Child Intake Form

West Houston Counseling Center, PLLC
707 South Fry Rd., Suite 465, Katy, Texas 77450
Phone: (281) 940-8515 Fax: (888) 972-1582 www.WestHoustonCounseling.com

Child Information:

Name: ____ **Today's Date:** _______________________ **Sex:** ***M F***
Age: _____ **Birth date:** ________________ **Grade:** _____________ **School:** _____________________________

Parent Information:

Name: ____ **Relationship to child:** ___________________
Custody/Court Papers: ***Y N*** **Right to seek counseling services?** ***Y N*** **Sex*:* *M F***
Occupation: ____ **Birth date:** ________________________
Address: ____
Home Phone: ______________________________ **Cell Phone:** _______________________________________
Email Address: ____________________________________ **Permission to communicate via email?** ***Y N***
Are you remarried? Y N **Name of Spouse:** ____

Other Parent:

Name: ____ **Relationship to child:** _____________________
Sex: ***M F*** **Occupation:** ____ **Birth date:** _____________________
Address: ____
Home Phone: ____________________________ **Cell Phone:** ____
Email Address: __________________________________ **Permission to confirm appointments via email?** ***Y N***
Are you remarried? Y N **Name of Spouse:** ____

In the event of an emergency, whom should we contact?
Name: ____ Relationship: _____________________________________
Cell Phone: _____________________________________ Email: ____

Please provide a copy of both sides of your insurance card and driver's license for verification of benefits and identity.

Responsible Party

Name: ____ Birth Date: _________________________
Address: ____
Driver's License # _____________________ SS#_________________________ Phone:_________________________

INSURANCE INFORMATION

Who is the insured? _______________________________ SS#: _____________________ Birth Date: ______________
Relationship to Client: ____ Cell Phone: ________________________
Employer of the insured: ____ Work Phone: _________________________
Insurance Company Name:_________________________ Insurance Phone # for Mental Health: ___________________
Member ID#: ______________________________________ Group ID#:______________________________________

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that West Houston Counseling Center, PLLC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold West Houston Counseling Center liable for insurance nonpayment due to misquoted benefits. I will not hold West Houston Counseling Center responsible to know and understand my benefits plan. West Houston Counseling Center will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request benefits be paid to West Houston Counseling Center.

Signature of Client and/or Responsible Party: ___________________________________**Date:** ___________________

Client Name: ____ **Date:** __________________

If there has been psychological testing completed for this child, please provide a copy of the reports with this form.

Have you ever sought counseling for your child before? Yes No

If yes, name of professional: ________________________________ **Duration of counseling:** __________________

How did you hear about this center? ____

Legally, we may not see your child until you supply a copy of all appropriate papers related to the custody of your child including the most recent legal custody arrangements.
Please initial in blank provided indicating you understand the above statement. __________

Medical Information:

Doctor's name____ **Office Phone:** ______________________________
Address: ____
Psychiatrist's name ____________________________________ **Office Phone:** _____________________________
Address: ____
Please list current medications: ____
Any problems with past or present medications: ____

Problem Description:

Please list the main reason for seeking counseling at this time____

____

How long has the problem or pattern existed? ____

What would you like to get out of counseling at this time? ____

____

Family/ Home Information

List all persons living in the home: (*please add any additional names on back of form*)

Name	Age	Relationship (biological, step, half, etc.)
_________________________	_______	____________________________________
_________________________	_______	____________________________________
_________________________	_______	____________________________________
_________________________	_______	____________________________________

Is there a family history of any of the following: (please check all that apply)
____Alcohol Abuse ____Dyslexia ____Tics or Tourettes ____Seizures
____Drug Abuse ____Learning Disabilities ____Arrests ____Domestic Violence
____Depression ____Oppositional Behavior ____Physical Abuse ____Bipolar Disorder
____Anxiety ____Schizophrenia ____Sexual Abuse ____ ADD/ADHD ____ Postpartum Depression

Family Atmosphere (circle the number that best describes how you view your current family)

Very Lenient	1 2 3 4 5 6 7 8 9 10	Very Strict
Very Relaxed Environment	1 2 3 4 5 6 7 8 9 10	Very Tense Environment
Very Unstructured	1 2 3 4 5 6 7 8 9 10	Very Structured
Few Expectations	1 2 3 4 5 6 7 8 9 10	High Expectations
Consistent	1 2 3 4 5 6 7 8 9 10	Inconsistent

Developmental History:

Pregnancy, Labor and Delivery

Duration of Pregnancy ______________ Did the mother smoke? ***Y*** ***N*** (if yes, how many packs per day?) ________

Was there any drinking or drug use by mother during this time? ***Y*** ***N***

(Please describe fully)____

Were there any complications during pregnancy (i.e., illness, injuries, hospitalization, etc.)? ***Y*** ***N***

(Please describe) ____

Any complications during labor/delivery (i.e., premature, lack of oxygen, injuries to mother or child, incubator care, infections, etc.?) ***Y*** ***N*** (Please Explain) ____

Infancy through 5 Years

During the first 5 years of life did your child experience problems with any of these?(Check all that apply)

____ Any changes in, or separation from, primary caregiver lasting more than 2 weeks ____
Did not enjoy cuddling

____ Was not calmed by being held or stroked

____ Difficult to comfort

____ Colic

____ Excessive restlessness

____ Excessive irritability

____ Diminished sleep

____ Frequent head banging

____ Problems with nursing or taking bottle

____ Constantly into everything

____ Excessively active

____ Cranky/irritable

____ Withdrawn/fearful

____ Irregular patterns of sleep, appetite, habits

____ Discomfort with any auditory, tactile, visual stimulation

Other concerns ____

Was your child on time, early, or late in reaching developmental milestones (talking, walking, education, etc.)?
If no, please explain.

____

Has your child ever experienced traumatic experiences (such as changes, deaths in family, divorce, etc.)?
If yes, Please explain.____

Guardian/Parent History - Stressors which may have an impact on parenting

___ I am a single parent

___ I have excessive work stress

___ I have a diagnosed medical/mental condition

___ I had a trauma as a child (___physical, ___sexual, ___ emotional) from (___ a parent, ___ family member, ___ someone else) ___
I was neglected as a child

___ I moved homes often as a child

___ I was raised by a single parent

___ I was raised by another family member

___ My parents divorced when I was young

___ My parent(s) died when I was a child

___ My parents were strict with discipline

___ My parents had excessive marital conflict

___ My parents were abusive to each other

Other concerns ____

West Houston Counseling Center, PLLC
Credit Card Authorization
All clients must have a credit card on file to receive services.

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, you will be charged the full non insurance rate for your therapist. If a check is returned unpaid, your credit card will be charged the amount of the check. An additional $35 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

I, ____, hereby authorize West Houston Counseling Center, PLLC, to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone, email, and Skype consultations
- Appointments that I have cancelled with less than a 24-hour notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

____ Visa ____ MasterCard ____ Discover

Card # ____ Expiration Date: ____________________

Name as Printed on Card: ____

Verification/Security Code (3 digit code on back of card by signature line): ________________________

Billing Address: ____

City: ____________________________________ State: ____________ Zip: ______________________

By signing below I am authorizing West Houston Counseling Center, PLLC to bill my credit card at the usual fee for professional services. I will not dispute charges (“charge back”) for sessions I have received or appointments I have missed according to the above policy.

Signature: ____ Date: ____________________

Print Name: ____

Client Informed Consent

Counseling Relationship: We schedule appointments based on availability and your need. If you experience a mental health emergency, obtain crisis services by dialing 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed and sometimes things may get worse before they get better. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful. If you are concerned about slow progress or lack of progress, you have the right to speak about your concerns. We assure you that our services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaints in writing to the Complaints Management and Investigation Section, Texas State Board of Examiners of Professional Counselors.

Cancellation/Fees: In the event that you will not be able to keep an appointment please notify us by phone at least 24 hours in advance to avoid payment. If this 24-hour notice is not respected, you will be charged the full non insurance rate for your therapist. . Cancelling an appointment means you are not able to make the scheduled appointment time. If you choose to reschedule your appointment at the time you call to cancel, that does not remove any fees for your cancelled appointment. Late arrive more than 20 minutes past a scheduled start time may result in your appointment being cancelled with fees assessed. This fee must be paid before additional sessions may be scheduled. An additional $35 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

Session Fees: Therapist fees range by licensure status and experience. Rates are listed below and may vary due to insurance contract rates where applicable. Therapist and client initials ___________________

___________ LPC ($100-$150)

Please understand that an LPC is not a psychiatrist, but a licensed Master's level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see a physician for a medical evaluation.

