McDermott Counseling
Child and Adolescent Intake

Clients Name: _____ DOB: / / Sex: Preferred Gender: _____

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

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

e-mail address: _____

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
_____		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Average ☐ Good

Others living in the household (i.e. step-parent, grandparent,)	Age		Relationship to child	Quality of Relationship
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ 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

__ Affectionate
__ Aggressive
__ Alcohol problems
__ Anger
__ Anxiety/ excessive worry
__ Attachment to dolls
__ Avoids adults
__ Bedwetting
__ Blinking, jerking
__ Bizarre behavior
__ Bullies, threatens
__ Careless, reckless
__ Chest pains
__ Clumsy
___Defiant
__ Depression
__ Destructive
___Difficulty speaking
__ Eating disorder
___Excessive masturbation
___Fatigue
__ Fearful
__ Frequent injuries
__ Expects failure
___ Frustrated easily
___ Hallucinations
___ Head banging
___ Heart problems
_____ Helplessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Loner
___ Low self-esteem
___ Moody
___ Nightmares
___ Overactive
___ Obsessive
___ Often sick
___ Oppositional
___ Overweight
___ Panic attacks
___Poor appetite
___ Phobias
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
____ Stomach aches
___ Steals
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Tics or twitching
___ Teeth grinding
___ Thumb sucking
___ Weight loss
___ 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 $115 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 **$250**. The fee per 38-45 minute session is **$150.** The fee for a 53-60 minute session is **$185. 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.

Any balances not paid within 30 days of the due date may be assessed a late fee of $25 per month. When fees are not paid for services rendered, a collection agency may be used and given appropriate billing and financial information (non-clinical information). A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

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 Haley Gee AMFT, Regina Nieto AMFT, Isabella Mausser AMFT, and Kassidy Perez AMFT are supervised by Rachel McDermott (Lic# MFC39944).

_____ _____

Signature of Parent/Legal Guardian #1 Signature of Parent/Legal Guardian #2

_____

Signature of patient Date

CREDIT CARD / HSA PAYMENT AUTHORIZATION AGREEMENT

Please complete the applicable payment information below. A regular credit card is required in addition to an HAS card because HAS funds may not be used for late-cancellation or no-show fees. For your security, do not write a card security code (CVV/CVC) on this form.

CLIENT INFORMATION
Client name: _____

Parent/guardian name (if applicable): _____

PAYMENT AUTHORIZATION

SESSIONS AND BALANCES: I authorize McDermott Counseling to charge the applicable payment due for services, including any client responsibility, copayment, deductible, or other balance, to the payment card designated for that purpose below, at or after the scheduled session.

LATE CANCELLATIONS AND NO-SHOWS: I understand that appointments canceled with less than a full 24 hours' notice, or appointments missed without notice, are subject to a $115 late-cancellation/no-show fee. I understand this fee is my responsibility and is not covered by insurance or eligible for payment with HSA funds. I authorize McDermott Counseling to charge my regular credit card listed below for this fee.

FORGOTTEN PAYMENTS: I authorize McDermott Counseling to charge the designated payment card on file for any payment due that I have not made at the time of my session.

RETURNED CHECKS: If a check is returned unpaid, I authorize McDermott Counseling to charge my regular credit card on file for the amount owed, plus any applicable returned-check fee.

HSA CARDS: I authorize McDermott Counseling to charge my HSA card only for eligible services, at or after the session. I understand that late-cancellation and no-show fees are not eligible HSA expenses and will be charged to the regular credit card I provide below.

HSA CARD INFORMATION — FOR ELIGIBLE SERVICES ONLY
Cardholder name: _____

HSA card number: _____

Expiration date (MM/YY): _____ **Billing ZIP code:** _____

REGULAR CREDIT CARD INFORMATION — REQUIRED FOR LATE-CANCELLATION / NO-SHOW FEES Cardholder name: _____
Card type: ☐Visa ☐Mastercard ☐American Express ☐ Discover
Credit card number: _____
Expiration date (MM/YY): _____ **Billing ZIP code:** _____

CLIENT ACKNOWLEDGMENT AND AUTHORIZATION: By signing below, I acknowledge that I have read and understand McDermott Counseling's full 24-hour cancellation policy and authorize the charges described in this agreement. I understand that I may ask questions about this authorization before signing.
Client signature: _____ **Date:** _____ **Printed name:** _____ **Date (if different):** _____

For security, complete and submit payment information only through a method approved by McDermott Counseling. Do not include or retain a card security code (CVV/CVC) on this form.