HGCC CHILD INTAKE PACKET

Parent/Guardian needs to complete this form

It is the policy of Healing Grace to provide services to all persons without regard to race, ethnicity, nationality, religion, gender, sexuality, age or ability status. No person shall be excluded from participation in, be denied the benefits of any service, or be subjected to discrimination because of race, ethnicity, nationality, religion, gender, sexuality, age or ability status.

CLIENT INFO

Client Legal Name: _____ Preferred Name:_____

Date of Birth: ____ / ____ / _____ Social Security # (For Billing Purposes): _____

Address: _____ City/State: _____ Zip: _____

Email:_____

*please note we do not send email reminders

Biological Sex:

□ Male □ Female □ Intersex

Gender:_____

Preferred Pronouns:_____

TEXT REMINDERS

For your convenience, Healing Grace now offers appointment text reminders. This electronic communication will only relate to scheduling and will not, under any circumstances relate to therapy itself. These are automated text reminders sent out from our HIPPA compliant scheduling software not from your therapist. You are not able to cancel replying to this text message. All cancellations must be done by phone directly to your therapist. Please be aware this is considered an unsecure form of communication and there is a potential chance that a third party may be able to intercept these messages

Do we have your permission to send appointment text reminders? YES NO (please circle)

Cell Phone # for Test Reminders (only 1 # allowed per our system):_____

Are you required by a court of law to receive counseling as part of a legal proceeding? Yes / No

Have you ever received counseling services from HGCC or any other organization? Yes / No If yes, where/when?

INVOLVEMENT IN CARE

I hereby request the following person(s) to be allowed to participate in my care and/or payment decision-making process. I understand these person(s) may be given health or payment information about me.

NAME	RELATIONSHIP	PHONE NUMBER	TYPE OF INFO (Billing, Scheduling, Clinical, All)

HGCC will make a reasonable effort to provide only the necessary information for the person(s) to make an informed decision or to receive printed/verbal protected health information.

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Relationship to client: _____

HEALTH & MEDICAL

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

_____

Please list any current medications: _____

PAYMENT POLICY

Insurance – The insurance benefits quoted by your insurance company and/or HGCC are not a guarantee of payment. Benefits can change periodically and may affect the amount that your insurance company will pay. The final confirmation of your benefits and copay will appear on the Explanation of Benefits you receive from the insurance company. You are financially responsible for any and all charges not covered by your individual policy.

Out of Pocket – All fees, including copays are due at the time of service. Our billing staff is not authorized to split payments or to run a specific dollar amount on certain days of the month. We accept cash, checks, (payable to Healing Grace) major credit cards, debit cards and health saving cards.

PAYMENT INFO

How will you be paying for services (✓which applies):

☐ **Seeing Cash Rate Provider** ☐ **Using Insurance**

(online scholarship application must be completed if seeing cash rate provider)

Primary Insurance Company: _____Policy Holder ID #: _____

Group #: _____ Policy Holder's Name: _____

Date of Birth: ____ / ____ / ____ SS#: _____ Relationship to Client: _____

Secondary Insurance Company: _____Policy Holder ID #: _____

Group #: _____ Policy Holder's Name: _____

Date of Birth: ____ / ____ / ____ SS#: _____ Relationship to Client: _____

CANCELLATION POLICY

Effective October 1st, 2022

Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is canceled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the waiting list, or a client with a clinical emergency.

For these reasons, we kindly ask for *at least* 24-hour cancellation notice by phone, directly to your therapist extension. If you cancel or no show after the 24-hour period, no matter what the reason is for cancellation, you **will** be charged a missed flat rate fee of **$100.00,** regardless of what you currently pay per session. The missed fee is your responsibility and cannot be billed to your insurance company.

