COMMUNITY COUNSELING CENTER

Child Packet (to be completed by Parents)

IDENTIFYING INFORMATION

Date of Assessment: ____________________________________Social Security_______________________

Name of Child ____ Sex: (M)_____ (F) _____

Birth Date __________________ Place of Birth ______________________________ Age _______________

Address (Number and street) ____

City ___________________State _________ Zip Code _____________________________________

Telephone _____________________ Religion (Optional) _______________________________________

Insurance Information: Carrier________________________Member #_____________________________

Group #___________________Primary"s Name_________________________DOB___________________

SS#____________________Employer______________________Relationship to primary_______________

Education (Grade) _________________________ Present School _________________________________

Referral Source:____

CHIEF COMPLAINT:

Presenting Problems (Check all that apply)

___ Very unhappy
___ Irritable
___Temper outbursts
___Withdrawn
___Daydreaming
___Fearful
___Clumsy
___Overactive
___Slow
___Short attention span
___Distractible
___Lacks initiative
___Undependable
___Peer conflict
___Phobic
___Impulsive
___Stubborn
___Disobedient
___Infantile
__ Mean to others
___Destructive
___Trouble with the law
___Running away
___Self-mutilating
___Head banging
___Rocking
___Shy
___Strange behavior
___Strange thoughts
___Fire setting
___Stealing
___Lying
___Sexual trouble
___School Performance
___Truancy
___Bed wetting
___Soiled pants
___Eating problems
___Sleeping problems
___Sickly
___Drug use
___Alcohol use
___Suicide talk

How long have these problems occurred? (Number of weeks, months, years)

____

What happened that makes you seek help at this time?____

____

____

Problems perceived to be: ___very serious ___serious ___not serious

What are your expectations of your child?____

____

____

What changes would you like to see in your child?____

____

What changes would you like to see in yourself? ____

____

What changes would you like to see in your family? ____

____

PSYCHOSOCIAL HISTORY

CURRENT FAMILY SITUATION

Mother - Relationship to child ___natural parent ___relative
___step-parent ___adoptive parent

Age: ________________________________ Birthdate: ____

Birthplace: ______________________________ Religion: ____

Education: _________________________________ Occupation: _____________________________________

Father - Relationship to child ___natural parent ___relative
___step-parent ___adoptive parent

Age: ______________________________ Birthdate: ____

Birthplace: __________________________ Religion: ____

Education: __________________________ Occupation: ______________________________________

Marital History of Parents:

Natural Parents: ___Married When___________________ Ages ________ _________
___Separated When___________________
___Divorced When___________________
___Deceased When__________________ ________________________

Step-parents: ___Married When___________________

If child is adopted- Adoption source: ____
Reason for circumstances:

____

Age when child first in home: ____

Date of legal adoption: ____

What has the child been told?

____

Was the child ever placed, boarded, or lived away from the family? _____Yes   _____No

Explain:____W

hat are the major family stresses at the present time, if ?____

____

What are the sources of family income? ____

____

BROTHERS and SISTERS: (indicate if step-brothers or step-sisters)

	Name	Age	Gender	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug abuse (yes or no)
1.							
2.							
3.							
4.							

Others living in the home (and their relationship):

1.____

2.____

Does or did any member of the child's family have any problems with:
_____reading   ______spelling   ______math   ______speech
(if yes, please explain)

Is there any history in the child's family of?
_____mental retardation   ______epilepsy   _____birth defects   _____schizophrenia
(if yes, please explain)

Has child ever been seen by a medical specialist?   ____Yes   ____No

Age	How Long	Reason

Has child ever taken, or is he/she taking presently, any Prescribed medications?
____Yes   ____No

Age	How Long	Reason

Name of Primary Care Physician ____

Describe special habits, fears, or idiosyncrasies of the child: ____

____

EDUCATIONAL HISTORY:

Types of classes: ___Regular ___Learning Disability ___Continuation
___Emotionally Handicapped ___Opportunity ___Other

Did child skip a grade? ___Yes ___No Repeat a grade? ___Yes ___No
(If yes, when and how many years appropriate grade level at the present time?)

