Alicia D. Hart, MMFT, MDiv., EdS., LMFT

CHILD/ADOLESCENT INFORMATION FORM

(Please Print)

Client Name:____ Date:___________________

PARENT/GUARDIAN INFORMATION			
Parent/Guardian Name:		Relationship to Client:	
Street Address:		Suite/Apartment Number:	
City:	State:	ZIP Code:	May We Send Mail Here: ❑ Yes ❑ No
Mailing Address or Post Office Box:			
City:	State:	ZIP Code:	May We Send Mail Here: ❑ Yes ❑ No
Home Phone:	( )		May We Leave a Message Here: ❑ Yes ❑ No
Mobile Phone:	( )		May We Leave a Message Here: ❑ Yes ❑ No
Work Phone:	( )		May We Leave a Message Here: ❑ Yes ❑ No
Email Address:	( )		May We Send Email Here: ❑ Yes ❑ No

EMERGENCY CONTACT	
Name:	Relationship:
Home Phone: ( )	Mobile Phone: ( )

EMPLOYMENT INFORMATION				
Employer:		Length of Employment:		
Occupation:		Average Hours Worked Per Week:		
Average Annual Salary:	❑ $0 to $10,000	❑ $10,001 to $20,000	❑ $20,001 to $40,000	❑ $40,001 to $50,000
	❑ $50,001 to $60,000	❑ $60,001 to $80,000	❑ $80,001 to $100,000	❑ More than $100,000

EDUCATION INFORMATION		
(Circle) Last Year of School Completed: 9 10 11 12 GED	College: 1 2 3 4	Other: ______________________
Are You Currently in School? ❑ Yes ❑ No	If Yes, What School:	

RELATIONAL INFORMATION			
Current Status:			
❑ Single	❑ Dating	❑ Married	❑ Divorced
❑ Engaged	❑ Living together	❑ Separated	❑ Widowed

I hereby give Eastside Family Therapy and its' staff permission to provide therapy services for the client mentioned above: Signature of parent or legal guardian:

Signature:____ Date: __________________

Alicia D. Hart, MMFT, MDiv., EdS., LMFT

CLIENT INFORMATION

Client's DOB:______________Age:_______School____Grade: __________

S.S. #_____________________________________(insurance clients only)

Has patient received counseling from a Pastor, Psychiatrist, or other counselor? ❑ Yes ❑ No

If yes, Who:____When:____________________________________

What was the previous symptom or diagnosis: ____

Has anyone in your family been treated for a mental disorder? ❑ Yes ❑ No

If yes, Who & What were they treated for? ____

____

Physician's Name:____Date of last physical exam: _______________

Significant past medical conditions and years occurred:____

____

Current medical conditions (include any known allergies or dietary concerns) _____________________________________

____

____

Medications/dosage patient is currently taking and for what reason: ____

____

Briefly describe major reasons for coming to counseling and what you hope to accomplish: __________________________

____

____

How would you describe the severity of the issues/problems: ❑ Crisis ❑ Severe ❑ Moderate ❑ Mild

Therapist Notes: ____

____

____

____

____

____

Alicia D. Hart, MMFT, MDIV., EdS., LMFT

Child/Adolescent Comprehensive Psychosocial Assessment Family Information:

Family	Name	Age	Educ.	Occupation	At Home
Dad					
Mom					
Stepdad					
Stepmom					
Bro/Sis					
Bro/Sis					
Bro/Sis					

Has your child ever lived with anyone else? ❑ Yes ❑ No

If so, who? ____

Is your child adopted? ❑ Yes ❑ No

If so, how old was your child? ________________________________

A. Your Child's Development:
Please list the approximate age at which your child:

	Age	Problems
Walked	________	❑ Yes ❑ No
Talked	________	❑ Yes ❑ No
Toilet Trained	________	❑ Yes ❑ No
Puberty/1st Menstruation	________	❑ N/A ❑Yes ❑ No
Sexually Active	________	❑ N/A ❑Yes ❑ No

