Griffin Therapy Center
EMPOWERMENT FOR HEALING

Child and Adolescent Intake

Child's Name _____ Age _____ Date of Birth _____

Parent Names _____

Home Address _____

Cell # _____ Cell # _____

Okay to call and leave messages? Yes No *(please circle)* Okay to text? Yes No

Parent Email _____

Is it okay to communicate via email*? Yes No *Email correspondence is not considered to be a confidential medium of communication

Child's School and Phone # _____ Current Grade _____

Primary Teacher or School Contact _____

What are your primary reasons for seeking counseling for your child at this time? _____

_____

_____

_____

How long have you been concerned about this problem? _____

What are your goals in bringing your child to counseling? What would you like to see change?

_____

_____

_____

Parents' Status

Married ___ Divorced ___ Separated ___ Domestic Partnership ___
Never Married ___ Mother Deceased ___ Father Deceased ___ Other _____

Please list important members of the child's family, including siblings and stepfamily.

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check the following reasons for seeking treatment and care at this time

___ Academic Problems (decline in grades, difficulty focusing)
___ Behavioral Concerns
___ Depression, Lack of interest in hobbies or activities
___ Delinquent Behavior; Describe _____
___ Poor Self-esteem
___ Repetitive or Obsessive Behavior; Describe _____
___ Bed Wetting
___ Adjustment to divorce or blended family
___ Adjustment to the death of a loved one; Who? _____
___ Fears and/or anxiety
___ Hyperactivity, Impulsiveness
___ Aggressive Behavior
___ Other; Describe _____
___ Other; Describe _____
___ Other; Describe _____

Have you sought treatment before? If so, provide the name of your child's previous counselor, psychologist or psychiatrist _____

How was this support helpful/unhelpful? _____

_____

How long did you see this provider? _____

List of child's current medication _____

Reason for current prescriptions _____

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-Coordination of Treatment –

Your absence of signature denies permission to coordinate care.

In an effort to provide the best wraparound services possible it can be helpful for counselors to communicate with the other healthcare providers involved in treatment, such as your primary care doctor and/or your child's psychiatrist. (Fill in only if applicable)

Treatment Provider's Name _____

Clinic Address _____ Phone # _____

_____ _____ _____
Parent or Guardian's Printed Name Parent or Guardian's Signature Date

_____ _____ _____
Counselor's Printed Name Counselor's Signature Date

Academic concerns can also be addressed by counselors keeping in contact with primary teachers and professionals in the school setting. (Fill in only if applicable)

Teacher's Name _____ Subject/Grade _____

Email Address _____ Phone Number _____

Teacher's Name _____ Subject/Grade _____

Email Address _____ Phone Number _____

_____ _____ _____
Parent or Guardian's Printed Name Parent or Guardian's Signature Date

_____ _____ _____
Counselor's Printed Name Counselor's Signature Date

If your child has been in trouble with the law please indicate the result

_____

Probationary concerns can also be addressed by counselors keeping in contact with your Probation or Parole officers. (Fill in only if applicable)

Probation/Parole Officer's Name _____
Office Address _____ Phone # _____

_____ _____ _____
Parent or Guardian's Printed Name Parent or Guardian's Signature Date

_____ _____ _____
Counselor's Printed Name Counselor's Signature Date

Limits of Confidentiality

The law protects the relationship between a client and a psychotherapist meaning information cannot be disclosed without parent or guardian written permission. Exclusions include:

- I must break confidentiality if a client is threatening serious bodily harm to another person/s, in order to notify the police and to inform the intended victim.
- I am required by law to immediately report any suspected child or elder abuse to the appropriate authority.
- If a client intends to harm him or herself, I will make every effort to enlist their cooperation to ensure client safety. If he or she does not cooperate, I will take further measures without permission that are provided to me by law in order to ensure safety.

In Case of Emergency

Below is a list of people that can be contacted in order to prevent harm or in case of emergency.

Name	Phone Number	Relationship
Name	Phone Number	Relationship

Parent or Guardian's Printed Name	Parent or Guardian's Signature	Date
Counselor's Printed Name	Counselor's Signature	Date

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Policies and Payment

Thank you for choosing Griffin Therapy Center. Griffin Therapy Center is a private practice counseling agency providing out-patient mental health care. Hilary Harrington is a Licensed Professional Counselor Intern under the supervision of Terri Gonzales, Ph.D, LPC-S.

Effects of Counseling: Successful growth and healing begins with a collaborative relationship between the client and therapist. We will work together to navigate your concerns and determine how your thoughts affect both your feelings and behavior. While benefits are expected from counseling specific results are not guaranteed. Counseling my lead to major changes in your relationships, job, and/or your understanding of yourself. Potential risks of counseling include a lack of progress, upsetting insight, and feelings of distress. Counseling requires a very active effort on your part and you will need to work on the things we talk about both during sessions and at home in order to be most successful.

