CHILD AND ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Georgia law.

BACKGROUND INFORMATION Date_____/_____/_____

Child's Name _____ Date of Birth_____/_____/_____ Age _____

Child lives with (check one): both biological parents _____ mother _____ father_____ other_____

If parents are divorced, describe custody arrangements: _____

_____

Child's Home Phone_____-_____-_____

Child's Address/City/St/Zip_____

_____

Emergency Contact Person (other than parent) _____

Phone Number _____-_____-_____

Custodial parent's Contact Information

What is the best way to contact you for appointment reminders? Home Work E-mail Cell Don't contact

Phone Number(s):

Is it OK to Text this number? *YES* *NO*

Is it OK to leave a voicemail? *YES* *NO*

Email:

Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

How were you introduced to us?

If you found us online what words did you search to find us?

INFORMATION ABOUT CHILD'S MOTHER

Mother's Name _____Age_____ Race_____

Employer_____

Occupation_____ Hrs./wk. _____ Can you be contacted at work by phone? Yes No

Circle the best way to contact you? Phone: (Cell) _____Work_____Ext._____

Home_____ Email_____

Is it Ok to contact you or leave messages at the above contact? YES NO

Denomination _____ Church _____ Active? Yes No

Describe any physical problems you have that require medication or physical care _____

_____

Are you currently receiving medical treatment? Yes No

Physician_____

Medication(s) currently using_____

Previous Counseling / Therapy? Yes, No If yes, when_____

With whom and for how long? _____

INFORMATION **ABOUT CHILD'S FATHER**

Father's Name _____Age_____ Race_____

Employer_____

Occupation_____ Hrs./wk. _____ Can you be contacted at work by phone? Yes No

Circle the best way to contact you? Phone: (W) _____ ext. _____Cell _____

Home_____ Email_____

Is it Ok to contact you or leave messages at the above contact? YES NO

Denomination _____ Church _____ Active? Yes No

Describe any physical problems you have that require medication or physical care _____

_____

Are you currently receiving medical treatment? Yes No

Physician_____

Medication(s) currently using_____

Previous Counseling / Therapy? Yes No If yes, when_____ With whom and for how long?_____ **FAMILY**

FAMILY MEMBERS List all people now living in the household:

Name Relationship to Child Age School Grade Completed Occupation

_____

_____

_____

_____

DESCRIBE THE ISSUE the child is having. If possible, list questions for which answers are sought:

_____

_____

Problem Areas: In the following list, please prioritize each item which identifies an area of concern to you by numbering them. For example, the number 1 would be placed by the item which concerns you the most today.

____ Anger
____ Depression
____ Education
____ Family Problems
____ Fearfulness
____ Marital Problems
____ Physical Problems
____ Problems with Social Relationships
____ Problems with Children
____ Religious / Spiritual Concerns
____ Sexual Concerns
____ Thoughts of Suicide
____ Trouble making decisions
____ Unhappy most of the time
____ Use of Alcohol
____ Use of Drugs
____ Work
____ Worry
____Other_____

CHILD'S MEDICAL HISTORY

List child's sicknesses, operations, and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious.

_____

_____

_____

Have there been any previous psychological, psychiatric, neurological, or EEG evaluations? Yes No

If so. Please list names and dates of contact. _____

Describe previous speech or hearing therapy, if any _____

What is the date of your child's last physical examination? _____Physician's Name _____

ACADEMIC/SCHOOL INFORMATION

School Name _____Grade_____ Teacher _____

How many previous schools attended, with dates? _____

Has child ever repeated a grade? Yes, No If so, when? _____

How does your child get along with peers and authorities at school? _____ Describe difficulties in learning at school: _____ I would like copies of all special testing (s)he has need for educational or Psychological purposes.

Have other family members had learning difficulties? Yes, No What? _____

Describe what your child likes to do for fun, special interests, hobbies, etc. _____

_____

Describe your child's religious background (denomination, church membership, attendance, spiritual training, bible reading, prayer, etc.)

_____

I learned about Advent Counseling and Training Services Inc. Center from: (Name, Address, phone if known)

_____

_____

Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Advent Counseling and Training Services Inc. **to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to Advent Counseling and Training Services Inc. prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name of Minor Child	DOB	Date

** Your signature signifies that you have printed or electronically kept a copy of the* "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Parent/Guardian	Signature	Date

Your Signature _____ Date _____/_____/_____

_____Date_____/_____/_____

Witness – ***James Ciraky PhD, LPC***

Client Information Sheet

We welcome you as our client and appreciate the opportunity to work with you. The following information has been prepared to answer some of the questions you may have regarding your visits to Advent Counseling and Training Services Inc. and to help you use our services more effectively. Please read this sheet carefully and keep a copy for future reference. Jim Ciraky PhD., LPC is clinically trained and licensed as a Professional Counselor in Georgia, USA.

Office Hours: Each therapy session is by appointment only and is usually 45 minutes long. In the case of a life-threatening emergency and you are unable to reach your therapist, call National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911. For mental health evaluations, you may also call Ridgeview Institute (844) 350-8800, or Peachford Hospital (770) 455-3200.

