Adolescent Information Form

(to be completed by adolescent)

Today's Date: _____ Phone Number: _____

Name: _____ Birthdate: _____ Age: _____

Nickname (if any): _____ Gender: _____

Home Address: _____

Parent's/Guardian's Names: _____

Where/with whom do you live? _____

Where do you go to school? _____ Highest grade completed: _____

Are you employed/where: _____ Do you enjoy your job: _____

Name of church (if applicable): _____

Did you participate in the decision to start counseling? _____

Please describe what brings you to counseling at this time._____

_____

_____

What do you hope to gain through counseling? _____

_____

What have you already done to deal with the issue you are seeking counseling for? _____

_____

_____

Are you struggling with suicidal thoughts? ☐ Yes ☐ No If yes, how often?

Circle one: Constantly Often Somewhat Not very much

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when?_____

Do you exercise? ☐ Yes ☐ No

If yes, how many times per week? _____ For how long? _____

Do you smoke cigarettes? _____ How many cigarettes do you smoke per day? _____

Do you consume alcohol? _____ How many drinks per day? _____ Week? _____

Do you take any non-prescribed (recreational) drugs? ☐ Yes ☐ No

If yes, what drugs do you consume and how often? _____

_____

Interactions between client and counselor are confidential. Unless I have permission from you, what we talk about will be private. I will not discuss it with anyone else.

There are four major exceptions to this confidentiality the laws requires all mental health professionals to report:

- Incidences of child or elder abuse or neglect.
- Intent to commit suicide.
- Threats to do harm to yourself or another person.
- Court order.

_____ _____

Client Signature Date

Adolescent Intake Information

(to be completed by Parent/Guardian)

Client's Full Name: _____

Client's Date of Birth: _____

Client's Address: _____

City, State, Zip Code: _____

Can mail be sent? Y N

Client's Phone Number: _____

[ ] Cell [ ] Home [ ] Work Can messages be left? Y N

Alternate Phone Number: _____

[ ] Cell [ ] Home [ ] Work Can messages be left? Y N

Email Address: _____

Can email be sent? Y N

Parent/Guardian Name: _____

Parent/Guardian Number(s): _____

Client's Social Security Number: _____

Who Referred Client: _____

Please take the time to fill out this form in its entirety.
Your answers on the following pages will help me give your child the best possible care.

Family Information

Please list everyone living in the home with your child other significant family members:

Name	Relationship	Age	Health Concerns	Comments

Medical Information

From whom or where does your child get medical care?

Clinic/Doctor's name: _____ Phone:_____

Address: _____

Current medication:

Medication	Strength	Dosage	Length Taken	Side Effects

Significant medical problems and/or diagnoses? ☐Yes ☐No

If yes, provide the description of problem(s):

Have your child ever been hospitalized for a mental illness?

☐ Yes ☐ No If yes, provide the description of problem(s):

School/Grade: _____

Does your child like school? ☐ Yes ☐ No

If no, describe your understanding for why they do not enjoy school (e.g., studying, social issues, etc.):_____

_____

Hobbies/Interests:_____

What would you like to accomplish with counseling? _____

_____

What obstacles could get in the way? _____

_____

Has your child been in therapy before or received any prior professional assistance for your concerns? If so, please give dates of treatment and results: _____

_____

_____

Do you have any other information you would like to share that would help me work with your child? _____

_____

_____

To the best of my knowledge, the information provided is accurate and true.