Relationship: Although our counseling sessions may be intimate psychologically, our relationship is professional rather than social. Contact with your counselor will be limited to communication directly related to your counseling process. If you see your counselor in public, we will protect your confidentiality by acknowledging you only if you approach us first.

Appointments: For appointments, cancellations, or to reschedule please contact me by call, text, or email. If you are not able to keep your appointment, please notify me as soon as possible and at least 24 hours in advance. *If you do not provide 24 hour notice, you will be billed the full cost of the counseling session.* If you are 15 minutes late it is considered a no show, and the cancellation fee will apply.

Contacting Me: Messages are usually returned within 24 hours. Phone messages left after 4pm Friday will be returned the following Monday. For life threatening emergencies, please call 911 or go to your local emergency room. Additionally, you may contact the Crisis Help Line at 972-233-2233 or the Teen Help Line 972-233-8336.

Fees: Individual and Couples rate is $60 per session. If insurance is filed and the insurance company fails to pay, you will be responsible for all counseling fees. If you do not provide 24 hours advance notice for cancellations, you will be billed the full cost of the counseling session. Additional hourly fees will be assessed on a prorated basis for phone calls lasting over 10 minutes and professional services you require such as report writing, attendance at meetings, consultation with other professionals which you have authorized, preparation of records, or the time required to perform other services you request of me.

If you become involved in litigation which requires my participation, you will be expected to pay for the professional time required at a rate of $150 an hour (3 hour minimum) for testimony and preparation time in addition to any travel fees even if I am compelled to testify by another party.

You are responsible for all fees including any no show fees, late fees, and fees that your insurance company fails to pay. Fees are due at the time of service unless other prior arrangements have been made. Unpaid fees may be subject to a $25 late fee, a $30 bounced check fee, and/or any collections fees plus a $70 collections fee.

I agree to the billing terms set forth above, and agree to store this card on file for the future use of billing. This includes automatic drafting of payments for late-cancellation and no-show fees.

Card Number: _____ Expiration Date:_____

3-Digit Code:_____ Billing Zip Code: _____

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Counselor's Printed Name	Counselor's Signature	Date

HIPAA

HIPAA (Health Insurance Portability and Accountability Act)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Notice of Client Rights

• You have the right to receive full information from your counselor about his or her professional knowledge, skills, preparation, experience, and credentials.
• You have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.
• You have the right to have explained to you how a therapy technique works as well as given an explanation for its intended purpose before it is employed.
• You have the right to refuse a particular therapy technique or method.
• You have the right to request restrictions on certain uses and disclosures of your counseling records. However, your counselor is not required to agree to a restriction you request.
• You have the right to request and receive confidential communications from your counselor by alternative means and at alternative locations. For example, if you don't want coworkers to know you are seeing a therapist, you can direct your counselor to telephone you only at home.
• You have the right to inspect and/or obtain a copy of your, or your minor child's, counseling record for as long as the record is maintained. Your counselor may deny your request.
• You have the right to request an amendment of your or your minor child's counseling record for as long as the record is maintained. Your counselor may deny your request.
• You generally have the right to receive an accounting of disclosures from your or your minor child's counseling record, for which you have neither provided consent nor authorization. Such disclosures are described under the section: "Limits of Confidentiality" above.
• You have the right to complain should you believe your privacy rights have been violated. In such cases first discuss the concern with your counselor to seek a satisfactory resolution, which may include a referral. If you are not satisfied with the outcome, you may file a written complaint to the Texas Department of Human Services (DHS) to further assist in resolving the matter:

Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369
Or call 1-800-942-5540 to request the appropriate form or obtain more information.

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Counselor's Printed Name	Counselor's Signature	Date

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Notice of Privacy Practices

• Your counselor has been and will always be totally committed to maintaining clients' confidentiality. He or she will only release information about your counseling records in accordance with federal and state laws and ethics of the counseling profession. This notice describes your counselor's policies related to the use and disclosure of your counseling records. Uses and disclosure of your counseling records for the purposes of providing services, providing treatment services, collecting payment, and conducting counseling operations are necessary activities for quality care. State and federal laws allow your counselor to use and disclose information from your counseling records for these purposes.
• Treatment—your counselor may need to use or disclose information from your counseling records to provide, manage, or coordinate your treatment or related services, which could include consultations with medical or mental health professionals and potential referral sources.
• Payment—your counselor may need to disclose information from your counseling records that is needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes.
• Counseling Operations—your counselor may need to use information about you to review his treatment procedures and business activity. This may involve supplying a government agency with statistical data. In such cases your name and personal information will not be divulged.
• Other uses or disclosure of your information that does not require your authorization or consent—these disclosures are described under the section: "Limits of Confidentiality" above

My signature below indicates I have been given a notice of this document for my personal keeping. In addition I have online access to the above HIPAA information at www.griffintherapycenter.com

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Counselor's Printed Name	Counselor's Signature	Date