

# Innovations Counseling and Consulting PLLC

## Patient Information

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_ Referred by: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive our quarterly newsletter by email? Yes \_\_\_\_\_ No \_\_\_\_\_

What phone number/method is best for communication with you: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

In the event of an emergency whom should we contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cellular # \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

## Who Is Financially Responsible for this account? Who is the insured?

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Insurance Co. Name and Policy #: \_\_\_\_\_

Insurance Co. Phone # for Mental Health: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Email: \_\_\_\_\_

## Authorization and Release:

- ❖ I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- ❖ I authorize/request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me.
- ❖ I am informed of HIPAA guidelines and regulations related to confidentiality of medical records.
- ❖ I agree to be responsible for payment of all services rendered on my behalf or for my dependents.
- ❖ I agree to notify your office more than 24 business hours in advance if I need to reschedule or cancel an appointment.

X \_\_\_\_\_

Signature and Printed Name of Responsible Party

Date

**\*\*\*Please Provide Your Insurance Card & Driver's License for Verification of Benefits and Identity\*\*\***

# Innovations Counseling and Consulting PLLC

## Credit Card Authorization

(Credit cards are the preferred method of payment or we will need a check retainer on file.)

**Please make no marks or add comments to this page of the document.** It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the event that you miss or fail to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

An additional \$25 fee will be assessed for 1.) returned checks, and 2.) inaccurately disputed charge-backs.

I, \_\_\_\_\_, hereby authorize Innovations Counseling and Consulting PLLC to bill my credit card at the usual fee for professional services including all of the following:

- ❖ Appointments and/or copayments that I elect to pay for by credit card
- ❖ Missed appointments
- ❖ Telephone and email consultations
- ❖ Appointments that I have cancelled with less than 24 business hours notice
- ❖ Returned checks
- ❖ Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

Visa       MasterCard       Discover       American Express

Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Verification/Security Code (3-digit code on back of card by signature line): \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

Your Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

By signing below I am authorizing Innovations Counseling and Consulting PLLC to bill my credit card at the usual fee for professional services as described above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

# Innovations Counseling and Consulting PLLC

## Patient and Responsible Party Informed Consent

❖ **Please make no marks or add comments to this page of the document. It is your consent for your child's psychotherapy services and treatment is conditional on your signing this consent without modification.**

❖ I understand that the therapists abide by state and federal regulations regarding health and medical record keeping and confidentiality (most commonly referred to as HIPAA regulations) and that a copy of this document has been provided to me to review in the office and on the website.

❖ I understand that if any assignment is given that I disagree with morally, ethically, spiritually, or emotionally, I have the right not to proceed with that assignment. I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.

❖ I understand that there are some occasions when confidentiality can/must be breached. These are: a) I sign a Release of Information Form or I verbally direct my counselor to tell someone else, b) My counselor determines that his/her client poses a threat to self or others, c) My counselor is ordered by a court to disclose information, or d) My counselor suspects child/elder abuse has taken place and will notify Child/Adult Protective Services.

❖ I understand that counseling can improve as well as upset the equilibrium in any person, relationship, or family.

❖ I understand that if I have a complaint I cannot resolve with my counselor and I wish to file a formal complaint I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

❖ **FEES:** I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay and that sessions are 45-minutes in duration, cost \$135.00 per session (or the insurance contracted rate), and that all fees and co-pays are due at the time of service and account balances are not carried. Professional letters, short-term disability paperwork/forms, and other documents may be completed for a fee starting at \$60.00 based upon the complexity of the task. I understand that there is a returned check fee of \$25.00 and that if a returned check is not cleared up in 30 days my counselor will file a suit with the Harris County District Attorney's Office. I understand that if I do not give at least 24 business hours notice in canceling an appointment I will be charged the regular session fee and I must pay this fee before additional sessions may be scheduled.

The preferred method of payment is credit card but I may keep a check retainer on file with the provider's office.

❖ I understand that my therapist is not a psychiatrist, he/she is a licensed Master's level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see a physician for a medical evaluation.

**By signing below I confirm that I have read, agree to and received the above information.**

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Child's Printed Name

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Parent or Responsible Party Signature and Printed Name

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Date Received and Read

# Innovations Counseling and Consulting PLLC

## CHILD INFORMATION FORM

Name \_\_\_\_\_ Date of 1<sup>st</sup> Appointment \_\_\_\_\_ Therapist \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

### MEDICAL HISTORY

Name of Primary Care Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: \_\_\_\_\_

Date of last medical evaluation: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Current medications being taken:

- 1) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 2) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 3) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 4) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems your child experiences: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Innovations Counseling and Consulting PLLC

## SCHOOL HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? (Circle One) YES NO If yes, please explain: \_\_\_\_\_

What was the last grade/year of school your child completed? \_\_\_\_\_

What school is he/she attending? \_\_\_\_\_ Is your child home-schooled? (Circle One) YES NO

Please check all information which applies to your child's biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____# of times		<input type="checkbox"/> remarried _____# of times

With whom does your child live: \_\_\_\_\_

What custody and/or visitation orders are in place? : \_\_\_\_\_

**\* Please copy orders to be placed in client's file.**

Does your child consider anyone else to be a "parent" in his/her life? YES NO If so, whom?\_ \_\_\_\_\_

Describe your relationship with your child:

Currently: \_\_\_\_\_

In the past: \_\_\_\_\_

Describe your child's relationship with his/her other parent:

Currently: \_\_\_\_\_

In the past: \_\_\_\_\_

List first names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse: \_\_\_\_\_

Sexual/physical/emotional abuse: \_\_\_\_\_

Others living in the home with your child:

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# Innovations Counseling and Consulting PLLC

## MENTAL STATUS

Please check any of the following that describe how you believe your child has been feeling lately:

sad  anxious  depressed  frightened  guilty  angry  ashamed  aggressive  resentful  
 worthless  tearful  irritable  confused  extreme ups/downs  jealous  hopeless  helpless

Describe any behaviors your child has demonstrated that cause concern: \_\_\_\_\_  
\_\_\_\_\_

Has your child had any change in sleeping habits? (Circle One) YES NO Describe: \_\_\_\_\_  
\_\_\_\_\_

Has your child had any change in eating habits? (Circle One) YES NO

Describe: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever considered suicide in connection with his/her **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: \_\_\_\_\_

Has your child ever **considered suicide** in the **past**? (Circle One) YES NO

Has your child **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: \_\_\_\_\_  
\_\_\_\_\_

Has your child tried to hurt others or animals recently or in the past? (Circle One) YES NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

## LEVEL OF FUNCTIONING

Please describe what activities your child participates in: \_\_\_\_\_  
\_\_\_\_\_

Who is in your child's support network? \_\_\_\_\_  
\_\_\_\_\_

Please describe your child's level of physical activity: \_\_\_\_\_  
\_\_\_\_\_

How much time does your child play on the computer, watch TV, or play video games: \_\_\_\_\_  
\_\_\_\_\_

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses.  
\_\_\_\_\_  
\_\_\_\_\_

Please list your therapy goals for your child:  
\_\_\_\_\_  
\_\_\_\_\_

THANK YOU!

Child Intake Form