sex Partners ☐ Widowed

If divorced or not married Parents have: ☐ Joint Custody ☐ Mother has custody ☐ Father has custody

Do both parents have equal rights to seek medical/psychological treatment for your child? ☐ Yes ☐ No
Can you provide legal documentation? ☐ Yes ☐ No

INSURANCE INFORMATION:

Primary Insurance Carrier:_____ID #: _____ Group#: _____

Insured: _____ Date of Birth: _____ Employer: _____

Insurance Co. Phone # (Mental Health): _____Relationship to child: _____

Please be prepared to provide our office staff with your insurance card so that we may make a copy.

HOUSEHOLD INFORMATION

Pets in the home? ☐ Yes ☐ No; If so, what type? _____

List any other individuals living in your home: _____

_____

Who will participate in your child's therapy? MOM: ☐ Yes ☐ No DAD: ☐ Yes ☐ No SIBLING: ☐ Yes ☐ No

STEP MOM: ☐ Yes ☐ No STEP DAD: ☐ Yes ☐ No OTHER: ☐ Yes ☐ No; If yes, who? _____

CHILD'S MEDICAL AND MENTAL HEALTH HISTORY / INFORMATION

Primary Physician: _____Primary Physician Phone: _____

Is the child currently being treated by a physician for any medical conditions? If so, please describe:

_____

Is the child currently taking medication? ☐No ☐ Yes; Medication name/dose: _____

_____

Has the child ever seen a Psychiatrist or any other mental health provider? ☐No ☐ Yes;

If yes, when? _____ Focus of treatment? Any diagnosis given?: _____

_____

Do you feel it was helpful? ☐ Yes ☐ No

CHILD'S EDUCATION:

What school does your child currently attend? _____ Current Grade: _____

Has your child ever skipped or repeated a grade? ☐ Yes ☐ No; If yes, which one? _____ was skipped/repeated (circle)

Child's Favorite Subject(s): _____ Least Favorite Subject(s): _____

Has your child ever received special education services? ☐ Yes ☐ No; If yes, please elaborate (under what classification):_____

Has your child received any academic or psychological testing done at school or elsewhere? ☐ Yes ☐ No

If Yes, when and where?_____

What do school teachers tell you about your child? _____

_____

Has your child experienced any of the following problems at school? (check all that apply):

☐ Poor Grades	☐ Lack of Friends	☐ Poor Attendance
☐ Learning Disabilities	☐ Emotional Issues	☐ Fighting
☐ Incomplete Homework	☐ Being Bullied	☐ Suspension
☐ Behavioral Issues	☐ Bullying Others	☐ Drugs/Alcohol

YOUR CHILD'S ROUTINE:

What kinds of physical exercise does your child engage in? _____

Are there any issues surrounding eating that you have observed with your child? _____

_____

Approximately how many hours of sleep does your child get per night? _____

COUNSELING CONCERNS

☐ Difficulty focusing or prioritizing	☐ Irritable
☐ Overactive/restless	☐ Nightmares
☐ Do or say things without thinking about the consequences	☐ Can't stop thinking about a past experience
☐ Hot temper	☐ Anxious
☐ Bad memory	☐ Preoccupied with body weight or shape
☐ Feel that people are conspiring against him/her	☐ Do things that are harmful to self or others
☐ Hear or see things that other people don't hear or see	☐ Chronic relationship problems
☐ Feel hopeless	☐ Difficulty telling the truth
☐ Thinking about suicide	☐ Getting into physical fights
☐ Weight loss/gain	☐ Stressful home conditions
☐ Intense highs and lows with his/her mood	☐ Experiences that he or she does not understand
☐ Can't slow down thinking	☐ Homicidal thoughts
☐ Panicky	☐ Overly dependent on others
☐ Extreme fear of a specific object, activity, or situation	☐ Lack of motivation
☐ Going out of my way to avoid things that he or she fears	☐ Working too hard
☐ Worry about what others might think of him/her	☐ Crying/tearful
☐ Feel driven to do things over and over	☐ Eating problems (i.e., not eating, binging, etc.)
☐ Frequent, unwanted thoughts or images	☐ Drinking or using drugs