B. Family History:
Has anyone in your immediate family ever had any of the following problems?

1. Epilepsy or Diabetes? ❑ Yes ❑ No
2. Significant Medical Problems? ❑ Yes ❑ No
3. Mental Illness Requiring Hospitalization? ❑ Yes ❑ No
4. Counseling for Emotional Problems? ❑ Yes ❑ No
5. Current or past use of alcohol/drugs? ❑ Yes ❑ No
6. Suicidal Behavior? ❑ Yes ❑ No

If yes to any of the above please list who:______________________________
____

Therapist Notes:
____

C. Your Child's Behavior:

1. Does he/she get along well w/others? ❑ Yes ❑ No ❑Sometimes
2. Does your child follow instructions? ❑ Yes ❑ No ❑Sometimes
3. Is your child appropriate with pets? ❑ Yes ❑ No ❑Sometimes
4. Does your child have self-control? ❑ Yes ❑ No ❑Sometimes
5. Has your child ever set a fire? ❑ Yes ❑ No ❑Sometimes
6. Does your child cry easily? ❑ Yes ❑ No ❑Sometimes
7. Has your child ever used alcohol or other drugs? ❑ Yes ❑ No ❑Sometimes
8. Has your child ever experienced problems with the law? ❑ Yes ❑ No
9. Has your child ever talked about, threatened or tried to harm himself or herself? ❑ Yes ❑ No
10. Has your child ever threatened to or harmed others? ❑ Yes ❑ No
11. Has your child ever used tobacco products? ❑ Yes ❑ No

D. Your Child's Education:

1. What school is your child attending?
 ____
2. In what grade is your child? ___________________________

1. Has your child attended a special education program? ❑ Yes ❑ No
2. Has your child repeated, skipped or had any Interruptions in his/her education? ❑ Yes ❑ No
3. How many days has he/she missed this year? __________

E. Activities, Interests and Strengths:

1. What does your child do in his/her spare time?
____

2. What does your child do well?
____

F. Spiritual: Please describe your child's religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of as we meet with him/her?

____

____

Therapist Notes

____

G. Health
Has your child experienced any of the following: If Yes, When?

Question	Yes	No
Problems during pregnancy?	❑ Yes	❑ No
Complications at birth?	❑ Yes	❑ No
Soiling or lack of bowel control?	❑ Yes	❑ No
Urinary problems?	❑ Yes	❑ No
Seizures or Convulsions?	❑ Yes	❑ No
Eye/Ear Problems?	❑ Yes	❑ No
Complications from high fever?	❑ Yes	❑ No
Persistent Headaches?	❑ Yes	❑ No
Persistent Stomach Aches/Nausea Or Vomiting?	❑ Yes	❑ No
Sleeping Problems?	❑ Yes	❑ No
Physical, Sexual or Emotional Abuse?	❑ Yes	❑ No
Poor Appetite?	❑ Yes	❑ No
Significant Weight Loss or Gain?	❑ Yes	❑ No
Frequent Colds/Respiratory	❑ Yes	❑ No
Self-Injury, Rocking, Head Banging?	❑ Yes	❑ No
Coma or Unconsciousness	❑ Yes	❑ No
Serious Injury Resulting From Accidents	❑ Yes	❑ No

Therapist Notes

TERMS OF SERVICE
I hereby give Alicia D. Hart, Therapist permission to provide therapy services for the client mentioned above:

Signature of parent or legal guardian:______________________________ Date: ______________

Alicia D. Hart, Therapist

FINANCIAL POLICY

- Initial assessment for 90 – 120 minutes ($200.00)
- One 50 minute session: $100.00
- Families are $______per hour, depending on size of family
- Insurance: We offer billing to clients with BCBS, SC STATE, Spartanburg Regional Health Care System, Medicaid: Healthy Connections, First Choice, and Blue Choice. We do not accept Cigna, United Health, or Humana. (We may sometimes courtesy file for you. In some cases, the amount billed will apply to your yearly deductable.)

I understand that a third party biller will provide insurance billing services for Alicia D. Hart, therapist. I consent to allowing a third party biller to bill my insurance company for services Rendered.

