Collin County Counseling
2150 S. Central Expwy Ste., 200
McKinney, TX 75070 • (469) 219-3256

DEMOGRAPHIC/INSURANCE INFORMATION

Date_____ Child's Name: _____DOB: _____ Age: _____

Child's Primary Residence: _____ City: _____ Zip: _____
Caregiver (s) at this address:
_____

Second Residence _____ City: _____ Zip: _____
Caregiver (s) at this address:
_____

Relationship Status of Child's Parents: Married * Divorced * Separated * Widowed *
If divorced, what is the custody agreement?
_____

Mother: _____ Father: _____
Occupation: _____ Occupation: _____
Email: _____ Email: _____
Home phone: (_____) _____Home phone: (_____) _____
Cell phone: (_____) _____ Cell phone: (_____)_____

Referred by: ☐ Insurance Co. ☐ Physician ☐ Friend ☐ Google ☐Website

Financial Responsibility—*If paying privately, please check here* ☐

Name of Insured: _____ Date of Birth: _____

Client's Relationship to Insured: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Child ☐ Guardian

Insurance Carrier: _____ Insurance Phone#: _____

Co-pay $____ Member ID#: _____ Policy/Group#:_____

Employer: _____ Employer Phone#: _____

- Your signature below authorizes your insurance company to pay me directly for services provided.
- You are also authorizing the release of information about your child's care to your insurance company. The information often required by insurance

companies may include, but is not limited to, diagnosis codes, dates of service, treatment and progress.

- **If your insurance company should deny payment, you will be responsible for any outstanding financial debt associated with therapy services.**

Parent or Legal Guardian:_____
Date:_____

Office Policies and Consent for Treatment

Welcome to my therapy practice. This document contains important information about my professional services and business practices and will serve as a therapeutic contract. Please read it carefully and jot down any questions that you would like to discuss.

My Philosophy

An important part of child therapy includes regular meetings with parents or parents & children together. These meetings are an essential part of your child's growth in therapy.

About the Therapy Process

- It is important for you to know that child counseling has risks and benefits. Therapy has been shown through research to be very beneficial to children. Although there are no guarantees about the outcomes of therapy, children often demonstrate a reduction in concerning behaviors and an increase in emotional well-being.
- One of the risks is possible disagreement between parents or disagreement between parents and therapist regarding treatment. If this occurs, I will make every effort to listen and understand your concerns. If at some time you decide to end therapy, I ask that you schedule a few closing sessions so that I can end treatment appropriately for your child.
- Trust between client and therapist is vital to the therapy process, even for young children. Therefore, I will not share the specifics of what your child has disclosed to me without the child's consent, unless there is a risk of harm to self or others. I will share with you general themes and treatment progress and will encourage your child to share important information with you as well.

- Although my responsibility to your child may require my involvement in conflicts between parents, I request your agreement that my involvement will be strictly limited to that which will benefit your child. This means that you agree that you will not attempt to gain an advantage in any legal proceedings between you and the child's other parent (guardian) regarding my work with your child. You also agree that you will not ask me to testify in court, whether in person or by affidavit and that you will instruct your attorneys not to subpoena me or to refer in any court filing to anything that I have said or done.
- Due to the current COVID-19 circumstances, all the counseling sessions will be offered online as video session via a secure portal (HIPPA Complaint) or over the telephone based on client preference for the unforeseeable future.

Custody/Guardianship

- Consent for services can only be authorized by a current legal guardian.
- For divorced parents, consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. (A copy of the divorce decree must be included in the client file indicating the custodial arrangement).
- Permission from both parents, regardless of the custodial arrangement is the preferred practice of this office.

Payment and Fees:

- **No shows/Late cancellations** *(less than 24 hours notice)* **incur a fee of $75.00**. This fee cannot be billed to your insurance and client will be billed directly.

- Payment (private pay or co-pay) is due at the beginning of each session (cash or check).
- My standard fee is $150 for the Clinical Intake/hour and 135/hour for Individual, Marriage, and Family Counseling sessions. Longer/Shorter sessions will be prorated at $2.25/minute in addition to the fee.

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- If using insurance, your co-pay is due at each session. Overtime fee for a session beyond the allowed time for Individual Counseling: 50 - 60 min & Family Counseling: 45 - 50 min will be prorated at $2.25/minute in addition to the copay. Please note overtime charge is client responsibility. Insurance/copay only covers for the above listed time limits per session.

- It is your responsibility to keep me updated with your insurance information. You are financially responsible for costs incurred when a claim is denied due to changes in, lapses or exhaustion of benefits or termination of coverage for any reason.

- Payment is due at the time services are rendered in the form of **cash, check or credit card**.
- A credit or debit card will be kept on file for copays or non-payment (insurance or client).

Other fees *not* covered by insurance: Client will be billed directly for services below):
Phone calls (with parent/caregiver) 1st **15 minutes–free**; **then $135/hour (pro-rated)**
Telephone consultation with other professionals at client's request: **$135/hour (pro-rated)** (i.e. teachers, school psychologist, psychiatrist, doctor, etc.)