You can avoid a cancellation/missed session fee by:

- Have a Telehealth session instead - this is where a counselor provides psychological counseling and support over video conferencing or a telephone call. This is especially beneficial during inclement weather, transportation issues, sick kids, etc. This is **not** our preferred method of therapy, however within good reason, can be approved by a supervisor. Remember to keep in mind the state that your therapist is licensed in, as they are not *all* licensed to provide therapy in states other than Missouri. Please note: Internet, a computer or mobile device, an integrated or external microphone and camera are required for video conferencing.

The information I have given is true and correct. I have read all the above policies and by signing below agree to its terms and conditions. I also agree to notify Healing Grace staff if address, insurance, or any other changes occur during my therapy.

Client's Signature: _____ Date: _____

(if applicable)

Parent/Guardian: _____ Date: _____

Spouse Signature: _____ Date: _____

Healing Grace
Counseling Center

Consent for Treatment

We are committed to providing you with the best possible care. Please read and initial each item:

_____1. Therapy

I understand there are no guarantees made to me regarding therapy treatment. My decision is voluntary, and I understand that I may terminate these services at any time. I understand that during treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

_____ 2. Compliance with Treatment Plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may force Healing Grace to transfer my care to a different counseling practice.

_____ 3. Payment

I understand all fees are due at the time of session. If I choose to use insurance, I authorize my insurance carrier to pay HGCC for billed services. I understand any and all charges not covered by my insurance are my financial responsibility and are subject to collections.

_____ 4. Confidentiality

All information shared in session is confidential except in circumstances governed by Federal and State law, including 1) to warn others of life-threatening concerns should it become necessary, 2) to notify appropriate state agencies of any suspicion of child or dependent adult abuse and 3) to provide information in legal cases when under court order.

_____ 5. Release of Information

I authorize the release of any medical or other information necessary to process claims, or otherwise collect payment on my account. All other medical records requests require a separate signed authorization document and records cannot be released until we receive that form.

_____ 6. Minor Children

We require at least one parent signature to authorize treatment for a minor. (Missouri law states any person under the age of 18 is considered a minor). Please be aware additional signatures/authorizations may be required depending on custody or other legal disputes. I agree to read the Parental Agreement document provided and bring a signed copy to my first session.

_____ 7. No Harm Agreement

I agree that I will not engage in self harm and/or harm to others. I agree I will take the following actions if I violate this agreement. 1) I will call 911 if I believe that I am in immediate danger of harming myself/ or others. 2) I will call any or all 24-hour suicide prevention lines (1-800-SUICIDE) and I will continue talking on the phone for as long as necessary until the suicidal thoughts have subsided. For non-life-threatening, clinical emergencies, please call 316-246-4465 and leave a message on your therapist voicemail box.

_____ 8. Services <u>not</u> provided

HGCC therapists are not qualified as legal experts in court cases. HGCC does not provide custody evaluations, sexual abuse investigations, or anything related to such matters.

_____ 9. Privacy Practices

A list of patient rights and responsibilities are available upon request to all patients. They are also posted in our waiting room.

_____ _____

Print Client Name Date of Birth

_____ _____ _____

Client/Parent/Guardian Signature Therapist Signature Date

_____

Parent/Guardian Signature (Both signatures are required for divorced parents who have joint custody)

Informed Consent for Telehealth

This Informed Consent for Telehealth contains important information focusing on doing psychotherapy using the phone or the video conferencing through the Internet. Please read this carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telehealth

Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the client and clinician can engage in services without being in the same physical location. This can be helpful if bad weather is expected, if the client or clinician moves to a different location, has transportation issues, or is otherwise unable to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person psychotherapy and telehealth, as well as some risks. For example:

Risks to confidentiality I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telehealth. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology There are many ways that technology issues might impact telehealth. If the session is interrupted for any reason and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telehealth platform on which we agreed to conduct therapy. If you do not receive an attempt to reconnect within two (2) minutes, then call me using the telephone.
If a technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates you understand the risk of telehealth and agree to engage in therapy through the means of video conferencing or telephone.