In your own words, what specifically are the issues for which you are currently seeking assistance? Please be specific:

1. _____ 3. _____

2. _____ 4. _____

What have you previously tried in order to resolve these issues (e.g. religious counseling, talking with family/friends)? Were any of these efforts helpful? _____

_____

Have you noticed anything that tends to make the issues more intensified? _____

_____

What would you say are your child's greatest strengths are as a person? _____

_____

COUNSELING GOALS

Goals are very important in counseling. They provide your child's therapist with a focus and direction that will help us to help your child. Please list the goal(s) that you hope to address in counseling. Please be as specific as possible.

1. _____ 2. _____

3. _____ 4. _____

RISK ASSESSMENT

Is there any family history of mental illness or substance abuse? ☐ Yes ☐ No; if so, please list relationship & diagnosis:

_____

List any of your child's personal history of emotional, physical, and/or sexual abuse: _____

_____

Has a family member or close friend of your child's ever committed suicide? ☐ Yes ☐ No If so, please list relationship to your child: _____

Has your child reported having any thoughts of harming self or others? ☐Yes ☐ No ☐ Self ☐Other(s)

If yes, please describe the situation:_____

_____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent/caretaker)? ☐ Yes ☐ No If yes, please explain: _____

_____

Are there any guns or weapons in your house? ☐ Yes ☐ No If so, please specify what type & who it belongs to: _____

_____

Has the child ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation)? If so, please state under what circumstances:_____

_____

Please list family, friends, support groups and community groups which are helpful to your child: _____

_____

REFERRAL SOURCE

How did you learn about this office? (Please check one and provide name as indicated):

☐Insurance Co._____ ☐ Physician _____ ☐ Advertising (source) _____

☐ Internet_____ ☐ Friend _____ ☐ Other _____

By signing below, I confirm that the above information is true and correct.

Client's Name (please print): _____

Guardian's Name (please print): _____

Guardian's Signature: _____ Date: _____/_____/____

New Perspective Counseling Services

Client Financial Agreement

CANCELLATIONS AND MISSED APPOINTMENT AND POLICY

I understand that my appointment time is reserved for me at the exclusion of others who may be waiting to see the therapist. I understand that if am not able to attend my appointment, I must give 24-hour advance notice. If I cancel on the day of my appointment, my account will incur a $50 fee and if I fail to show without any advance notice, my account will incur a $100 fee. I agree to call the office at 469-362-8004 if I need to cancel or re-schedule and appointment and I am aware that the voicemail system at NPCS records the day and time of all messages left. If I cancel or miss appointments on a consistent basis without reasonable cause, NPCS reserves the right to refer me elsewhere for services. I understand that this policy is not meant to be punitive, but instead is to request consideration for the professionals who are providing me a valuable service.

RETURNED CHECKS

I understand that any check not honored by our bank will result in a $35 returned check fee. Returned checks must be re-paid by cash, money order, or credit card. Failure to pay any returned check and fees may result in criminal prosecution.

FEES, PAYMENT, & INSURANCE REIMBURSEMENT:

I understand that I am fully responsible for the payment of all fees for services provided by NPCS. I understand that if I have insurance, NPCS will either file the claim on my behalf or will provide me with the necessary information so that I can file the claim myself. I understand that I am ultimately responsible for any therapy fees not covered by my insurance carrier. Co-pays and non-covered services are payable at the time of service. In the event that insurance is billed on my behalf, my signature below authorizes payment of mental health benefits to New Perspective Counseling Services.