Over time Charges: $2.25/minute for conversation going over the time limit in addition to fee/copay/deductible amount for a session

Other services (i.e. write letters, fill out forms, report writing): $**135/hour (pro-rated)**
Legal: attorney calls, reports: **$150/hour**
Preparation of Copies of Client Records: **$30.00**
Returned Check Fee: $35.00

Confidentiality - (please refer to the HIPPA notice for additional information):

- The law requires that I report suspicions or evidence of child abuse, or child's/parent's expressed intention to harm oneself or others.
- Individuals may choose to contact me via email, fax or phone. In doing so, they agree to the understanding that email, fax and phone communication are not guaranteed confidential methods of communication.

Therapist Availability/Emergencies:

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- By phone, you can leave a confidential message at **(469) 219-3256.**
- If your child is having a crisis or clinical emergency, **please call 911.**
- If your child is seeing a Psychiatrist, I advise that you contact him/her in times of emergent need.

Consent to Treatment:

- Your signature below indicates that you have had the opportunity to read the information in this document and that your questions regarding your child's care have been satisfactorily answered.
- Furthermore, it indicates that you are a legal parent or guardian of _____ and that you **consent to treatment for your child.**
- It also indicates that you understand and give permission for your child's therapist to seek clinical supervision or consultation about client issues when necessary (while maintaining client anonymity).
- A copy of this document will be provided at your request.

Parent/Guardian signature _____ Date _____

Parent/Guardian signature_____ Date _____

INTAKE QUESTIONNAIRE

Child's Name: _____ DOB: _____ Age: _____

Person completing form: _____

Describe the main reason you are seeking help for your child:

_____

_____

When did you first become concerned about these problem(s)?

_____

Please list **all those living in your home** besides the child. This includes spouse, siblings, partner, friends and relatives. *Please use the back of this form if needed.*

Name	Age	Gender	Relationship to Child
		☐ M ☐ F	

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		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

Separation/Divorce:

Are parents separated or divorced? ☐ Yes ☐ No If yes, for how long? _____

If parents are separated/divorced, does non-custodial parent share legal custody? ☐ Yes ☐ No

Are both parents aware that this child will be receiving counseling? ☐ Yes ☐ No

Does child have contact with both parents? ☐ Yes ☐ No How often?_____

Counseling History

Has your child previously received counseling? ☐Yes ☐ No If yes, when and for what?

_____

Do you think that it was a positive experience for your child? ☐Yes ☐ No

Was it a positive experience for both parents? ☐Yes ☐ No

Has your child received medication for behavior or moods? ☐Yes ☐ No

If yes, what was the outcome?_____

Please complete the following questions:

How well does your child fall asleep, stay asleep and wake up from naps and in the morning?

_____

How does your child respond to separation?

_____

What is your child's favorite thing to do?

_____

Please describe a typical day in the life of your child:

_____

What is the most important thing that I can do for you today?

_____

_____

Medical History

Pediatric office: _____ Doctor: _____

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Address: _____Phone: _____

Does your child have any **current** or **past** medical or physical concerns? Yes No
If yes please describe:

_____

Has your child had any of the following? If yes, please explain:
Head injuries? Yes No If yes, did child lose consciousness? Yes No
Hospitalizations? Yes No
Surgeries? Yes No
Medical procedures? Yes No
Seizures? Yes No
Serious illness Yes No
☐ hearing difficulties ☐ eye/vision problems ☐ asthma
☐ sensory problems (i.e. doesn't want to touch certain textures; bothered by bright lights)
☐ fine motor problems (handwriting, cutting, using fingers)
☐ gross motor problems (clumsy, poor balance, trouble running)
☐allergies (food, pet, etc) Yes No If yes, what?

Current Medications:

Name of Medication	Dose/frequency	Reason	How long prescribed	Prescribing Doctor

Prenatal/Birth History

Did mother receive prenatal care? Yes No
Were there any complications during: Pregnancy Yes No
Labor Yes No _____
Delivery Yes No _____
Was child born premature or full-term? _____ Vaginal or Caesarian?_____
Child's Weight at birth _____
Was there an extended hospital stay for mother or child after delivery? Yes No
Did child spend any time in the NICU? Yes No
Alcohol or drug use during pregnancy? Yes No
Use of medication during pregnancy? Yes No
Did mother have post-partum depression? Yes No

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Please check any items below that your child experienced as an <u>infant or toddler:</u>

__ Exposure to lead
__ Walking/gross motor delay
__ Speech/Language delay
__ Hand coordination/fine motor delay
__ Poor attachment to parents/caregivers
__ Sleeping difficulties
__ Problems eating
__ Not wanting touch
__ Clingy
__ Repetitive movements
__ Difficult to comfort
__ Eating non-foods
__ Overly social/friendly
__ Slow response when called by name
__ Avoidance of eye contact
__ Separation from parents
__ Loss of previous abilities
__ Other _____

