VALLEY CHRISTIAN COUNSELING

5151 Research Drive NW Suite 1B, Huntsville, AL 35805
Tel: 256-722-8091 Fax: 256-270-7019

CHILD INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here remains confidential.

Please describe the main issue, reason, or event that has brought your child here today:

_____
_____
_____
_____

CLIENT INFORMATION:
Name of person filling out this form:

_____
Child's Name: _____
Date of Birth:____/____/____
Address: _____City: _____Zip:_____
Home Phone:(___)_____Work:(___)_____Cell:(____)_____
Gender: _____ (specify preferred pronouns if applicable)
Race (optional): _____ (specify)

Mother's Name:

_____
Address: _____City:_____Zip:_____
Home Phone: _____Work: _____Cell: _____
Email:_____
May we leave a message? Yes ( ) No ( )

Father's Name:

_____
Address: _____City:_____Zip:_____
Home Phone: _____Work: _____Cell: _____
Email: _____
May we leave a message? Yes ( ) No ( )

EMERGENCY INFORMATION
In case of an emergency please contact: _____
Relationship: _____
Telephone: _____

TREATMENT HISTORY

Is your child currently receiving any other mental health services?
( ) yes ( ) no
Has your child had previous psychotherapy?
( ) no ( ) yes, with (previous therapist's name)_____
Is your child currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no
If yes, please list: _____
Prescribed by: _____

HEALTH INFORMATION

Does your child currently have a primary physician? ( ) yes ( ) no
If yes, who is it? _____
Is your child currently seeing more than one medical health specialist? ( ) yes ( ) no
If yes, please list: _____
Please list any persistent physical symptoms or health concerns:
_____
_____

SLEEP

How would you describe your children's sleep habits?
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) Other
Explain:_____

EXERCISE

How would you describe your child's physical activity?
( ) sedentary (little to no exercise)
( ) Lightly active (a few times a month)
( ) moderately active (a few times a week)
( ) highly active (nearly every day)

APPITITE

Is your child having difficulty with appetite or eating habits? ( ) no ( ) yes
f yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting
Have you noticed any significant weight change in the last 2 months? ( ) no ( ) yes

Substance History and Use:

Are you aware of any substance use from your child? Yes ( ) No ( )
If yes, please
explain:_____
_____

SUICIDE ASSESSMENT

Has your child expressed any suicidal thoughts? Yes ( ) No ( ) Unsure ( )
Has your child previously attempted suicide? Yes ( ) No ( ) Unsure ( )
If yes, how long ago and how may times? _____
Is there any family history of suicide? Yes ( ) No ( ) Unsure ( )

CHANGES/STRESSORS

In the last year, has your child experienced any significant life changes or stressors? (Example: Parents' divorce or remarriage)

_____
_____
_____
_____

Has your child ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	
Adoption	Yes / No	
Abuse	Yes / No	
Other (use box to explain)		

TRAUMA ASSESSMENT

To your knowledge has your child personally experienced or witnessed any of the following? If, Yes, were they the victim or the witness?

Experience	**Please circle**	**Victim**	**Witness**
Physical abuse	Yes / No		
Sexual abuse	Yes / No		
Emotional/mental abuse	Yes / No		
Neglect	Yes / No		
Abandonment	Yes / No		
Community violence	Yes / No		
Bullying	Yes / No		
Natural Disaster	Yes / No		
Other	Yes / No		

OTHER INFORMATION

Are you looking for court related services? If yes, please explain.

_____
_____
_____

What do you consider to be your child's strengths?

_____
_____
_____

What are your child's hobbies and interests?

_____
_____
_____

What are ways your family copes with stress?

_____
_____
_____

What would you like your child to achieve as a result of therapy?

_____
_____
_____

IMPORTANT NOTE: If your child is over the age of 14, please pay careful attention to the section titled "***Minors and Parents***" when reading and signing the informed consent section.