Signature for billing consent Date

- Additional Services: Treatment Summary Requests, Professional Letters, Emails or Phone/Conference calls, if requested, will be billed in 15 minute increments @ $25 per 15 minutes of billable services.
- Administrative Services: Letters, insurance forms, authorization requests will be billed at $25 each request.
- Court Appearances and Depositions are billed at $600.00 per half day (3 hours) with a minimum of $600.00. Any time over 3 hours is billable at $950.00
- Returned checks are subject to a $30 fee.
- No-show fees are charged for appointments canceled or broken without 24 hours advance notice unless there is an emergency or illness. Monday appointments must be canceled by the Friday in advance at Monday appointment time or before. **The no-show fee is $100**. **When leaving a message, all calls are time and date stamped.**

Policy on Insurance Reimbursement:

If you have medical Insurance that provides coverage for mental health counseling, we are anxious to help you receive your maximum allowable benefits.

We will be happy to provide you with a receipt to forward to your insurance company. You are responsible for generating the claim and mailing it to the insurance company and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.

Rate Calculation Policy:

- Each therapist regulates their own minimum rate. Appointments are scheduled directly with the therapist.
- Fees listed are for one clinical hour (50 minutes). Longer sessions are calculated by .5 hour increments
- Proof of income may be required. All financial information kept confidential.
- Discounts for multiple clients or weekly sessions, from the same family, may be arranged on a case by case basis.

We understand that at times financial hardships arise and it may be necessary to discontinue therapy for a season. However, it is our policy to work within our clients financial means in order to support the therapeutic process. Should your fee for service become a financial hardship for you, please discuss this with your therapist. As is the policy of the State of South Carolina and included in the AAMFT code of ethics, Marriage and Family Therapists are prohibited from bartering for service.

Signature____Date______________________

Alicia D. Hart, Therapist

Therapist________ ____Date_________________________

Section applicable only for reduced fees

Clients Initials: _______________

Amount agreed upon for initial assessment $ _______________

Amount agreed upon for therapy per 50 minute session $ ______________

Therapist Initials: ______________

Time agreed upon for reduced fee _________________________________

Date fee agreement revisited____________, Notes: ____

Informed Consent & Release of Liability

This form is to document that I, ______________________________ give my permission and

PRINT NAME

Consent to ______________________________ (clinician), to provide psychotherapeutic treatment to me

and/or who is/are my child/children or for whom I am legal guardian custodian, or legal Power of Attorney.

PRINT NAME(S) ______________________________

I understand the following:

- ❑ This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend and evening hours.
- ❑ Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. The therapist will make reasonable efforts to resolve these situations before breaking confidentiality.
- ❑ I am financially responsible for this treatment.
- ❑ I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.
- ❑ I have read and received the Office Policies & General Information Agreement for Psychotherapy Services and I agree to the policies. I have also received a copy of the HIPAA Notice of Privacy Practices. I have discussed any concerns about the policies with the therapist prior to signing this consent.
- ❑ I understand that my case may be reviewed by one of the following state approved supervisors with my confidentiality being held in highest regard.
- ❑ I understand that peer to peer supervision may be done on a case by case basis.

Disclosure Statement

Your decision to enter into therapy was undoubtedly a serious one arrived at after considerable thought. Whether you were referred by your physician, urged to come by family or friends or have come because of problems and feelings only you know about, the decision to come here was yours.

Therapy is a two-way effort entailing mutual respect, responsibility and consideration between you and your therapist. The policy presented is designed to make your therapy productive and to avoid any misunderstanding regarding the mutuality of the therapeutic process.

As a Marriage and Family Therapist, my area of training is the systemic treatment of individuals, couples, and families. The systemic approach to thearpy takes into consideration all immediate family members in family therapy sessions. I, along with you, will decide which family members (if any) need to be included in therapy. Various goals will be established together with you at the outset of therapy.