Developmental Milestones: Please list age that each milestone was achieved:

Sitting _____
Crawling _____
Standing _____ _
Walking _____
First word _____
Two-word sentences _____
Toilet trained _____
Imitates others _____

Childcare

Childcare: _____ Phone# _____
☐ center ☐ home daycare ☐ in your home ☐ before/after school ☐ friend/neighbor
#Days/week:____ #hours/day: ___ # Children in facility:_____
Has child been asked to leave any childcare? ☐ no ☐yes

Education

School: _____ Grade: _____ Teacher _____
Has your child attended other schools? ☐ No ☐ Yes : How many? _____
What prompted the change? _____
How is your child's academic progress? ☐ excellent ☐ good ☐ fair ☐ poor ☐ struggling
Does your child receive any special services?
☐ tutoring (in school/ private) ☐ occupational/speech/physical therapy ☐ 504 plan ☐ IEP ☐ Other_____

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Have you ever been called to pick your child up at school due to misbehavior? □ No □ Yes

_____

Has your child ever had detention, been suspended or asked to leave a school? □ No □ Yes

_____

Does child ever report not liking school or teachers? □ No □ Yes

Child and Family History - Please indicate any that child has experienced:

___ Parent injury/ illness/hospitalization
___ Unemployment of family member
___ Alcohol or drug abuse by family member
___Abuse (Sexual, emotional, verbal, physical)
___Violence in the home
___Violence in the community
___ Family members that have been arrested
___ Family members that have been incarcerated
___ Police confrontation/arrest of parent/guardian
___ Death in the family
___ Parental Conflict
___ Witness to drug abuse
___ Family Financial stress
___ Exposure to a traumatic event
___ Car accident
___ Home robbery/invasion
___Natural/other Disaster
___ Frequent moves

Family Mental Health History

Please indicate below if anyone in the family has experienced the following.

Has anyone experienced:	**Mother's Side**	**Father's Side**
Anxiety		
Depression		
Bipolar disorder		
Learning disorders (ADHD, dyslexia…)		
Drug abuse		
Alcohol abuse		
Schizophrenia		
Suicide attempts		
Completed suicide		
Panic Attacks		
Collecting useless items		

Violent temper		
Abuse (Physical/ Emotional/ Verbal / Sexual)		
Hallucinations or Delusions		
Strange behavior or thinking		
Other:		
Other:		

BEHAVIOR CHECKLIST: Please check items that describe your child's behavior for the **past year:**

□ Academic problems/homework difficulties	□ Not interested in things
□ Angry mood/Rages	□ Paying attention; focusing difficulties
□ Anxiety	□ Perfectionism
□ Arguing	□ Playing with fire
□ Being bullied or bullying	□ Repetitive habits
□ Blames others	□ Rigid routines
□ Bossiness	□ Unusual behavior
□ Confused thinking	□ Self injury
□ Crying frequently	□ Separation anxiety
□ Defiant (to parents or other adults)	□ Sexualized behavior (that seems inappropriate)
□ Destroys things	□ Shyness (excessive)
□ Disorganized, loses things	□ Sleeping, waking difficulties
□ Doesn't want to try new things	□ Somatic complaints (headaches/stomachaches)
□ Eating issues (too much, too little)	□ Stealing
□ Easily frustrated	□ Strong feelings of guilt or shame
□ Emotional outbursts	□ Suicide attempts
□ Fears	□ Suicidal thoughts (says wants to die)
□ Forgetfulness	□ Talking back
□ Frequent conflict	□ Tantrums

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□ Grief/loss	□ Threats or comments about hurting self
□ Hair pulling	□ Threats or comments about hurting others
□ Hard to make/keep friends	□ Too concerned with neatness
□ Hears or sees things others do not	□ Toileting
□ Hits others	□ Transitions are difficult
□ Hurts animals	□ Strong reactions to textures, light, sound
□ Hyper; trouble sitting still	□ Unhappy, sad or depressed
□ Impulsive	□ Unusual thoughts
□ Irritable	□ Wetting/ soiling pants or bed
□ Lack of confidence	□ Withdrawn; not sociable
□ Learning and remembering difficulties	□ Worries a lot
□ Mood quickly goes up and down	□ Yelling
□ Nightmares/Night terrors	□ Won't speak outside the home

Credit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. The card information is kept safe and confidential. You may pay by cash or check, but a card must still be kept on file.****

Name

_____

Print Last *First* *Middle Initial*

Name on Card if different

_____

I authorize Collin County Counseling to charge my credit/debit card for professional services as follows: *Initial*

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_____ All visits for which payment was not made at time of visit (this includes fee for service, deductibles and co-pays).

_____ To charge my card for the balance of fees not paid by my insurance company within 90 days.

_____To charge my card $75.00 for each no-show or late cancellation (less than 24 hours notice).

Type of Card: □ Visa □ MasterCard □ Discover

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____
3-digit number on the **back** of the card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements:

_____

Street *City* *State* *Zip*

Card Holder Signature _____, Date ____ /_____ /___