____

Did child have any specific learning difficulties? ___Yes ___No
Has child ever had a tutor or other special help with school work? ___Yes ___No
Does child attend school on a regular basis? ___Yes ___No
Does child appear motivated for school? ___Yes ___No
Has child ever been suspended or expelled? ___Yes ___No

Does child participate in extracurricular activities? ___Yes ___No (explain)

____

____

In school, how many friends does child have: ___a lot ___a few ___none

What are child's educational aspirations? ___quit school ___graduate ___go to college

Has child had special testing in school (If yes, what were the results?)
Psychological ___Yes ___No Vocational ___Yes ___No

List child's special interests, hobbies, skills:

____

____

____

____

____

____

Has the child ever had difficulty with the police? ___Yes ___No (if yes, explain)

____

Has child ever appeared in juvenile court? ___Yes ___No (if yes, explain)

____

Has child ever been on probation? ___Yes ___No
From To Reason Probation Officer

____

____

____

ADDITIONAL COMMENTS

____

____

COMMUNITY COUNSELING CENTER

515 N. Penelope Street, Belton, TX 76513
254.933.3306

POLICIES AND COUNSELING AGREEMENT

Thank you for selecting Community Counseling Center. Please carefully read the information provided below. Before you begin therapy, it is important that you fully understand your rights and responsibilities as a client of the Community Counseling Center.

YOUR RIGHTS AS A CLIENT

You have the right to ask questions about therapeutic procedures or methods used during your therapy.

You have the right to end therapy at any time without any legal or financial obligations other than the those already incurred.

You have the right to select a different therapist. If you wish to continue therapy with a different therapist, you will be provided with the names of other qualified professionals whose services you may prefer.

One of your most important rights involves confidentiality. All therapeutic communications, records and contacts with professional and support staff will be held in strict confidence. Information may be released, in accordance with state law, only when:

(1) the client signs a written release of information indicating informed consent
(2) the client expresses serious intent to harm himself/herself or someone else
(3) there is evidence or reasonable suspicion of abuse against a minor child, elder person (65 years or older), or dependent adult
(4) a subpoena or other court order is received directing the disclosure of information

THE THERAPEUTIC PROCESS

A major benefit of therapy is resolving the concerns that brought you to therapy. Another benefit is the ability to better handle or manage marital, family and other interpersonal relationships. Many times, you will have a better understanding of personal goals and values which may lead to greater maturity and happiness as an individual.

In working to achieve these potential benefits, your therapy may involve a firm effort on your part to change. These changes may cause significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings such as fear, anger, depression and frustration. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not have originally been intended.

WORK AGREEMENT

It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his or her life. Client gain is most important in professional counseling. Suspension, termination, or referral shall be discussed between the counselor and client for a pattern of behavior that reveals disinterest or lack of commitment to counseling or for any unresolved conflict between counselor and client.

FEE AND SERVICE AGREEMENT

All fees are due at the time that services are provided. Professional fees are as follows:

Initial (Diagnostic) Session.......... $210.00
Subsequent 60 Minute Sessions………. $165.00

A **CASH DISCOUNT** WILL BE OFFERED TO ALL CLIENTS PAYING BY CASH OR CHECK. **THE Initial (Diagnostic) Session WILL BE REDUCED to $165.00 and the 60-minute Session WILL BE REDUCED TO $110.00**. If for some reason a client is not able to pay the day the service is rendered, the cash discount will still apply if the session fee is paid within seven (7) days of the session date.

Please also be aware that professional fees will be prorated for sessions that exceed 50 minutes. Please let your therapist know if additional charges resulting from longer sessions will be a problem. If you are using insurance, sessions that exceed 50 minutes are not covered under most plans.

There will be a fee for telephone consultation or sessions (of 15 minutes or more) based on the above-mentioned rates. You will be mailed a statement at the end of the business day that the telephone session occurred.

We take limited insurance at this time. If we are not in-network with your Insurance Provider, we will give you the information you need to file the insurance yourself.