I understand that it is NPCS' policy that the fee for any session is payable at the beginning of the session. NPCS accepts cash, checks, credit cards, or PayPal as forms of payment. *All sessions are 45 - 50-minutes in length (*longer sessions may be available for additional fee*)*. The fee for an initial intake session is $175.00 and the fee for follow up sessions is $140. My therapist may offer me a sliding scale fee based on my income (which would be determined at the time of my intake). While sessions are not typically conducted by phone, if an emergency phone consultation is initiated by the client, the first 10-minutes are at no charge. However, $25.00 will be billed to your account for each subsequent 15-minute period. Should you request a copy of your counseling records, please be aware that there is a $50 record preparation fee (and a "Release of Records" must be signed).

My signature below indicates that I have read, understand, and agree to the statements made above regarding Cancellations and Missed Appointments, Returned Check Policy, and Payment & Insurance Reimbursement. I authorize and agree to have my credit card information (as listed below) kept on file and charged for Late Cancel appointments, No Show appointments, and outstanding balances on my account that have not been paid or payment arrangements made after 30 days. By signing below I also certify that the credit card information I am providing is accurate and I am an authorized user on the account.

Client Name (please print): _____

Guardian Signature: _____ Date: _____/_____/_____

*** NPCS*REQUIRES A CREDIT CARD ON FILE***

☐ VISA ☐ MasterCard ☐ DISCOVER	CARD NUMBER	EXP DATE	CVV CODE
I hereby give consent to charge my credit card below for any outstanding balance at the end of each month such as deductibles, co-payments or other amounts my carrier determines as payable by me.		CARD HOLDER NAME	
CARD HOLDER SIGNATURE			DATE

New Perspective Counseling Services

Limits of Confidentiality and Client Rights

Limits of Confidentiality

I understand that the contents of a counseling, intake, or assessment session are protected under the confidentiality laws of the State of Texas. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- Signed authorization to release information to a specific individual or organization.
- Therapist determination that you may harm yourself or someone else
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or disabled
- Disclosure of professional misconduct of another mental health professional
- Court order or requirement by law to disclose information
- Prenatal exposure to controlled substances
- In the event of a client's death (the spouse or parents of a deceased client have a right to access their child's or spouse's records)
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client's records)
- Insurance Companies (only information required for billing purposes)

Client Bill of Rights

NPCS does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability, or public assistance status.

Every client shall:

- be informed prior to, or at the time of the intake appointment of services available at NPCS and of any financial charges that are the client's responsibility to pay beyond the coverage of health insurance.
- expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
- have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
- have the freedom to place grievances and recommend changes in policies and services to NPCS staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, services offered by practitioners licensed by the State of Texas have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; and (c) obtain a copy of the rules of conduct

By my signature below, I agree that I understand my right to confidentiality and the above noted exceptions.

Client Name (please print): _____

Guardian Signature: _____ Date: _____/_____/_____

New Perspective Counseling Services

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

When the therapists at NPCS consult, evaluate, diagnose, treat, and/or refer you (the client or minor client that you represent), we will be collecting what the law calls “protected health information” (PHI) about you. At NPCS, we are very careful to keep your health information secure and confidential. The HIPAA law requires us to maintain your privacy, to give you this notice, and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; or disclose your health information for payment of your services from your insurance company; or in an emergency, we may disclose your health information to a family member or another person responsible for your care. We also may release some or all of your health information when required by law (please refer to our “Limits of Confidentiality”).

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will need to submit any limitation requests in writing. Although we will try to respect your wishes, we are not legally required to accept these limitations. You have the right to know of any uses or disclosures we make with your health information. You have the right to transfer copies of your health information to another practice. You have the right to request an amendment or change to your health information. Please submit your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. If you believe that your privacy rights have been violated, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F, Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, we ask that you please contact our office at info@npcs.com or 469-362-8004 x300.

By signing this form, you are agreeing to let us use your PHI in the manner described above. Your signature below acknowledges that you have read this notice and are aware our notice of privacy practices.