_____ _____

Signature of Parent/Guardian Date

Counseling Informed Consent

CONFIDENTIALITY: Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission, except where disclosure is required by law. **Initial _____**

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychotherapy, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper treatment. For this purpose, I may also contact the person whose name you have provided on the client information sheet as your emergency contact. **Initial _____**

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. **Initial _____**

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for at least 6 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstance or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records with signed authorizations from all the adults involved in the treatment. **Initial _____**

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call me at 580-744-9811. If an emergency situation arises, indicate it clearly in your message. If you need to talk to someone right away, call 911 or go to your nearest emergency room. **Initial _____**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. I want you to be open and honest. We may talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. I do not prescribe medications. **Initial _____**

TREATMENT PLANS: I usually consider our first 1-3 sessions to be an evaluative time where I am working to better understand you and your concerns and you are exploring what it would be like to continue working together. Should we feel that I am a good fit for you, I will typically schedule one session per week at a time we agree on, although we may decide to meet more or less frequently. I will then discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits.
Initial _____

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that case, I will give you a number of referrals you can contact. If at any point during therapy you are non-compliant, I will terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time. **Initial _____**

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are unavoidable. I will never publicly acknowledge working with you without written permission. I will not accept you as a client if I feel a significant dual or multiple relationships exists. It is your responsibility to advise me if any dual or multiple relationships becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare. You may do the same at any time. **Initial _____**

COURT TESTIMONY: The goal of psychotherapy is the reduction of stress and interpersonal conflict. Additionally, by starting treatment, you are agreeing not to involve me in legal proceedings or attempt to obtain treatment records for legal or court proceedings. In the event that I am required to provide treatment records or testimony in any legal proceeding, you will be charged $150 per hour for any preparation time I or other personnel spend getting ready to appear or turn over documents. You are agreeing to pay $600 per 4-hour block of time that I spend being "on call" to testify, traveling to and from court/deposition, waiting to appear, and/or testifying. The minimum charge will be for 4 hours of time and subsequent time will be billed in 4-hour blocks. The initial $600 is due in full one-week prior to any scheduled court appearance/deposition. **Initial _____**

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, I may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking sites. **Initial _____**

I have read the above policies. I understand them and agree to comply with them.

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date

Revised 3.24.17

Financial Agreement

This Financial Agreement contains information that informs you about my financial policies and procedures. Please read this Financial Agreement carefully and ask any questions you may have. You will be asked to sign this agreement, indicating that you have read it, understand and agree to the policies and procedures outlined.

- Attendance at Appointments
  - If you are unable to keep a scheduled appointment, please notify by phone at least 24-hours in advance to avoid a $50 no show/late cancellation charge.
  - Arriving more than 15 min late for any scheduled appointment will be considered the same as a no show/late cancellation and $50 will be charged to the debit/credit card on file.
- Fees and Payment
  - The standard fee for a counseling session is $100.00 per 50 minute session.
  - Payment for your portion is expected in full at the time of your session. Checks are made payable to: Amanda Percival. I also accept cash, Visa, MasterCard and Discover.
  - I am a contracted provider with several insurance companies. I will be happy to file claims to those insurance companies that I am contracted with. If you wish to file for out-of-network insurance benefits, your fee cannot be reduced and you must pay the standard fee of $100. A receipt appropriate for submitting to your insurance company will be provided. You must pay for your session and have your insurance company reimbursement made directly to you.
  - I will review all past due accounts on a monthly basis. Clients who have balances on their account will be mailed a statement. If a client owes for two appointments, a third appointment will not be scheduled until the account balance is paid in full. In addition, if there is a return check or missed appointment charge on an account, payment is required prior to an appointment being scheduled.
  - There may be a charge based on the standard fee for the following: for any phone consultation over 10 minutes in length, for letters or forms requiring the therapist's time, for consultation time with an outside party or other professional provider.
  - A $25 fee is charged for each returned check.
- Initial Appointment
  - During your initial appointment, you will be asked to put a valid debit/credit card number on file. This policy gives consent to charge you $50 if you fail to give 24 hours advance notice when canceling an appointment or are more than 15 minutes late.
  - I will discuss with you how I handle emergency situations in regards to charging your debit/credit card.
- Agreement (please initial appropriate fee agreement)

_____ I agree to pay $100 per counseling session.

_____ I would like to have my insurance billed for counseling sessions. I agree to pay my portion at the time of service.