Print Client Name_____

_____ _____

Client Signature Date

Healing Grace
Counseling Center

Agreement for Parents & Guardians

Effective Date: October 1, 2022

Psychotherapy can be an important resource for children. A therapeutic relationship can be beneficial by:

- Facilitating an open and appropriate expression of the strong feelings which routinely accompany emotional and mental difficulties, including guilt, grief, sadness and anger.
- Providing an emotionally neutral setting in which children can explore these feelings.
- Helping children understand and accept their emotional and mental health needs and how to appropriately communicate these needs to the important people in their lives such as their parents, siblings, family, friends, etc.
- Offering feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

Who can authorize treatment for Minor

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child.

- If you are married, only one parent needs to consent for treatment for your child.
- If you have joint legal custody of your child – both parents *must* consent for treatment and a copy of the divorce decree needs to be provided.
- If you are separated but still *legally* married, only one parent needs to consent for treatment, however, please be aware that it is our policy to notify the other parent we are meeting with your child. We believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

Confidentiality

At Healing Grace, we treat our minor clients the same way we treat our adult clients in terms of confidentiality. By bringing a minor in for counseling, you are acknowledging that the counselor will protect the information received within the therapeutic relationship between the minor and counselor. We have made it our policy to maintain confidentiality by only releasing protected health information of a minor with a court ordered subpoena. The following are some situations where we are required by law or by the guidelines of our profession to disclose information, whether we have you or your child's permission. Confidentiality *cannot* be maintained when:

- Child patients tells us they plan to cause serious harm or death to themselves or others and we believe they have the intent and ability to carry out this threat in the very near future. We must take steps to inform a parent or guardian or others of what the child has told us and how serious we believe this threat to be and to try to prevent the occurrence of such harm.

- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, we will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell us, or we otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, we are required by law to report the alleged abuse to the appropriate state child-protective agency.
- We are ordered by a court to disclose information.

Divorce, Custody or other Legal Disputes

In the cases of separation and divorce, we ask parents to remember that this decision was not initiated or made by the child, but he or she must find a way to deal with and come to terms with this change in their family. The usefulness of such therapy is extremely limited when the therapy itself becomes simply another matter of dispute between parents. With this in mind, and in order to best help your child, we strongly recommend that each of the child's caregivers mutually accept the following as requisites for the child's participation in therapy.

- It is our primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers, psychologists, social workers, etc.). In some cases, this may include a recommendation that you consult with a physician, should matters of your child's physical health be relevant to this therapy.
- We ask that all caregivers remain in frequent communication regarding this child's welfare and emotional wellbeing. Open communication about his or her emotional state and behavior is critical. In this regard, we invite each of you to initiate frequent and open exchange with their therapist.
- In the course of treatment, we may meet with the child's parents/guardians either separately or together. Please be aware, however, at all times, our patient will always be your child – not the parents/guardian, siblings or other family members of that child.

We recommend that parties who are disputing custody strongly consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than try to settle a custody dispute in court. **We make it clear to the families we work with that we do not make custody evaluations or recommendations for court.** There are two key reasons for this position. The first is that we see it as a conflict of interest. If the child or family we are engaged in therapy with knows we may be making a custody recommendation, they may come in with a hidden agenda that will interfere with the therapy's effectiveness. Secondly, we see custody evaluation as a specialized area that requires additional training past a standard mental health degree. We have chosen not to specialize in this area and therefore do not practice in this area. It is crucial for us to set and maintain firm boundaries on this issue because there is often still important work to be done post-divorce.

Your understanding of this may not prevent a judge from requiring our testimony, even though we will not do so unless legally compelled. If we are required to testify, we are ethically bound *not* to give our opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, we will provide information as needed, if appropriate releases are signed or a

court order is provided, but *we will not make any recommendation about the final decision(s).* Furthermore, if we are required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse their therapist at the rate of $ per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Appointments

Please make every effort to get your child to their appointment on time. We do ask that you give us a minimum of 24-hour notice if you need to cancel/reschedule your appointment. This allows us time to fill that spot with someone else. If no cancel notice is given and you are not able to reschedule within the same week or have a telehealth session, you will be charged a $100 missed session fee.

