Confidential Children's Intake

Please complete ALL information

Therapist:______________________________ Date: _________________________

Child's Name: _________________________Date of Birth: _____________Age: ________ Sex:_____
Address: ________________________________City, State, Zip: _______________________________
Child's Cell Phone (if over 16):________________________ Religious Affiliation: _________________
School: ____ Grade: ____________

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Parent/Guardian Information

Father: ___________________________________ Mother: ___________________________________
Date of Birth: _____________________________ Date of Birth: ______________________________
Address: _________________________________ Address: __________________________________
City, State, Zip: ____________________________ City, State, Zip: ____________________________
Phone- Home: ______________________________ Phone- Home: ____________________________
Work:________________ Cell: _______________ Work: _______________ Cell: ________________
Employer: _______________________________ Employer: _________________________________
Occupation: ______________________________ Occupation: _______________________________
Marital Status: _____________________________ Marital Status: _____________________________

Step-Parent Information *(if applicable)*

Father: ___________________________________ Mother: ___________________________________
Date of Birth: _____________________________ Date of Birth: ______________________________
Address: _________________________________ Address: __________________________________
Contact #: ________________________________ Contact #: _________________________________

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Siblings- Please list all children oldest to youngest

First & Last Name *Sex* *Age* *Grade* *School*

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____
____
____

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Insurance Company: ____
Policy Holder: ____________________________Policy Holder SSN:___________________________
Primary Physician: _____________________________ Date of last exam: _______________________
List any medical problems, allergies, or illnesses:____
____
Present Medications: ____
____
Has your child received previous counseling? Y / N
If so, by whom: ____
How were you referred to our office? ____

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I understand that by signing below I am responsible for payment of service at the time rendered.

Client Signature: ______________________________________ Date: __________________________

Social Security Number (SSN): _____________________________

Acknowledgement of Receipt of Privacy Practices

Interactional Services, Inc. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Interactional Services.

_____

Name of Client/Client Representative

_____

Signature

_____

Date

_____

Relationship of Client Representative to Client
(Required if the patient is a minor or adult who is unable to sign the form.)

NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures

Treatment- Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of your therapy evaluation and plan of treatment will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment- Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations- Your health information may be used or disclosed in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities.

Law Enforcement- Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Abuse or Neglect- Your health information may be disclosed to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We 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.

Public health reporting- Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Appointments- Your health information will be used by our staff to schedule appointments and verify your insurance benefits.

Information about treatments- Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest.

Marketing Health-Related Services/Fundraising- We will not use your health information without your written consent.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information, you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights

You have rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical conditions and treatment
- The right to request restrictions on the use and disclosure of your protected health information
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy practices that are outlined in this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting The Front Office Staff or The Privacy Contact.

Complaints

If you would like to submit a comment or complaint about our privacy practices or if you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to this address. You will not be penalized or otherwise retaliated against for filing a complaint.

Privacy Contact: Office Manager
707 Southfield Road
Shreveport, LA 71106

This notice is effective on or after April 14, 2003 and will remain in effect until replaced.

INTERACTIONAL SERVICES, INC.
707 Southfield Road
Shreveport, LA 71106
Telephone- 318-869-1632
Fax- 318-869-1633

REQUEST AND AUTHORIZATION TO EXCHANGE INFORMATION

I, _____, (_____)
Patient's name or parent, guardian or authorized representative Date of Birth

Authorize- Interactional Services, Inc.

Attn: _____

(Therapist)

and

_____

_____

Phone (_____) _____

To release and exchange with each other written/oral reports concerning my:

_____ Attendance

_____ Participation in counseling

_____ Results in evaluations

_____ Clinical progress

_____ Billing

_____ Other_____

I understand that no disclosure of my records can be made without my written consent unless otherwise provided in legal statues and judicial decisions. I also understand that I may revoke this consent at any time except to the extent that action has already been taken upon this release.

_____ _____
Patient Date

_____ _____
Witness Signature of parent, guardian, or authorize representative (if required)

INTERACTIONAL SERVICES, INC
707 Southfield Road
Shreveport, LA 71106
Telephone- 318-869-1632
Fax- 318-869-1633

INSURANCE AUTHORIZATION- SIGNATURE ON FILE

(*Your signature is required on this form if you are filing insurance*)

I permit this authorization to be used in place of the original signature on all of my insurance claim forms.

I authorize release of information to all of my insurance carriers.

I authorize Interactional Services to act as my agent in helping me obtain payment from my insurance carrier(s).

I authorize direct payment to Interactional Services.

I understand that I am responsible for all charges incurred in the event services are not paid or covered by my insurance carrier(s).

Note: Patients that are incapable of signing, or are under the age of 18, must obtain the signature of a parent or legal guarding in the patient's place.

_____ _____

Signature Date

MEDICARE CLIENTS ONLY

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to Interactional Service for services rendered. I authorize any holder of medical information about me to release any information needed to determine those benefits payable for related services to the Medigap Insurer.

_____ _____

Signature Date

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the provider or organization furnishing the services or authorized such provider or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Signed: _____Date: _____

Print Name: _____ Title or Relationship:_____

Witnessed by: _____