Integrated Counseling, LLC
7286 S Yosemite St. #150
Centennial, CO 80112
(303) 220-7319

Child and Adolescent Intake Form

This information is considered confidential and will not be released without written permission of parents and/or guardian. Please complete the form and provide details where possible.

PART I: Family Information Date _____

Child's name: _____ D.O.B.: _____
Gender: _____ Telephone number: _____
Address: _____City, State/Zip:_____
Place of birth/Hospital: _____
Mother's name: _____ Mothers Date of Birth:_____
Phone: _____W: _____ Mothers email:_____
Mothers Address: _____ City/State/Zip:_____

Father's name: _____ Fathers Date of Birth:_____
Phone: _____W: _____ Fathers email:_____
Address:_____ City/State/Zip_____
Parents' marital status: (circle one) Married Divorced Separated Never Married Living Together
Who is the major caretaker of the child?_____

Who does the child live with (please list adults and siblings/ages):_____

_____

Private insurance: _____Group #: _____ Policy #:_____

How were you referred to our office? _____
May we send you information about upcoming appointments or programs by email? Y or N
If yes list email address:_____

PART II: Reason for Referral

What is the main concern and what are some of the behaviors you observe that make you suspect that there is a problem?

_____
_____
_____
Does the present problem occur at home? _____ school? _____ other? _____
Are there other concerns?_____

Social and Behavioral Questions Place a check mark next to any behavior or problem that your child currently exhibits:

_____Has difficulty with speech _____Has frequent tantrums _____ Is oppositional/defiant
_____Has difficulty with school _____Has frequent nightmares _____Has difficulty with language
_____Has trouble sleeping _____Has difficulty socially _____Has poor appetite
_____Has poor bowel control _____Has memory problems _____Has difficulty with coordination
_____Has attachment problems _____Wets bed _____Is aggressive
_____Is distractible/short attention _____Is too active _____Is slow to learn
_____Is Angry _____Is impulsive _____Is fearful _____Does not get along with peers
_____Runs away _____ Is violent _____ Uses drugs or alcohol _____ In trouble with the law

Please use this space to describe any problems in more detail:_____
_____
_____
Does he/she have a problem controlling his temper or with controlling anger? (describe) _____
_____
Does he/she ever get sad or withdrawn? (describe)_____
_____

Has your child ever been in trouble with the law? (describe) _____
_____
Is your child fearful of being left alone or experiencing new situations? Yes or No
Doeshe/she have a hard time sitting still and paying attention to things? describe)_____

_____

Does he/she have any problems interacting with peers outside the home? (describe) _____
_____
How does he/she get along with other family members?
_____
Does his/her behavior cause difficulty within the family?
_____
When was the problem first observed and by whom?
_____
What was done at that time?
_____

Has the child been evaluated for the current problem before? Y or N If yes, when, and by whom?
_____

Has the child seen a psychiatrist or psychologist previously? Y or N If yes, when_____

Was it in reference to this or another problem? Same: _____ Different: _____ If different, please explain: _____

PART III: Family History

Please list those persons who are important in your child's life. Name, Age, Relationship and whether they live with your child:

_____

_____

Are there any other family members with similar problems to those discussed on this form?

_____

Has anyone in the family of either parent had any of the following problems? If so list their relationship to him/her:

Learning Problems in School _____ Mental Retardation _____
Addictions _____ Diabetes _____ Blindness _____
Seizures _____ Alcoholism _____ Depression _____
Anxiety _____ Birth Defect _____ ADD/ADHD_____
Other family history: _____

Is he/she adopted or a foster child? ____No ___ Foster ____ Adopted _____ Step

If fostered or adopted how long has he/she been with you? _____
What were you told about the child's history?

_____

PART IV: Prenatal, Birth and Developmental History (if known)

During pregnancy was there use of: ____Tobacco ____Alcohol ____Medications ____ Drugs If so, what _____ Weight at birth: _____
Any problems during the birth?: Y or N Nature of the Problem: _____
Full Term: Y or N If not, how many weeks' gestation? _____

This is a list of developmental milestones. If you remember please give the approximate age when your child did following.

Finger fed _____ Cooed _____ Undressed completely _____
Understood "no" _____ Tied shoes _____ Laughed aloud _____
Toilet trained _____ Rolled over _____ Waved bye _____
Sat unassisted _____ Crawled _____ Walked _____
Said first words _____ Put two words together _____

PART V: Medical History

Have there been any health problems? _____ If yes, please explain _____

_____

_____

Has he/she ever been hospitalized?_____
_____

Has he/she ever had surgery? _____
_____

Does he/she have allergies? Y or N (please list) _____
_____

Medications: Please list any medications your child currently takes regularly?

Name, Frequency, Dosage _____
_____

Physician name: _____ Telephone number: _____

PART VI: Educational History

Name of school: _____Grade: _____ Special Ed services: Y or N

Has the child had any educational testing? Y or N Is the child on an IEP/504 plan? Yes or No

What grades does the child typically earn? _____

Does the child receive: Speech therapy _____ Occupational therapy _____ Physical therapy _____

If so, what type, where and when? (date of last assessment) _____
_____

Has the child been held back in a grade? Y or N # of schools the child has attended: _____

Place a check next to any educational problem that the child currently exhibits:
_____ Has difficulty with reading _____ Has behavior problems _____ Has difficulty with math
_____ Does not like school _____ Has difficulty with peers _____ Has difficulty focusing

PART VII: Employment History (if applicable)

Has the child ever been employed? Y or N If yes, give details _____
_____

Part VIII: Other Information

What are the child's strengths?
_____

What are the child's favorite activities?
_____

What is the child's temperament like?
_____

Please discuss anything else it would be important to know about the child:_____
_____
_____
_____

Permission for Treatment

In presenting my child for diagnosis and treatment, I voluntarily consent to the rendering of counseling services provided by Integrated Counseling LLC. I acknowledge no guarantees have been made to me as to the effect of treatment on my child's condition. I acknowledge I am responsible for all reasonable charges in connection with care and treatment. I have read this statement and acknowledge that I understand it.