We strive to provide a safe and peaceful environment for all our clients. As such, we ask that you not leave unattended minors at the clinic at any time. It is likely that your child's therapist has sessions before and after your scheduled time and cannot be responsible for your child after the session has ended. We encourage you to stay at the office for the length of your child's session but understand that unexpected situations may require that you briefly leave our location. Should these situations arise, we ask you to inform your therapist at the start of the session, so that they are aware of your absence. We also ask that you return 15 minutes prior to the end of your child's therapy session. This ensures that your child's therapist can update you (if needed) and schedule upcoming sessions. We ask that you come into the building to check in and to pick up your child at the end of the appointment time.

Payment

Payment for my services is due, in full, at the time of service. The parent or guardian who brings the child to the session is responsible to pay any outstanding balances and the amount due at the session. If you are divorced and the court has issued both parents pay 50/50 for counseling, the two of you will have to settle that outside of our office. We will not split, divide or partial bill each parent.

Your understanding of these points and agreement in advance of starting this therapy may resolve difficulties that would otherwise arise and will help make this therapy successful. Your signature, below, signifies that you have read and accept these points.

_____ _____ _____

Child's Name Date of birth Age

_____ _____

Caregiver's Signature Date

_____

Printed Name / Relationship to Child

_____ _____

Caregiver's Signature Date

_____

Printed Name / Relationship to Child

HGCC CHILD EVALUATION

Parents/Guardians, please complete this form for your child or teen and give it to their therapist at the time of your first appointment. This information will help your child's therapist identify problem areas and provide the best treatment possible.

Childs Name _____ Date _____

Are the parents of this child: • Married • Separated • Divorced • Never Married

What are the custody arrangements? • N/A • Joint • Sole • Other _____

If joint custody exists, are both parents aware of the child's involvement in counseling? • Yes • No

Was this child adopted? • Yes • No

Where is the child living at this time? _____

Please check (✓) below

FEELINGS RELATED TO PARENTING	NEVER	SOMEWHAT	OFTEN	ALWAYS
I am worried about my child.				
I am confident in childrearing.				
I have conflict with others related to how I discipline my child.				

FAMILY HISTORY

Anyone in the family, (immediate or extended), have or exhibit the following:

Psychiatric Problems • Yes • No If yes, whom (parent, sibling, aunt, etc.) _____

Depression or Anxiety • Yes • No If yes, whom _____

Abuse of alcohol or drugs • Yes • No If yes, whom _____

Suicidal behavior • Yes • No If yes, whom _____

Physical violence • Yes • No If yes, whom _____

Health conditions (or deceased) • Yes • No If yes, whom _____

DEVELOPMENT HISTORY

Did this child's biological mother use alcohol or drugs during her pregnancy? • Yes • No • Unsure

If yes, what substances: _____

Did the biological mother experience unusual stress or health complications during this child's pregnancy? • Yes • No

If yes, describe: _____

Did the child experience any trauma at birth (anoxia, etc.)? • Yes • No • Unsure

If yes, explain: _____

Were the child's developmental milestones (walk, talk, toilet training, etc.) within normal limits? • Yes • No

If no, explain:

_____

EMOTIONAL & BEHAVIORAL HISTORY

Has your child ever seen a counselor/therapist before? • Yes • No

Has your child ever been hospitalized for emotional/behavioral reasons? • Yes • No

Has your child taken medications for emotional or behavior problems? • Yes • No

If yes, specify drug name: _____

Has your child ever received Psychological Testing (WISC-III, etc.)? • Yes • No

If yes, describe: _____

Has your child ever witnessed violence (domestic, homicide)? • Yes • No • Unsure

Has your child ever suffered from physical abuse or neglect? • Yes • No • Unsure

Has your child ever been a victim of sexual abuse? • Yes • No • Unsure

MEDICAL HISTORY

Please list all prescription and over the counter medications/supplements your child is currently taking (include doctor's name who prescribed):

_____

Please check (✓) below all the health problems that apply to your child.

