**Mindful Psychology and Wellness, LLC**
**Child/Adolescent Intake Form**

Today's Date: _____
Name of person filling out intake/relationship:_____

**Identifying/Contact Information**
Child's Name:_____Birthdate:_____Age:_____
Sex: M F
Street Address:
_____
City:_____ County: _____ State:_____
Zip:_____
Child's Racial/Ethnic Background:
_____
Emergency Contact: _____Phone: _____
Child lives with: Both biological parents _____Mother _____Father _____ Mother and stepfather _____ Father and stepmother _____ Other (please specify):
_____
If parents are divorced, describe custody arrangements:
_____
_____

**Information about Child's Mother**
Mother's Name: _____Date of Birth _____
Address: Same _____ If different:
_____
Telephone: (H)_____(C)_____(W) _____ OK to leave confidential messages? ____ Y ____ N Occupation: _____Employer: _____ Work address:
_____ Email Address: _____OK to send confidential messages? ___Y ___N

**Information about Child's Father**
Father's Name:_____Date of Birth:_____
Address: Same: _____
If different:_____ Telephone: (H)_____(C)_____(W) _____ OK to leave confidential messages? ____ Y ____ N ____ Y ____ N ____ Y
Occupation:_____Employer: _____
Email Address: _____ OK to send confidential messages? ___Y ___N

**Other Family Members**

Please list your child's siblings, including any step siblings, in birth order and their ages.

_____

_____

**Counseling Concerns**

Describe briefly the problem which prompted you to seek counseling for your child at this time:

_____

_____

_____

When did the problem appear?_____Have there been times when the problem got better or disappeared?_____

_____

_____

What do you think helped?

_____

_____

Are there other people who helped your child or you cope with the problem?

_____

Describe when the problem has been especially bad._____

_____

_____

Are there other people who play a major role in causing this problem or making it worse?_____

_____

Is there anything else you would like your counselor to know at this time?

_____

_____

Has your child had any previous counseling? If yes, where and by whom? _____

**Developmental History**

Were there any complications surrounding your child's birth? Yes_____ No____ If yes, please describe _____

_____

_____

Were developmental milestones normal? (walking, talking, toilet training)Yes___ No_____ If no, then please describe_____

_____

_____

List your child's sicknesses, operations, and injuries. Indicate age when occurred and describe severity. Pay special attention to head injuries and any time your child was unconscious, had convulsions, a high fever or hospitalization:

_____

_____

_____

_____

_____

List current medical problems

_____

_____

_____

Is child currently taking any prescription medications? Yes_____ No_____ If yes, please list:
Name of drug _____Dosage_____ For what condition? _____Who prescribed it?

_____

_____

When was your child's last physical exam?

_____ Name of primary care physician

_____

**Academic/School Information**

Name of School child attends

_____

Grade_____Teacher_____County

_____ Has your child ever repeated a grade?_____Which one?_____ What kind of grades does your child get?_____ Does your child have any learning difficulties? If so, please specify._____

_____

Describe your child's behavior at school._____

_____

Describe your child's personality at school (example: shy, outgoing, friendly, active). _____

_____

_____

How easily does your child make friends?

_____ How do your child's teachers describe your child? _____

_____

What kinds of extracurricular activities does your child participate in? _____

_____

_____

Describe what your child likes to do for fun at home.
_____
_____
_____
Spiritual Background Religious affiliation of your family (if any):
_____ Does your child regularly attend religious services? __Y __N Where? _____ What role does spirituality have in your child's life? _____

**MINDFUL PSYCHOLOGY AND WELLNESS, LLC**
**Authorization for Treatment and/or Counseling and Notification of Client Rights**

I understand that my (my child's) admission to Mindful Psychology and Wellness, LLC, is on a voluntary basis, and I understand and accept the consequences of treatment as explained to me. I have read and understand my rights as listed below, along with the accompanying orientation:

I (my child) have the right to be served without discrimination as to age, sex, race, creed, color or national origin.
I (my child) have the right to have the nature of treatment and any specific risks involved carefully explained to me.
I (my child) have the right to participate in the plans for treatment, goals at intake and throughout treatment.
I (my child) have the right to confidentiality. Except as required by law, no information, written or verbal, concerning me (my child) shall be released or requested without a dated, signed, and witnessed statement made by me authorizing the clinic to do so. The statement of authorization shall indicate by name whom, what specific information, and for what purpose this information will be transmitted.
I have the right to be notified if services requested cannot be provided. Each request for services shall be acknowledged by the clinic, and if services cannot be provided I will be notified what other resources might be available. I can be discharged if services cannot be provided for my condition, if I am not cooperative in the treatment, or if my behaviors are disruptive to the therapy or to the clinic, or for non-payment of fees.
I have the right to communicate freely with my attorney and/or private physician and have information about my treatment made available to them upon my written request/authorization.
No medication may be administered except upon the order of a physician.
I (my child) have the right to an individualized treatment plan and periodic review to determine progress.
I have the right to ethical treatment by my therapist according to the ethical standards and ethical codes of his/her profession.
I am responsible for all payment of fees incurred and to inform the therapist of all that is essential for the therapist to perform services and work with me.
Expectations are that clients will come in for their scheduled appointments, talk about and actively attempt with the therapist to reduce their problems.
No seclusion or restraint is used. There is no smoking in the building. No illicit or licit drugs may be brought into the program unless prescribed by a physician or are OTC medications. No weapons may be brought into the premises unless by law enforcement who are required to do this.
When a child of divorced parents is involved in therapy, both parents have access to the child's record, regardless of custody, unless a particular parents rights have been revoked. Likewise, the parents (NOT the therapist) of a child in therapy will assume responsibility of communicating information to each other about therapy appointment days/times, transportation to appointments, etc. Generally speaking, the therapist preference is to obtain both custodial parent's consent for treatment in a divorce situation, rather than entering into a situation where one parent opposes his/her child's participation in treatment. Therapists may decline taking on the role of therapist for a minor without consent of both parents.
In emergencies, please contact your family physician, call 911 or go to the nearest emergency room. In Oakland County, Common Ground Crisis Center offers a 24 hour crisis phone line: 1-800-231-1127. You should also leave a message on our voicemail at (248) 716-9025 and we will do our best to return your call as soon as possible. However, you should not wait for us to return your phone call. As a private practice, we are unable to provide emergency crisis intervention.

The laws and standards of our profession require that we keep Protected Health Information (PHI) about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in your therapist's presence, or have them forwarded to another mental health professional so you can discuss the contents. Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. It is usually the policy at Mindful Psychology and Wellness, LLC to request an agreement from any patient between 14 and 18 and his/her parents allowing the therapist to share general information with parents about the progress of treatment and the child's attendance at scheduled sessions. Since children and teens benefit from an expectation of some privacy, we try to limit details of content that is shared in therapy sessions, but we will share progress in treatment, as well as notify parents of any risks of harm. We include parents in treatment for the benefit of the child.

At Mindful Psychology and Wellness, we attempt (when clinically indicated) to coordinate care between our staff and other health care providers, such as your Primary Care Physician. When we communicate with other healthcare providers, we communicate basic information, such as diagnosis, medications, or treatment recommendations. This communication is only done with your written consent.

Print name:_____

Signed:_____

Relationship to Patient:_____

Witness (person coordinating services)_____

Date:_____

**Mindful Psychology and Wellness, LLC**
**BEHAVIORAL HEALTH CARE AND PRIMARY CARE PHYSICIAN COORDINATION OF CARE FORM**

**Patient Name_____ DOB:_____**

**Primary Care Physician_____**

**Address for PCP_____**

**Phone number_____Fax number_____**

**I, the above named patient, authorize Mindful Psychology and Wellness, LLC, and my PCP to exchange information regarding my mental health treatment and medical treatment for coordination of care purposes, including information relating to diagnosis, testing, or treatment. I understand that I may revoke this authorization at any time by written notice.**

