

McDermott Counseling

Child and Adolescent Intake

Client's name: _____ Age: _____ DOB: / / _____

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

Home Phone : () - _____ Cell Phone (If child has their own): () - _____

Insurance Company Name: _____ ID # : _____ Group # : _____

Answer the following regarding PRIMARY INSURED: Name: _____ DOB: / / _____

Address: _____

SSN: - - Telephone # () - _____ Employer: _____

Secondary Insurance Company Name _____ ID#: _____ Group#: _____

Answer the following regarding SECONDARY INSURED: Name: _____ DOB: / / _____

Address: _____

SSN: - - Telephone # () - _____ Employer: _____

INSURANCE DISCLAIMER: Failure to provide **all necessary insurance information** may lead to billing issues. If issues arise because the patient failed to provide McDermott Counseling with any and all insurance information, **fault will be found with the patient and not McDermott Counseling**. It is the patient's responsibility to provide all medical insurance coverage. If the correct information is not provided and claims are denied any outstanding balances will be the patients responsibility to pay.

X

PLEASE ACKNOWLEDGE YOU HAVE READ THE ABOVE INSURANCE DISCLAIMER

Person to contact in case of Emergency: _____

Relationship: _____ Phone (home):() - _____ (cell): () - _____

Primary reason(s) for seeking services: _____

Family Information

With whom does the child live with at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Is there any significant information about the parents' relationship ? Yes No If Yes, describe _____

Client's Mother

Name: _____ Cell phone: () - _____ DOB: / / _____ Social Security#: - - _____

Mother's Education: _____ Occupation: _____ Employer: _____

Mother's Address: _____

Is there anything notable, unusual or stressful about the child's relationship with the mother? Yes No

If Yes, please explain: _____

Client's Father

Name: _____ Cell phone: () - _____ DOB: / / Social Security#: - -

Father's Education: _____ Occupation: _____ Employer: _____

Father's Address: _____

Is there anything notable, unusual or stressful about the child's relationship with the father? Yes No

If Yes, please explain: _____

Client's Siblings and Others Who Live in the Household

Names of Sibling	Age	Gender	Lives at	Quality of relationship with the child
_____		<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Home <input type="checkbox"/> Away	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____		<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Home <input type="checkbox"/> Away	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____		<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Home <input type="checkbox"/> Away	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____		<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Home <input type="checkbox"/> Away	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good

Others living in the household (i.e. step-parent, grandparent,)	Age	Relationship to child	Quality of Relationship
_____		<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____		<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____		<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____		<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good

Pregnancy/Birth

Was the pregnancy with your child planned? Yes No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

While pregnant did the mother use tobacco, drugs, or alcohol? Yes No If Yes, describe: _____

While pregnant, did the mother have any medical or emotional difficulties: Yes No If Yes, describe: _____

Length of labor: _____ Induced: Yes No Caesarean? Yes No Baby's birth weight: _____

Describe any physical or emotional complications with the delivery: _____

Describe any complications for the mother or the baby after the birth: _____

Infancy/Toddlerhood (Check all which apply)

- Breast fed Milk allergies Vomiting Diarrhea Resisted solid food Bottle fed
- Rashes Colic Constipation Not cuddly Cried often Rarely cried
- Overactive Trouble sleeping Irritable when awakened Lethargic

Developmental History (Please note the age at which the following behaviors took place)

Sat alone: _____ Dressed self: _____ Took 1st steps: _____ Tied shoelaces: _____ Spoke words: _____

Rode two-wheeled bike: _____ Spoke sentences: _____ Toilet trained: _____ Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____ Overall your child's development was: slow average fast

Education

Current school: _____ Grade: _____ School phone number: _____

In special education? Yes No If Yes, describe: _____

Has child ever been held back in school? Yes No If Yes, describe: _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? Yes No If Yes, describe: _____

Has the child been tested psychologically? Yes No If Yes, describe: _____

Check the descriptions which *you feel*, specifically relate to your child:

Feelings about School Work:

Anxious Passive Enthusiastic Fearful Eager No expression Bored Rebellious

Other (describe): _____

Approach to School Work:

Organized Industrious Responsible Interested Self-directed No initiative Refuses

Does only what is expected Sloppy Disorganized Cooperative Doesn't complete assignments

Other (describe): _____

Performance in School:

Satisfactory Underachiever Overachiever Other (describe): _____

Child's Peer Relationships:

Spontaneous Follower Leader Difficulty making friends Makes friends easily Long-time friends

Shares easily Other (describe): _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious (parents answer - regarding you and your family)

How important to you are spiritual matters? Not Little Moderate Very Much Not Currently Practicing

Are you affiliated with a spiritual or religious group? Yes No. If yes Name and type: _____

Leisure/Recreational

Describe special areas of interest, sports, or hobbies your child enjoys. (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

List any current health concerns: _____

List any previous health concerns since birth: _____

Current prescribed medications	Dose	Dates	Prescribing M.D.	Purpose
_____	_____	_____ to _____	_____	_____
_____	_____	_____ to _____	_____	_____
_____	_____	_____ to _____	_____	_____

Current over-the-counter meds	Dose	Dates	How Often	Purpose
_____	_____	_____ to _____	_____	_____
_____	_____	_____ to _____	_____	_____
_____	_____	_____ to _____	_____	_____

Chemical Use History

Has your child (to your knowledge) ever used alcohol or drugs? Yes No If yes, describe: _____

Counseling/Prior Treatment History

Has child ever received counseling, therapy, or psychiatry in the past? Yes No.

If yes: Name & telephone # of Provider: _____ Treatment dates: _____

Reason for treatment: _____

List Concerns and Significant Changes in Your Child's Life

Relationship issues or concerns (describe): _____

Please write a 1 in front of the problems listed below which are of *primary* concern to you
Please write a 2 in front of the problems listed below which are of *secondary* concern to you

- | | | |
|---|--|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Head banging | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Anxiety/ excessive worry | <input type="checkbox"/> Helplessness | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Attachment to dolls | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Irritable | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Lazy | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Loner | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Moody | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Overactive | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Obsessive | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Often sick | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Overweight | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Withdrawn |

Please describe any of the above concerns: _____

What are **your** goals for the child's therapy? _____

Consent for Treatment and Patient Agreement

Welcome to McDermott Counseling. Your therapy is an important joint venture in which you (your child & family) and your therapist will work together to understand the problems that you are having and to explore your options and obstacles in resolving those problems. This document contains information about our professional services and business policies. Should you have any questions about these at any time, we will be happy to answer them.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on many factors, including the personalities of the patient and therapist, your early experiences, your life stage, and your goals. There are several different approaches that can be used. Psychotherapy requires an active effort on your part and a working relationship with your therapist in which together we identify the issues you and your child would like to resolve.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing difficult aspects your child's life, your child may experience uncomfortable feelings and you may initially notice undesirable changes in your child's behaviors. This is a normal part of the therapy process. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. It often leads to a significant reduction of feelings of distress, improved relationships, and resolutions of specific behavioral problems.

Your first sessions will involve an evaluation of your child's needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan/goals if you decide to continue.

You have the right to stop treatment at any time. The process of termination is generally one of the most important times in therapy. It is highly recommended that you spend at least three to four sessions to work through this process of termination. We also ask that we work with the parents to set a termination date before it is discussed with the child. Termination is a delicate process with children and must be handled appropriately by all of us.

CONFIDENTIALITY

With certain specific exceptions described below, you and your child have the absolute right to the confidentiality of your child's therapy. We cannot and will not tell anyone else what you or your child has told us, or even that your child is in therapy with us, without your prior written permission. The following are legal exceptions to your right to confidentiality. Should one of these situations occur, we will make every effort to discuss it with you fully before taking any action.

- If we reasonably suspect that a person under 18 or over 65, or a disabled person, is being abused or has been abused, I must file a report with the appropriate state agency
- If a patient threatens to harm him/herself, we may be obligated to seek hospitalization for the patient, or to contact family members or others who can help provide protection.
- If a patient communicates a serious threat of physical violence against an identifiable victim, we must take protective actions, including notifying the potential victim and contacting the police. We may also seek hospitalization of the patient or contact others who can assist in protecting the victim.
- We may find it helpful consult with professional colleagues about our work from time to time. In these consultations, we make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.
- If you are involved in a court proceeding and a request is made for information about the services that we have provided you and your child and/or the records of them, such information is protected by therapist-patient privilege law. When working with minors, the therapist (not the parent) is holder of the privilege. We therefore cannot provide any information without, a court order, compulsory process (a subpoena) or discovery request from another party to the court proceeding where we do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information about you or your child.

