



Child & Adolescent (under 18) Intake Information – Please fill out for CLIENT information

Last Name: _____ First Name: _____ MI: _____
Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____
Gender: Male Female Age: _____ Ethnicity: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Other Phone: _____ May we leave a message? Yes No
Please indicate any calling/contact restrictions: _____
Email Address: _____ Language Spoken: English Spanish Other

Relationship/Family:

Please name the main caretaker(s) for the child: _____

Marital Status of Caretaker(s): Single Parent Married Parents *Divorced but Co-parenting
 *Divorced with Conflict Foster Home Widowed **Other Relative **Other

*If Divorced or Divorcing, please explain below [and also refer to section on Legal Matters].

**If Other, please explain: _____

If child is not living with family of origin, when did s/he start living with this caretaker? _____

Does child have siblings? Yes No If yes, please list siblings and step-siblings below:

Name:	Gender:	Age:	Name:	Gender:	Age:
_____	M F	_____	_____	M F	_____
_____	M F	_____	_____	M F	_____
_____	M F	_____	_____	M F	_____

Name of person completing this intake: _____

Relationship to client: _____

Name of Counselor _____ Date of Initial Appointment: ____/____/20____

Please describe briefly the reason for seeking counseling at this time:

Chief Complaints: (Please check all that apply for the client):

- | | | |
|--|---|--|
| <input type="checkbox"/> Very Unhappy | <input type="checkbox"/> Short attention span | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Addiction | <input type="checkbox"/> Spiritual Issues |
| <input type="checkbox"/> Irritable/Angry | <input type="checkbox"/> Self-mutilating | <input type="checkbox"/> Parenting Issues |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Intrusive Thoughts | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Worried | <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Relationship Issues |
| <input type="checkbox"/> Temper Outbursts | <input type="checkbox"/> Drug Use | <input type="checkbox"/> Abuse Victim |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Lethargic, No Energy | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Low Self-Esteem |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Intimacy Issues | <input type="checkbox"/> Hallucinations/Delusion |
| <input type="checkbox"/> Excessive Crying | <input type="checkbox"/> Trust Issues | <input type="checkbox"/> Educational Issues |

Medical/Mental Health:

Please rate the general condition of client's health: Good Fair Poor

Describe any difficulties: _____

Please list any medication currently taken by the client below or check for no medications.

- 1) _____ Dose _____ Freq _____ Purpose _____ Start Date _____
2) _____ Dose _____ Freq _____ Purpose _____ Start Date _____

Please name any diagnosis client has been given: (This includes for Medical and Mental Health)

Diagnosis: _____ Approx. Date: _____ Physician: _____

Has the client ever been hospitalized for medical or psychiatric reasons? Yes No

Hospital	Month/Year	Reason
_____	_____	_____
_____	_____	_____

Education:

Name of School Client attends [or indicate homeschool]: _____

Current Grade: _____ Teacher (if applicable): _____

Please describe performance in school: _____

Legal Matters:

Are the parents of the client divorced or separated? Yes No

Are there court-ordered rulings for this client? Yes* No

***If yes, please include a copy at the time of the first session or at least by the second session.**

If parents are divorced or separated, does the other parent know about this counseling? Yes No

Are there potential or pending custody matters? Yes No

Is the client coming to counseling at the request of an attorney or another person? Yes No

If yes to the above questions, please explain: _____

Concerns: Please list any additional concerns _____

Emergency Contact: In case of an emergency, who should we contact?

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Healthcare/Payment Resources: Please check the method to pay for counseling

- Private Pay Insurance Medicaid STAR Plus Amerigroup EAP StarHealth
- CHIPS Another Source: _____

Insurance Information (Please supply a copy of the insurance card and driver's license):

Primary Insurance: _____ Phone: (____) _____

Insured's Name: _____ DOB: ____/____/____

SS#: ____/____/____ Policy ID #: _____

Group #: _____ Relationship to Insured: Spouse Daughter/Son Other

Secondary Insurance: _____ Phone: (____) _____

Insured's Name: _____ DOB: ____/____/____

SS#: ____/____/____ Policy ID #: _____

Group #: _____ Relationship to Insured: Spouse Daughter/Son Other

Other: Who is responsible for payment of services (if different from above)?

Full Name: _____ DOB: _____

Address: _____ Relation to Client: _____

City: _____ State: _____ Zip Code: _____

Please note that we accept cash, check, or credit card for private pay or co-pays. Payment is expected at the time of service.

We want to thank you for choosing Crossover Counseling!

I _____ give consent for Crossover Counseling to release diagnostic codes and session dates to my insurance(s) (and person responsible for payment), if needed for billing purposes. This also allows Crossover Counseling to communicate with my Emergency Contact, in case of emergency.

Client/Guardian's Signature

Date

We are pleased you have chosen Crossover Counseling. We recognize the boldness required to initiate the counseling process, and we hope and pray this experience will be positive and beneficial for you. This is your informed consent for entering into the therapeutic relationship. It details general counseling information, HIPAA information, our office and confidentiality policies. If you have any questions or concerns, please do not hesitate to speak with one of our office managers or your counselor.

**Please initial each page indicating you have read and understand the information. You will be provided with a copy of your signed consent upon request.

General Counseling Information:

Goals of Therapy: Counseling is a process whereby the counselor partners with each client and s/he moves toward healing and resolution of any pertinent matters which are brought to the counseling process. Counseling may be beneficial for most people, but at the same time there are risks. These risks may include the client experiencing intense feelings, such as sadness, anger, fear, guilt or anxiety while issues are being discussed. It is important to remember that these feelings are a natural and normal part of the counseling process. In fact, this indicates progress toward healing. Even though the emotions may be intense at first, with continued progression, these feelings should subside.