___________ LPC-Intern ($90)

An Intern has earned a Master's degree and is provisionally licensed while gaining the necessary clinical hours to receive full licensure. Your name and certain aspects of your case may be disclosed to supervisors during the course of supervision so that you receive the best care possible. Your counselor does not provide legal and/or disability input.

___________ Graduate Level Counselor ($30)

A graduate level counselor is a Master's level student in a counseling related field and is not licensed. Your name and certain aspects of your case may be disclosed to supervisors during the course of supervision so that you receive the best care possible. Your counselor does not provide legal and/or disability input.

Legal Fees* We are not forensic experts, therefore, not generally deemed an expert witness by the court. However, in the event of court proceedings where we are court-ordered to appear for any reason, or provide our records, our hourly fee is $200 plus legal fees incurred by the therapist in association with the case. This includes but is not limited to: drive time, wait time, depositions, court reports, and consultation with other professionals. We require a retainer fee of a minimum of $1500 no later than 48 hours before the court date. The fee for copying records will be a $30 processing fee plus $0.50 per page.*A 10% charge will be added to all outstanding balances over 30 days

Confidentiality: All of our communication is confidential, except in the following cases: a) We are using your case we will identify you by first name only; b) We determine that you are a danger to yourself or someone else; c) You disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; d) You disclose sexual contact with another mental health professional; e) We are ordered by court to disclose information; f) You direct us to release your records; or g) We are otherwise required by law to disclose information. If we see you in public, we will protect your confidentiality by acknowledging you only if you approach us first. Therapists may consult with other professionals regarding your case, however, all identifying information remains confidential except as otherwise specified under supervision requirements or with your written consent.

Couples/Families: I understand that if I am working with a therapist for couples/family counseling, the relationship is considered the client. I understand that anything I tell my therapist individually, whether in person, on the phone, or through written communication, will not be held as confidential and may be shared with the spouse/partner/family at the therapist's discretion. This policy is intended to maintain the integrity of the counseling relationship between members of the couple/families and the counselor as well as avoiding a conflict of interest. I understand that my therapist will not keep secrets which jeopardize the therapeutic work of the relationship counseling. If at any point, you feel that you need to share information that must be kept from your partner/spouse/family, you may request a referral to another counselor for individual therapy.

By your signature below, you are indicating that you read and understood this statement, or that any questions you had about this statement been answered to your satisfaction and that you were furnished a copy of this statement if one was requested. By our signature, we verify the accuracy of this statement and acknowledge our commitment to conform to its specifications.

______________________________ ______________________________

Child's Printed Name
Parent's Printed Name

______________________________ ______________________________

Parent's Signature (Please do not sign if you do not have the right to consent to treatment) Date

Parent or Legal Guardian Responsibility/Consent: You, the parent, are a full partner in counseling. Your honesty and effort is essential to success. You are responsible to attend parent sessions as deemed necessary by your child's therapist. If, as we work together you have suggestions or concerns about your child's counseling, I encourage you to share these with me so that we can make the necessary adjustments. Your child's therapist sees you, the parent, as part of therapeutic change, and without you change will not be as successful; therefore your child's therapist will give suggestions, advice, or homework in order to help your child meet their counseling goals both inside and outside the counseling session. You, the parent, are considered a client of West Houston Counseling Center. Thereby all above information on rights, fees, referrals, effects, applies except as follows: I understand that if I am working with a therapist for a child, the child is considered the client. I understand that anything I tell my child's therapist individually, whether in person, on the phone, or through written communication, will not be held as confidential and may be shared with the child, other legal guardians or individuals with signed release at the therapist's discretion. This policy is intended to maintain the integrity of the counseling relationship between child, and the counselor, as well avoiding a conflict of interest. I understand that my child's therapist will not keep secrets which jeopardize the therapeutic work of the child's counseling. If at any point, you feel that you need to share information that must be kept from your child, or other parties mentioned above, you may request a referral to another counselor for individual therapy.

I have read and I understand the above information: ____

Parent Signature Date

Client Name: ____

Date of Birth: ____

Parent/Guardian Name: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of West Houston Counseling Center's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can talk to my counselor about it or contact Jana Henry or Melissa Melnar at West Houston Counseling Center. I understand that I may also contact the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201.

________________________________ ________________________________
Signature of Client Date

________________________________ ________________________________
Signature of Parent, Guardian or Date
Personal Representative
(If client is under 18 years of age) * If you are signing as a personal representative, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Client Refuses to Acknowledge Receipt (reason):

________________________________ ________________________________
Signature of Staff Member Date

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