APPOINTMENTS

Psychotherapy appointments are usually scheduled for 45 or 60 minute sessions. We agree to meet here and to be on time. **Sessions are scheduled on the hour and end 15 minutes before the next hour or on the hour.** If we are ever unable to start on time, we ask for your understanding, and we assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time.

CANCELLATION POLICY

Because the scheduling of an appointment involves the reservation of a large amount of time set aside specifically for your child, a minimum of **24 hours notice is required for rescheduling or canceling an appointment.** **Insurance companies do not pay for missed appointments; therefore, your credit card will be charged \$108 if you do not show up for your appointment or do not cancel within the 24 hour timeframe.**

PROFESSIONAL FEES

Your first session will be an initial assessment and the fee is **\$220**. The fee per 38-45 minute session is **\$130**. The fee for a 53-60 minute session is **\$162**. **Fees are to be paid at the time of each visit.** We charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations (lasting longer than 5 minutes), attending meetings or consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. When fees are not paid for services rendered, a collection agency may be used and given appropriate billing and financial information (non-clinical information).

CONTACTING US

We are often not immediately available by telephone. When we are unavailable, my telephone is answered by voicemail, which we monitor frequently. We will make every effort to return your call on the same day you make it, with the exception of calls on weekends and holidays. If you are unable to reach us and feel that you can't wait for us to return your call, you can contact the Mental Health Info line at (800)321-1616, National Crisis Hotline (800)784-2433, Tulare County Crisis Line (559) 733-6877, or the emergency/police dispatcher at 911.

INSURANCE BENEFITS

You the patient are responsible for knowing and understanding your own insurance policy and benefits. McDermott Counseling is an out of network provider, therefore is not held to the limitations of your plans usual and customary rate schedule. Should your insurance company not consider the entire fee, you will be responsible for the remaining balance. McDermott Counseling is not responsible for misquoted benefits. It is always advisable for you to contact your insurance plan and confirm your benefits and obtain a reference number for the call.

I have read the above information and have had an opportunity to ask questions which clarify the conditions under which I consent to treatment. I give McDermott Counseling permission to provide evaluation and psychotherapy. I am aware that Esmerelda Alvarez AMFT is a Marriage and Family Associate Supervised by Dr. Hoehing (Lic#21474); and Jeffrey Langer AMFT, Regina Nieto AMFT and Nora Espino AMFT are supervised by Rachel McDermott (Lic# MFC 39944).

Signature of Parent/Legal Guardian #1

Signature of Parent/Legal Guardian #2

Signature of patient

Date

Credit Card/HSA Authorization Agreement

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, _____, authorize McDermott Counseling, to use the credit card information below to charge my card in the following events:

SESSIONS: Session fees will be charged on the day of (or after) a scheduled session.

MISSED SESSIONS: I understand that when I schedule an appointment, that time is held for me, and that insurance will not pay for missed sessions. Therefore, I understand if I cancel a session without 24 hours' notice or if I do not show for the appointment, I authorize McDermott Counseling to charge my credit card for the missed session. I understand I will be charged the full session fee (not just my insurance copayment, if using insurance).

FORGOTTEN PAYMENTS: I understand that if I do not have my payment when I come to a session, the expected payment will be charged.

RETURNED CHECKS: If a check is returned unpaid, the amount of the check will be charged to the credit card, plus any returned check fees.

HEALTH SAVINGS ACCOUNT (RSA) CARDS: If I have a HSA credit card, I authorize McDermott Counseling to charge the card for all services at the time of the session or afterward. I understand that missed sessions cannot be billed to HSA credit cards.

I will not dispute charges ("charge back") with the credit card company for sessions I have received or appointments I have missed according to the above policy.

I understand that my card will automatically be charged \$108, in the event of cancellations in less than 24 hours. I understand that failure to attend will also result in a charge of \$108.

X

PLEASE SIGN HERE CONFIRMING YOU ARE AWARE OF OUR 24-HOUR CANCELLATION POLICY

My credit card information: VISA MC AMEX

Name as it appears on card: _____

Credit card number: _____

Expiration date: _____

Security code: (3 digits on back of card, 4 digits on front of AmEx): _____

Zip code where you receive credit card bill: _____

"I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied."

Signature: _____

Client Written Name: _____

Date: ____ / ____ / ____