Active Client Involvement: Crossover Counseling expects that clients will participate in the development of a service approach that best fits their personal strengths, abilities, needs, and preferences. Together, the client(s) and counselor will assess the issues presented and establish goals for counseling that might best serve the client. Each counselor will not make decisions for the client, but will assess and facilitate achievement of the specified goals. Clients' input and feedback in the process, including indications that treatment is complete, is a vital part of a successful outcome in therapy.

HIPAA: Laws and Regulations: HIPAA is an acronym for the Health Insurance Portability and Accountability Act and is enforced "to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes." Section one of the HIPAA legislation intended to lower the risk of individuals losing their existing health care coverage, limiting the use of pre-existing conditions, and helping those without insurance coverage find it on their own. A full description of the HIPAA rules/regulations forms are available upon request.

Office Policies:

Hours of Operation: Crossover Counseling has regular scheduled office hours Monday-Friday 8:00-5:00. Appointments are scheduled on an individual basis by your counselor. Evening appointments may be available upon request depending on the availability of the counselor.

Messages: Calls are either received by a staff member or recorded by a confidential voice mail system and are returned as soon as possible. To facilitate this, the caller needs to leave a daytime/evening phone number along with current concerns. *NOTE: We are NOT an emergency crisis facility.* If you have an emergency, please call 911 or the mental health crisis hotline at 1-800-392-8343. If you have a life-threatening emergency, please go to the nearest Emergency Room. In an emergency, please contact an emergency facility or hotline as listed above FIRST. There is a national suicide prevention hotline 1-800-SUICIDE that is available 24 hours daily.

Appointments: Counseling services are offered by appointment only. The length of the counseling session is typically a clinical hour (approximately 45-50 minutes). We require a 24-hour cancellation notice if you are unable to make your scheduled appointment. *You are financially responsible for a missed session unless there is an emergency or 24-hour notice is given.*

Grievance Policy: We hope that our clients will find Crossover Counseling to be a safe and pleasant environment. However, in the event that a client may have an issue with one of our staff members, please see that staff member to resolve the issues. If resolution does not occur, please then see Laura Smith, LPC-Supervisor who will work with all parties involved to seek remedy for any problems that have occurred. Also, it is important that each client understand they have the right to change counselors to facilitate the best therapeutic relationship for their own counseling process. Persons filing grievances are free from restraint, coercion, reprisal, or discrimination.

Confidentiality Policies and Limitations:

Confidentiality: In general, the privacy of all communications between a client and a provider is protected by law, and a provider can only release information about therapeutic work to others with a client’s written authorization, or if subpoenaed by a judge.

Limitations of Confidentiality: There are certain instances that a counselor is required by law to report. Below are the instances where professional counselors are required to report:

- Reported or suspected physical or sexual abuse (including neglect) of a child, dependent or elderly adult
- If a client is threatening serious bodily harm to another person/s, the provider must notify the police and have the right to inform the intended victim based on individual clinical opinion.
- This release includes reporting information indicating the intentional spreading of a communicable or venereal disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as the acquired immune deficiency syndrome (A.I.D.S.)
- If a client intends to harm him/herself, a provider will make every effort to develop a safety plan with the cooperation of the client. If necessary, the counselor is required by law to take further measures with or without the client's permission to ensure the client's safety.
- If a client reports an intended (future) crime or reveals a past crime, the counselor retains the right to report the said crime.

Signature of Client

Printed Name of Client

Signature of Parent/Guardian

Relationship to Client

Signature of Counselor

Date Signed

Service Fees

Description	Includes	Fee
Individual Counseling	45-55min session with an LPC	\$100 a session
Marriage/Family Counseling	45-55min session w/ two or more people with an LPC	\$125 a session
Counseling With LPC-Intern	45-55min session with an LPC-Intern	\$50 a session
Consult	20-30min with an LPC to discuss counseling options	\$50 a consult
Psychological Services	There are various types of assessments and testing available	Please consult with office for the specific testing needed
Supervised Visitation	45-55min of supervised visit of a child and family member by LPC or LPC/Intern	LPC - \$50 per session LPC-Intern - \$30 per session
Court Retainer Fee	Includes: 1.) Testimony in court 2.) Reading over notes 3.) Calls to reschedule clients 4.) Legal counsel	\$500 first 4 hours \$100 per additional hour
Initial Subpoena Retainer Fee	Includes: 1.) Testimony for deposition 2.) Copies of records 3.) Legal counsel	\$200 first hour \$100 per additional hour
School Consult	4-hour consult including observation with client, parents, and school personnel	\$500 first 4 hours \$100 per additional hour
Copy of Records	Includes copies of counseling notes, pictures, drawings, correspondences through mail or email (Allow two weeks)	\$25 min/varies for size Additional fees if subpoenaed
Phone Consult/ Phone Counseling	Any conversation over 10 minutes with an LPC, LPC/Intern	Fee varies depending upon duration. Minimal \$25
Missed Session Fee	Fee for a missed session without 24-hour notice (except in emergency)	\$50 per missed session

Initials

Note any bill outstanding above \$200 will cause a suspension of counseling services. These services may resume after the bill is paid in full or a payment plan is agreed upon with office management.

I understand that I am responsible for payment of all services rendered. I agree to pay for any outstanding balance not covered by insurance.

Client Name: _____ Signature: _____ Date: _____