**Please select one: _____ I authorize communication with my PCP**
**_____ I do not authorize communication with my PCP**

**_____**

**Signature of Patient** **Date**

**Mindful Psychology and Wellness, LLC**
**Fee Schedule/Cancellation Policy/Consent to Bill Insurance**

I understand that the current fee schedule at Mindful Psychology and Wellness, LLC is as follows:

Initial Evaluation $250
Individual Full Session $200.00 (extended)
Individual Session 150.00
Family/Conjoint Session $200.00

Mindful Psychology and Wellness, LLC, participates with Blue Cross and Blue Shield and other insurances. Fees will be adjusted according to our contractual arrangements. The above fee schedule applies for private pay and when the direct pay insurance benefits are exhausted. I understand and agree, that regardless of my insurance status, I am ultimately responsible for the balance of my account for all professional services rendered. Mindful Psychology and Wellness, LLC, may check on insurance to verify my benefits. However, it is my responsibility to understand how my co-pays, co-insurance, and deductible information applies to my cost, and to verify what services are covered or not covered. I will also let Mindful Psychology and Wellness, LLC know if there are any changes to my insurance coverage. **Copayments are due on the day of services rendered.** I understand that should I not provide my therapist with a minimum of 24 hour notice for not attending a session, I will be charged for that session. This charge is not covered by insurance benefits and is due prior to or at the next scheduled appointment. The cancellation policy is as follows: My therapist will charge for missed or late cancellations unless the appointment is rescheduled within the week of the missed session, if there is an opening in his/her schedule.

I give my consent to allow Mindful Psychology and Wellness, LLC to communicate with my insurance carrier any information necessary to process my mental health claim.

Accounts running a balance will be addressed promptly. Prompt payment of account balances is expected. In the event that a balance is not paid, the matter may be turned over to a collection agency.

_____ _____
Date Patient Signature

_____ _____
Date Parent/Guardian Signature (if minor)

_____ _____
Date Witness Signature

Other fee arrangement:_____Date_____

# *Mindful Psychology and Wellness, LLC*

**Acknowledgement of Receipt of Notice of Privacy Practices and Authorization to Contact by Telephone/Verbally in the Event of Breach of PHI**

By my signature below, I, _____ acknowledge that I have read a copy of the Notice of Privacy Practices for Mindful Psychology and Wellness, and upon my request I have received a copy of this notice. A copy of the Privacy Practices is available on the Mindful Psychology and Wellness website (www.mindfulpw.com).

Additionally, I authorize Mindful Psychology and Wellness, LLC to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Mindful Psychology and Wellness, LLC. Such conversation shall be documented by Mindful Psychology and Wellness.

Pursuant to the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not simply be for the administrative convenience of Mindful Psychology and Wellness, LLC.

_____

Signature of Client (or personal representative) Date

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For office use only:
I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement

**Mindful Psychology and Wellness, LLC**

**Consent for Release and Exchange of Information**

I give my consent for clinical information to be exchanged between

_____ of Mindful Psychology and Wellness, LLC

8906 Commerce Road, Suite 1, Commerce Township, MI 48382

**and**

_____ (name of individual or agency)

_____ (address)

_____

(  ) _____ (phone)

The information exchanged will be in regard to:

◯myself

◯the minor child/ adolescent _____ , for whom I am a legal guardian.

The purpose of this information release and exchange is:

◯coordination/ continuity of care

◯records from prior services needed for current assessment and/ or treatment

◯other:

The information to be released and exchanged may consist of:

◯diagnosis, assessment, & clinical impressions

◯treatment plan & progress ◯treatment/ discharge summary

◯medication regimen & response ◯psychological testing report

◯other:

I understand that this consent will expire on _____ unless revoked by me in writing prior to that date.

_____ _____

Signature of Patient or Patient's Legal Guardian Date

_____

Printed name or Patient or Patient's Legal Guardian