Client Name (please print): _____

Guardian Signature: _____ Date: _____/_____/_____

New Perspective Counseling Services

Court Testimony Agreement & Information

NPCS providers DO NOT perform court evaluations nor do they voluntarily appear in court on behalf of individuals, children or families. NPCS services are designed to assist clients with their difficulties through individual or relational psychotherapy. NPCS providers are not trained for, nor do they typically maintain the type of records intended for use in court.

In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, to testify whether factual or in an expert nature, in court or deposition.

In the event that it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer or to testify at a deposition, whether the testimony is "factual" or "expert", or is required to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services. These billable services include, but are not limited to: travel, necessary expenditures (e.g.: copies, parking, meals, etc.), time spent speaking with attorneys, reviewing records, and preparation of reports at the rate of $250.00 per hour, rounded to the nearest half hour.

The client further agrees to pay a retainer fee of $2,000.00 *two weeks prior* to the appearance, presentation of records, or testimony requested (or at time of subpoena if less than two weeks' notice is given). Checks will not be considered an acceptable form of payment for these services.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (the client) nor your attorney, or anyone else acting on your behalf, will call on your therapist at NPCS to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. ***My informed consent signature below shows that this litigation limitation is clearly understood and agreed to.***

Initial one of the following:

_____ I AM seeking counseling for court testimony or court involvement on behalf of my therapist at NPCS.

_____ I AM NOT seeking counseling for court testimony or court involvement on behalf of my therapist at NPCS.

By signing this form, you are acknowledging you have let a NPCS representative and/or Therapist (before a counseling relationship is established) know if you and/or your child is attending counseling for court or court related purposes/motivations.

Client Name (please print): _____ Date: _____/_____/_____

Guardian Signature: _____ Date: _____/_____/_____

Therapist Signature: _____ Date: _____/_____/_____

New Perspective Counseling Services

Electronic Communication and Contact Policy

SOCIAL NETWORKING

The therapists at NPCS do not accept friend requests from current or former clients on social networking sites (e.g. Facebook) due to the fact that these sites can compromise both the clients' and therapist's confidentiality and privacy. For the same reason, NPCS therapists request that clients do not communicate with them via any interactive or social networking websites.

IN PERSON, OUTSIDE OF OUR OFFICE

In an effort to further protect your confidentiality, if your therapist sees you in public, the therapist will only acknowledge you if you approach him or her first.

TEXTING POLICIES

If you checked "yes" on your intake form indicating that you give your permission for our office to contact you via text, you may be contacted to schedule, confirm, or cancel an appointment with your therapist. Unless otherwise stated by your therapist, texting your therapist should be limited to scheduling or confirming an appointment or notifying her that you may be running late for an appointment. Please be aware that texting is not an appropriate method of reaching out to your therapist in a crisis.

PHONE CONTACT

Outside of your regularly scheduled weekly session, in the event of a crisis situation one brief (no more than five minutes) phone call is acceptable on occasion between sessions. It is important that you first consider utilizing your therapy tools, and other support systems between therapy sessions before contacting your therapist unless it is an emergency or a crisis situation. For phone consultations exceeding ten minutes, you will be billed according to our financial policy. If you are suicidal or have a life threatening situation, please contact 911 immediately.

E-MAIL CONTACT

Outside of your regularly scheduled weekly session, a short email (no more than a paragraph) is acceptable on occasion between sessions. Your emails should be geared toward confirming or changing appointments, and not discussing therapeutic topics, sending photos, jokes, or other such emails as the relationship is of a professional therapeutic nature. Any other topics outside of this are best saved for your session.

RESPONSE TIME

Please allow at least 24-hours for a reply regarding routine matters. As your therapist sees numerous clients per week, s/he may receive multiple emails and calls from many clients. Please be considerate of your therapist's personal time.

My Signature below indicates that I have read and agree to NPCS' Electronic Communication and Contact Policy

Client Name (please print): _____ Date: _____/_____/_____

Guardian Signature: _____ Date: _____/_____/_____