VALLEY CHRISTIAN COUNSELING
INFORMED CONSENT

Overview
Welcome to Valley Christian Counseling. The following information is to assist you in establishing your expectations for psychotherapy and functions as an agreement between you and your therapist. Please read the following carefully and complete all sections before the first session. Please feel free to call with any questions or concerns throughout the course of treatment.

Sessions
Therapy appointments are approximately 45-55 minutes in duration, however longer sessions are also available upon advanced request. The number of sessions is determined by both the therapist and the client depending on the client's individual needs.

Cancelation Policy
A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled without 48 hours' notice, the clinician reserves the right to charge you a missed/cancelled appointment fee equal to your agreed upon session rate. It is important to note that insurance companies will not reimburse you for canceled or missed appointments.

Confirmation Calls
To better serve our clients, our staff strives to provide confirmation calls to remind you of your appointment approximately 48 hours in advance. However, please make efforts to set self-reminders in the event we are not able to place a call.

Emergency Options and Additional Resources
If you are unable to reach our office during normal business hours and are experiencing a crisis or medical emergency please call 911 or head to your nearest emergency room.

Records
Your professional records may include information regarding your reason for seeking therapy, a description of the impact your problems may be having on your life, your treatment goals and your progress toward said goals, your medical and social history, your billing records, and any reports received from other clinicians. You have the right to review your records at any time, however, it is recommended that the records be reviewed in the presence of your therapist before viewing them individually. A fee may be applied to the request of your records. Your records are stored in a locked filing cabinet behind two locked doors, and will be stored for 7 years (per requirements of the Alabama Board of Social Work) before being properly destroyed.

Offsite Consultation
Consultation are sometimes requested by other professionals involved in your care. In the event that you or another professional request a consultation, your clinician reserves the

right to bill at the hourly rate for consultation services. It is important to note that billable time may also include travel and prep time.

Minors and Parents

Children under the age of 14 cannot consent to therapy on their own, however in the State of Alabama a minor child over the age of 14 may seek therapeutic services without the consent or knowledge of their parents/guardians. Children over the age of 14 have the right to privacy and the parents are not privy to confidential information, unless a release has been obtained. The Clinician will strongly urge the teenager to sign said release as treatment is often inhibited when guardians are not involved in the process. Clients under the age of 14 can not consent for themselves and therefore will need the permission of a guardian to seek therapeutic services. If a child is in danger or is a danger to someone else, the therapist will notify the parents of this concern as well as the appropriate authorities if necessary. Before, giving sensitive information to parents, the clinician will discuss the matter with the child, if possible, and do their best to mitigation any objections and explain the benefits of guardian support.

Contacting your Clinician

If you need to contact your clinician, please call Valley Christian Counseling Center and leave a message with the receptionist or on the appropriate extension. Your therapist will periodically check messages, and return your call as soon as possible.

Release of Information

Valley Christian Counseling is not a HIPAA covered entity; however, your therapist is subject to all ethical and legal standards that protect your confidentiality. We will only disclose your personal information given legal obligations due to a duty to report, and/or given your written authorization.

Limits on Confidentiality

1. Occasional consultations with other mental health professionals about a case are helpful or even necessary in order to provide quality care. We make every effort to ensure your confidentiality during this process.
2. If you or a minor in your care are a harm to yourself or others, I have a duty to report in order to prioritize your safety.
3. The following are some examples of situations in which I may be required or legally permitted to disclose information without your consent or authorization:
    a. Requests made from court order
    b. In the event I become the defendant in a case filed against me I have the right to release privileges information that may be relevant to my defense.
4. I am considered a mandatory reporter, meaning if I suspect that any vulnerable population is being abused and/or neglected that I must report to the appropriate authorities.

Client or Guardian Name: (PRINT)_____Date:_____

Client or Guardian Signature:_____ Date:_____

Clinician's Signature:_____Date:_____

The above signature certifies that I understand that I am consenting to counseling services, and that I understand the limits of confidentiality within those service.