If insurance(s) will be filed:
With my initials, I acknowledge that:

____ I hereby authorize Community Counseling Center to furnish information to my insurance carrier(s) concerning my illness and/or treatment.

____ I authorize payment of medical benefits to be paid directly to the Community Counseling Center and/or my counselor.

____ I understand that if I cancel an appointment later than the 24-hour cancellation period, or if I miss the appointment with no cancellation notice, I acknowledge the fee for the session will be billed to my account, and not to my insurance company.

____ I understand that even though insurance claims may be filed, I am still directly responsible for payment of this account if the claims are not paid by the insurance company.

Signature: ____ Date: ____________________

We, the undersigned therapist and client(s), have read, discussed together, and fully understand this agreement and these policies. We agree to honor these policies.

Client Signature: ______________________________________Date: _____________
Therapist Signature: ___________________________________ Date: ________________

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***** POLICY ON MISSED APPOINTMENTS *****

Therapy is by *APPOINTMENT ONLY*. The following charges will apply to missed or canceled appointments:

Appointments canceled, with 24 hours' notice .... no charge
OR
Appointments canceled, with less than 24 hours' notice; or not kept, with no notice given:
1st time ....1/2 session fee
2nd time ....full session fee

Missed or late canceled appointment charges will appear on your monthly statements or be brought to your attention by the office manage. Payment is due upon the receipt of a statement or the notification by the office manager.

WITH MY INITIALS, I ACKNOWLEDGE THAT:

____ I have read and do understand the Community Counseling Center's policy on missed appointments.

____ I understand that payment is expected as services are rendered unless prior financial arrangements have been made with the office manager.

____ I also understand should my account become 90 days past due, this information may be turned over to a collection agency.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT:

I understand that under the Health Insurance Portability Accountability Act (HIPAA) of 1996, I have certain rights to privacy in regard to my protected health information (PHI). I have been given the opportunity to review a copy of the Notice of Privacy Practices for the **Community Counseling Center.**

I understand that the **Community Counseling Center** reserves the right to change the terms of its Notice of Privacy Practices from time to time. I understand the **Community Counseling Center** will provide a current Notice of Privacy Practices upon request.

If signed by someone for a minor or incapacitated person indicate below the relationship of the person signing to the client.

________Parent ______Guardian _____Other: ______________________

Signature: _____________________________________ Date: __________________________

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THE TEXAS FAMILY CODE

THE TEXAS FAMILY CODE, SECTION 34.01,
PROVIDES THAT "ANY PERSON HAVING CAUSE TO BELIEVE THAT ANY CHILD'S PHYSICAL OR MENTAL HEALTH OR WELFARE HAS BEEN OR MAY BE ADVERSELY AFFECTED BY ABUSE OR NEGLECT SHALL REPORT IN ACCORDANCE WITH SECTION 34.02 OF THIS CODE"

IT IS OUR POLICY TO INFORM ANY PARENT THAT WE WILL ADHERE STRICTLY TO THE INTENT AND THE LETTER OF THIS STATUE. IT IS NOT ONLY IN THE BEST INTEREST OF THE CHILD AND THE FAMILY, BUT WE ARE CRIMINALLY LIABLE IF WE DO NOT. THIS INCLUDES, BUT NOT LIMITED TO, STRIKING OR HITTING A CHILD OR PUNISHING TO THE P0INT OF LEAVING BRUISES.

I UNDERSTAND SECTION 34.01 OF THE TEXAS
FAMILY CODE AND THE REPORTING REQUIREMENTS

____
SIGNATURE

____
DATE

Patient | Library Links | Appointment Reminders

If you want to send appointment reminders by email,
PLEASE READ THE FOLLOWING TO THE CONSUMER

We can send you an appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your service provider name. We will not encrypt the messages. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, I need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

By checking the box below that enables E-mail reminders and entering an E-Mail address, you acknowledge that you have received consent from the patient.

☐ Enable E-mail Reminders for this patient

Send reminder [2] days prior to their next appointment

Recipient E-mail: [ ]