Therapy naturally involves activities such as identifying emotions and revealing secrets. There may be risks associated with our disclosures to other family members or other family members' disclosures during the course of therapy, as well as exploration of issues. Decisions to disclose will be made by you except where mandated by law. It is expected that some uneasiness or painful emotions may occur as you are involved in therapy. Discussing painful issues will naturally create discomfort. Your participation in therapy is essential toward helping address your concerns. The Board of Examiners for the Licensure of Professional Counselors, Marriage and Family Therapists and Psychoeducational Specialists requires that all clients be informed that all forms of dual relationships such as business ventures and sexual intimacy are prohibited.

It is important that you understand there is no guarantee all of your concerns, issues, or problems will be successfully resolved. I cannot guarantee outcomes. The outcomes may vary from your expectations. You may discontinue participation in therapy at any time.
If you are not satisfied with the course of the therapy, please discuss this concern with me.

Signature: ______________________________ Date: ______________________________

Alicia D. Hart, Therapist

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 this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIP AA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIP AA provides penalties for covered entities that misuse personal health information. As required by HIP AA, we have prepared this explanation of I how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- ***Treatment*** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- ***Payment*** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- ***Health Care Operations*** include-the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health- related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

- You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
  - The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
  - The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
  - The right to request an amendment to your PROTECTED HEALTH INFORMATION.
  - The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a

For more information about our Privacy Practices, please contact:
South Carolina Labor, Licensing, and Regulation
www.llr.sc.us/pol/counselors

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C 20201
877.696.6775 (toll-free)

KEEP FOR YOUR RECORDS

Alicia D. Hart, Therapist

ACKNOWLEDGEMENT OF RECEIPT PRIVACY PRACTICE NOTICE

I,____ have received a copy of
(Print Full Name) Notice of Privacy Practi:es.

Parent/Guardian
Signature:____ Date: ____________________

Therapist
Signature: ____ Date: ____________________

ACKNOWLEDGEMENT OF RECEIPT OF EMERGENCY INFORMATION

I,____ have received a copy of
(Print Full Name) Emergency Information.

Parent/Guardian
Signature:____ Date: ____________________

Therapist
Signature: ____ Date: ____________________

CLIENT E-MAIL USAGE CONSENT

Your therapist will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks identified below, your therapist cannot guarantee the security of e-mail communication, and is not liable for improper disclosure of confidential information that is not caused by the therapist's intentional misuse.

RISKS OF USING E-MAIL TO COMMUNICATE WITH YOUR THERAPIST

Transmitting client information by e-mail has a number of risks that clients should consider before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks:

E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
E-mail can be received by unintended recipients.
E-mail senders can easily type in the wrong email address.
E-mail is easier to falsify than handwritten or signed documents.
Backup copies or e-mail may exist even after the sender/recipient has deleted their copy.
Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
E-mail can be used to introduce viruses into computer systems.
E-mail can be used as evidence in court.

CLIENT OBLIGATIONS WHEN CONSENTING TO E-MAIL

Use e-mail for general client information only.
Follow up with your therapist if you have not received a response to your email within 5 business days.
Take precautions to preserve the confidentiality of e-mail. Use screen savers and safeguard your computer with a password. Change your password regularly.
Inform your therapist of any changes to your e-mail address.
Withdraw consent to email client information through hardcopy written communication to your therapist.

ALTERNATE FORMS OF COMMUNICATION

I understand that I may communicate with the therapist via telephone or during a scheduled appointment, however e-mail is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

TYPES OF E-MAIL TRANSMISSIONS THAT CLIENT AGREES TO SEND AND/OR RECEIVE

The types of information that can be communicated via e-mail with your therapist includes: appointment scheduling requests, billing and insurance questions and client education. If you are not sure if the issue you wish to discuss should be included in an e-mail, you should schedule an appointment.

HOLD HARMLESS

I agree to indemnify and hold harmless Alicia D. Hart, Therapist, and any employee, website designer, and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the therapist or the use of the therapist's web-site, any arrangements you make based on information obtained by the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The therapist does not warrant that the functions contained in any materials provided will be interrupted or error-free, that defects will be corrected, or that the therapist's website or server that makes such site available is free of viruses or other harmful components.
I also understand that all of the above information, notice and agreements apply for text messages sent to or from the therapist's office cell phone.

Client Signature:____ Date: ____________________