_____ _____

Signature of Parent/Guardian of Minor Child Date

Integrated Counseling, LLC

Policy Statement

- Each minor session is 45 minutes in length; the cost of each child session is $75.00.
- Payment is due at the end of each session. A receipt will be provided for the client to make their own insurance claim.
- Patients will be charged $25 for returned checks. Upon the occurrence of a returned check the client will be required to pay by cash or credit card for future sessions.
- Sessions begin at your designated appointment time and are 45 minutes in length.
- Patients arriving more than 15 minutes after their designated appointment time without calling will be considered a No Call / No Show.
- Missing an appointment without prior notice is considered a No Call / No Show.
- All No Call / No Show's will be billed directly to the client for the full amount of the scheduled session.
- Late cancellation is any cancellation notice given within 24 hours of the designated appointment time. Late cancellations will be billed directly to the client at the rate of $45.00 per occurrence.
- Patients that accumulate 3 late cancellations or No Call / No Show's in any combination will be referred out to another counseling service.
- Time spent preparing letters, misc. paperwork, court documents etc. on behalf of a client will be billed directly to the client at the rate of $50.00 per hour with a $25.00 minimum.
- Court time or consultations with third parties (NOT related to billing / insurance issues) on behalf of a client will be billed directly to the client at the rate of $100.00 per hour with a $50.00 minimum.

By signing below, I signify that I have read and fully understand this Policy Statement, and that I agree to pay any charges that may be applied to my account as a result of these policies.

Signed: _____ Date: _____

Revised 4/2/15

Integrated Health Center, LLC
7286 S. Yosemite St. #150
Centennial, CO 80112
(303) 220-7319

COLORADO NOTICE FORM OF HIPAA LEGISLATION

Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your counselor may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.

• "Treatment, Payment, and Health Care Operations"

– Treatment is when your counselor provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your counselor consults with another health care provider, such as your family physician or another psychotherapist.

– Payment is when you obtain reimbursement for your healthcare. Examples are if your counselor discloses your PHI to your health insurer for reimbursement for health care.

– Health Care Operations are activities that relate to the performance and operation of your counselor's practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits, administrative services, case management, and care coordination.

• "Use" applies only to activities within your counselor's [office, clinic, practice group,etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "Disclosure" applies to activities outside of your counselor's [office, clinic, practice group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Your counselor may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your counselor is asked for information for purposes outside of treatment, payment or health care operations, your counselor will obtain an authorization from you before releasing this information. Your counselor will also need to obtain an authorization before releasing your notes. "Psychotherapy Notes" are notes your counselor has made about your conversation during a private, group, joint, or family counseling session, which your counselor has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your counselor has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Your counselor may use or disclose PHI without your consent or authorization in the following circumstances:

• Child Abuse – If your counselor has reasonable cause to know or suspect that a child has been subjected to abuse or neglect, your counselor must immediately report this to the appropriate authorities.

• Adult and Domestic Abuse – If your counselor has reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then your counselor must report this belief to the appropriate authorities.

• Health Oversight Activities – If the Grievance Board for Unlicensed Psychotherapists or an authorized professional review committee is reviewing my services, your counselor may disclose PHI to that board or committee.

• Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and your counselor will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

• Serious Threat to Health or Safety – If you communicate to your counselor a serious threat of imminent physical violence against a specific person or persons, your counselor has a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If your counselor believes that you are at imminent risk of inflicting serious harm on yourself, your counselor may disclose information necessary to protect you. In either case, your counselor may disclose information in order to initiate hospitalization.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

• Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, your counselor is not required to agree to a restriction you request.

• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing your counselor. On your request, your counselor will send your bills to another address.)

• Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in your counselor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your counselor may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your counselor will discuss with you the details of the request and denial process.

• Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your counselor may deny your request. On your request, your counselor will discuss with you the details of the amendment process.

• Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, your counselor will discuss with you the details of the accounting process.

• Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

• Your counselor is required by law to maintain the privacy of PHI and to provide you with a notice of his or her legal duties and privacy practices with respect to PHI.

• Your counselor reserves the right to change the privacy policies and practices described in this notice. Unless your counselor notifies you of such changes, however, your counselor is required to abide by the terms currently in effect.

• If Christina Szarka revises her policies and procedures, she will notify you by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision your counselor makes about access to your records, or have other concerns about your privacy rights, you are encouraged to discuss this with your counselor prior to your first session. If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to: Christina Szarka 7286 S. Yosemite St #150 Centennial, CO 80112. You may also send a written complaint to the Division of Complaints, 1560 Broadway, Suite 1350, Denver, Colorado 80202. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

IV. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on the date you sign this notice. Integrated Counseling, LLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that your counselor maintains. Christina Szarka, MFT will provide you with a revised notice by mail within ten business days prior to changes.

VII. Client Signature

I have read the above terms and understand them as stated. I have been informed of my therapist's policies and practices to protect the privacy of my health information.

_____

Client Name (Printed) Signature Date

_____

Therapist Name (Printed) Signature Date

Revised 4/2/15