_____ _____

Signature of Client/Guardian Date

118 N. Oakwood Road • Enid • OK • 73703 • contact@amandapercival.com

My Valid Debit/Credit Card Information

Debit/Credit Card: (circle one) VISA MASTERCARD DISCOVER

Number: _____

Expiration Date: _____

CVV: _____ Billing Zip Code: _____

I authorize Amanda Percival, PLLC and Amanda Percival, LPC to charge payments for services as stated in the Financial Agreement.

_____ _____

Signature of Client/Guardian Date

The following is about who carries the insurance

Subscriber's Full Name: _____

Subscriber's Date of Birth: _____

Subscriber's Address: _____

City, State, Zip Code: _____

Subscriber's Phone Number: _____

Insurance Company: _____

Subscriber ID: _____

Policy Group Number: _____

Client's relationship to the insured: (circle one) Self Spouse Child Other

I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the supplier of services, Amanda Percival, PLLC, LPC.

_____ _____

Signature of Client/Guardian Date

HIPAA Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review this information carefully.

WHAT I AM REQUIRED TO DO:

I am required by applicable federal and state laws to maintain the privacy of your health information. I am also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this notice while it is in effect.

I reserve the right to change the Notice at any time, provided changes made are applicable to the law. I reserve the right to make changes in our privacy policy and the new terms of the policy will be effective for all health information that I maintain, even the information created or received before the policy was changed. Before any significant changes are made to the policy, I will change this notice and make the new notice available upon request.

You may request a copy of this notice at any time. For more information about our privacy practices, or for additional copies of his notice, please contact me using information listed at the end of this notice.

Private Health Information may be used and disclosed in the following circumstances:

PAYMENT: Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.

TO YOUR FAMILY AND FRIENDS: Unless directly involved in your treatment or responsible for the payment of your account, your healthcare information cannot be disclosed to family or friends without your written prior approval. The only exception to this policy is if you become a danger to yourself or others, I may notify your friends or family members.

MARKETING HEALTH-RELATED SERVICES: I will not use your health information for marketing communications without your written prior consent.

REQUIRED BY LAW: I may disclose your health information when required by law to do so.

ABUSE OR NEGLECT: Your Private Health Information will be disclosed to appropriate authorities if I reasonably believe that you are a possible victim of abuse or neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: I may disclose to military authorities the health information of Armed Services personnel under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence or other national security activities. Under certain circumstance, I may disclose your health information to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients.

APPOINTMENT INFORMATION REMINDERS: I may use or disclose your health information to provide you with appointment reminders such as voice-mail, text message, email, postcards or letters.

PATIENT RIGHTS

YOUR AUTHORIZATION: In addition to the uses listed above, you may give written authorization to use your health information or to disclose it to any other professional for professional purposes. If you give a written authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give a written authorization, I cannot use or disclose your health information for any reason except those described in this notice.

ACCESS: You have the right to review or get copies of some of your health information by signing a written release. If needed, interpretation of the records will be provided for reasonable cost-based fee of $520. Requests for records will be honored within 30-60 days.

DISCLOSURE ACCOUNTING: You have the right to request a listing of all instances in which your health information was released for purposes other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12 month period, you may be charged a reasonable cost-based fee for responding to these additional requests.

AMENDMENT: You have the right to request that amending to your health information. Your request must be in writing, and it must explain why the information should be amended. Your request may be denied under certain circumstances.

As a private practitioner, I have the responsibility to make each client aware of the Privacy Notice and make the necessary changes to the Privacy Notice that are required by law.

If you as the client feel your privacy has been violated, you have the right to contact the U.S. Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/.

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

Notice to Client:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of this office's HIPAA Notice of Privacy Practices.

_____
Please print your name here

_____
Signature of Client/Guardian

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this client, but it could not be obtained because:

_____ Client refused to sign.
_____ Due to an emergency situation, it was not possible to obtain an acknowledgment.
_____ I wasn't able to communicate with the client.
_____ Other (please provide specific details) _____

_____ _____
Therapist Signature Date

118 N. Oakwood Road • Enid • OK • 73703 • contact@amandapercival.com