Client's Rights

- Receive humane care and treatment, with respect and consideration
- Privacy and confidentiality when seeking or receiving services except in the case of life-threatening situations or conditions
- Confidentiality of your health records
- Receive accurate information concerning diagnostic impressions, treatment, and risks
- Participate actively in decisions regarding your own treatment
- Accessible information regarding the scope and availability of services
- Be informed about any legal reporting requirements regarding any aspect of screening or treatment
- A copy of your records upon request and written authorization
- You may file a complaint with the director of VCC regarding any concerns related to the privacy, confidentiality or security of your medical record
- Receive competent treatment in a respectful environment that acknowledges your dignity and worth
- Gain knowledge regarding strategies and therapy techniques used to aid in your treatment.
- Participate in establishing and reestablishing goals throughout therapy
- Participate or refrain from services (except when mandated)
- Request referrals for alternative services

Client or Guardian Signature: _____ Date:_____

Client or Guardian Print: _____ Date:_____

VALLEY CHRISTIAN COUNSELING
FINANCIAL AGREEMENT

5151 Research Drive NW Suite 1B, Huntsville, AL 35805
Tel: 256-722-8091 Fax: 256-270-7019

Thank you for choosing Valley Christian Counseling to be your mental health provider. We are committed to providing the best care possible. It is important that you understand that payment for services is considered part of your treatment; therefore, the following information explains our financial policies. We ask that you sign this form as an indication that you have read and agree with the information presented.

Reimbursement/Insurance Coverage
Currently, your clinician does not accept insurance, however this is subject to change depending on clinicians' preferences. Because Valley Christian Counseling is not an in network provider, you may choose to submit you receipts to your insurance company for reimbursement. Reimbursement options vary depending on your insurance provider. Each visit, you will be provided an itemized statement that contains the information needed to file a claim.

Methods of Payment
We ask that you pay in full upon the time of services, unless previously agreed upon by you and your therapist. We accept most forms of payment including cash, check, or credit card.

Unpaid Balance
If you accrue an unpaid balance, we ask that you make arrangements to pay balance within 30 days. In the event that we cannot reach you to collect payment, Valley Christian Counseling may peruse reimbursement by submitting a claim to small claims court, or hiring a collections agency. Payment plans may be offered when requested with approval from director of VCC. Confidential information may be shared in claims court or to collections agency on as needed basis.

Late Cancelation/No Show Fees
If cancelations have not been made within 48 hours of the appointment or client did not show up for the session, the client is subject to a no-show fee. Exceptions are made in cases of emergencies. Late cancelation/no show fee is $50.00; however, the clinician reserves the right to charge the entire session fee of $120.00 if the client is a repeat offender. Grace is often offered, especially in unforeseen circumstances. Your practitioner asks for communication and in response fees may be waved at your practitioners' discretion.

Court Related Fees
Clients who require court related services can expect a rate of $200 per hour. Court related work can include, but not limited to, consultations, phone calls, travel time,

depositions, and time spent at court. There is a minimum retainer fee of $1000 to appear/testify in court. Payment must be received 48 hours prior to the court appearance. Subpoenas must be received within 48-hour notice or client may be subject to an additional charge of $200. In the event that the court date is rescheduled with less than 72 business hours, the clinician reserves the right to charge an additional fee of $300 in addition to any previous accrued fees. It is important to note that any given testimony may not result in your favor. In the event that you lose your case, you will still be responsible for court related fees.

Statement of Understanding

I certify that I understand the above statement and I agree to its terms. By signing below, I am stating that I have read and agree with the financial fees set by my practitioner. I understand that Valley Christian Counseling and/or my practitioner reserve the right to adjust or lower that fee on as needed basis.

Client or Guardian Print: _____ Date:_____

Client or Guardian Signature: _____ Date:_____

Clinician Signature_____ Date:_____