HEALTH PROBLEMS	NONE	HAD IN THE PAST	CURRENT
Allergies			
Asthma			
Headaches			
Seizures			
Head Injury			
Encephalitis			
Meningitis			
Unconsciousness			

HEALTH PROBLEMS	NONE	HAD IN THE PAST	CURRENT
Cancer			
Heart Problems			
Sinus Problems			
Hearing Problems			
Vision Problems			
Concussions			

Other serious illnesses not listed: _____

SCHOOL FUNCTIONING

If your child is school age, please state the grade and school your child attends: _____

Does your child appear motivated for school? • Yes • No

Has your child ever been suspended or expelled from school? • Yes • No

Has your child ever been diagnosed with a learning disability or attention deficit? • Yes • No

If yes, describe: _____

Does your child have difficulty making friends or getting along with peers? • Yes • No • Unsure

CURRENT SYMPTOMS

Please rate all symptoms that apply to your child currently. If not applicable, please leave blank.

Sometimes = (1-2 days/week) **Often** = (3-4 days/week) **Most days** = (5-6 days/week) **Always** = (7 days/week)

CURRENT SYMPTOMS	SOMETIMES	OFTEN	MOST DAYS	ALWAYS
Very Unhappy				
Fearful				
Peer Conflict				
Animal Cruelty				
Running Away				
Soiled Pants				
Suicide Talk				
Insomnia				
Irritable				
Phobic				
Disobedient				
Cutting Self				
Stomachaches				
Fire Setting				
Overeating				
Daydreaming				
Destructive				
CURRENT SYMPTOMS	SOMETIMES	OFTEN	MOST DAYS	ALWAYS
Bed Wetting				

CURRENT SYMPTOMS	SOMETIMES	OFTEN	MOST DAYS	ALWAYS
Failing Grades				
Temper Tantrums				
Sluggish				
Argumentative				
Sibling Violence				
Head Banging				
Hallucinations				
School Refusal				
Poor Appetite				
Withdrawn				
Distractible				
Regressed				
Overactive				
Rocking Self				
Mute				
Drug Use				
Victim of Bullying				
CURRENT SYMPTOMS	SOMETIMES	OFTEN	MOST DAYS	ALWAYS
Stealing				

Legal Trouble				
Impulsive				

Initiates Bullying				
Alcohol Use				

Presenting Problem: Please describe the problem(s) that prompted you to seek help: _____

_____

_____

_____

Please describe any changes or events that might have contributed to the problems' development: _____

_____

_____

_____

Therapy Goals:

_____

_____

_____

_____

I verify that I have completed this form to the best of my knowledge.

_____ _____

Parent Signature Date

UD: 12/27/21

Credit/Debit Card Authorization Form

CLIENT NAME(S) we are authorized to use this card for _____

Phone Number for Billing Questions _____

Cardholder's Name (As Shown On Card) _____

Billing Address _____

Street City State Zip Code

Credit/Debit Card Number _____

(We accept Visa, MasterCard, Discover, & American Express)

Expiration Date _____ CVV _____

(3-4 digit code on the back)

PLEASE READ AND SIGN BELOW

My signature below authorizes Healing Grace billing department to keep my credit card on file and charge my credit/debit card account for any outstanding balances, including, but not limited to: deductible, co-pay, coinsurance, and private pay fees; missed appointment or late cancellation fees; along with any other outstanding balances.

I acknowledge that Healing Grace does not need any further authorization, such as phone calls or emails, prior to charging my card.

All information entered on this form will be kept strictly confidential by Healing Grace Counseling Center and stored on our HIPAA compliant software.

If you have any further questions, please feel free to contact our billing staff at 816-944-3251.

Cardholder Signature _____ Date _____

Email Receipt to _____