Payments and Fees: All visits are to be paid in full at the time of service. We do not bill. We welcome cash or check. The standard fee for a 45-minute therapy session is $175.00. If the child is a client, the adult bringing the child is responsible for the bill regardless of any custody decrees. A fee of $35 will he charged to the client for an insufficient check. A credit card authorization form will be required to be filled out and signed by you

Insurance: We provide you with a super bill to send to your insurance company. We will not file claims for you. All fees are your responsibility to pay at the time of appointment. It is your responsibility to see that authorizations or referrals are obtained and that your bill is paid. Utilization of your insurance benefits is likely to necessitate disclosure of diagnosis and necessary clinical information to your insurance company or managed care company, which may affect your future such as life insurance, etc.

Cancellations: Except in cases of emergency, please give 48 business hours' notice if you are unable to keep any appointment; otherwise, the full charge will be made for the time reserved for you. I do not overbook my clients. Consequently, I reserve a complete session time for each client. Charges for appointments which are either late cancellations or fail-to-shows will not be covered by your insurance company. Repeated missed appointments without 48-hour notice may be the basis for termination of services.

Confidentiality: All communications between client and therapist will be held in confidence and will not be revealed unless authorized by you and/or required by law such as situations of child abuse or threats of physical harm to self or others. Failure to pay may necessitate forwarding information related to your account to a collection agency. We reserve the right to discuss information regarding your counseling/therapy with insurance companies concerning benefits, coverage, or payments, and with clinical peers and/or supervisors relative to case review.

Children: We cannot accept responsibility for the supervision of unattended children in the waiting room. If you are bringing your child to see a therapist, please bring another adult with you to supervise your child while you meet with the therapist.

I have read and agree to the Advent Counseling and Training Services Inc. policies as listed above.

_____

Signature **Date**

Description of Services

I welcome you as a client and look forward to the opportunity to work with you. This page is to inform you of what counseling entails. It is a science and art that seeks to understand and improve human behavior. As a counselor/psychotherapist I am a trained professional focusing on the treatment of relationships, depression and anxiety that uses my skills to help persons with their efforts to lead more effective and satisfying lives. I am prepared to work with individuals, couples and families. I work with children (ages 8 and up) and adults, provide guidance for my clients as they present their concerns and set goals for the counseling process. I then assist them in reaching those goals. I use a variety of counseling methods and strategies in my office and assign appropriate homework assignments to aid my clients in learning how to achieve your goals.

Confidentiality

What you say and do in the sessions with me will be kept in confidence. You must know however that if there is ever reason for me to believe that you are likely to do harm to yourself, another person, or that any sexual abuse exists or has occurred, then it is my professional and legal responsibility to notify the appropriate persons or authorities.

Client freedom and responsibility

I respect your values and will not require you to do anything that you are not in agreement with. Although you are encouraged to remain in counseling until you have successfully reached your goals, terminating the therapy is your right from the very beginning. It is important, however, that you cooperate with me in carrying out the plans you make in your therapy program. If your cooperation does not exist, the therapy will be fruitless. You have the ultimate responsibility for growth and change.

Other services

My theoretical orientation is primarily cognitive-behavioral counseling, and it is one of several psychotherapy services offered in this community. I will assist you in seeking out another source of help if/when you or I consider a referral to be in your best interest.

Questions

Please feel free to discuss any questions or concerns you may have about your counseling program with me. You may also visit my website which may address some of your questions. www.AdventHelp.com

Consent

I have read the above information and understand what I can expect from a counseling therapy program offered by Jim Ciraky PhD., LPC. I give my consent to enter a psychological counseling program with Jim and understand that signing this form does not commit me to a binding contract but merely indicates my consent to begin therapy.

_____

Signature Date

_____

Signature Date

Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA laws and regulations are extremely detailed and difficult to grasp if you do not have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read and print this document on my website at www.AdventHelp.com as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we make every effort to do what we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Advent Counseling and Training Services Inc. (Jim Ciraky PhD., LPC) is required to secure your signature indicating you have read and may print a copy from my website of the Patient Notification of Privacy Rights document.

Patient Name (print)_____

I have read or will read a copy of the Advent Counseling and Training Services Inc. and Training Services Patient Notification of Privacy Rights document that provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that this document may be printed from Advent's website at HTwww.AdventHelp.com TH. I understand that I have the right to review this document before signing this "acknowledgment form", and that I may at any time, now or later, ask any questions about, or seek clarification of, the matters discussed in this document. Signing below indicates only that I have read or will read a copy.

(a) _____

Patient Signature Date

(b) _____

Parent Signature **(if patient is a Minor)** Date

(c) _____

Guardian Signature **(if patient is Legal Charge)** Date

(d) _____

Witness Date

Revised 1.25.19

Signature Page for HIPAA, Therapy Agreement, Policies, Consent Forms

I have read and understand the following forms and understand that I may ask any questions about them. I understand that I may download them from the website (AdventHelp.com) anytime if I wish to store or print them for myself.

HIPAA

Therapy Agreement

Policies

Consent Forms

_____

Signature

_____

Printed Name Date

_____

Witness Date

Payment Policy and Client Authorization

Should I, _____, not pay for services rendered or fail to meet my financial obligation to Advent Counseling as evidenced by neglect of payment for services rendered, I agree to and authorize Advent Counseling to debit my credit card account for the service or product provided and/or any balance due.

As a means of holding myself accountable to Advent Counseling, I agree to provide the following current and active credit card information and do hereby authorize Advent Counseling to charge my card for payment of services rendered and/or remaining balance in the event I should fail to uphold my agreement. The charge is usually made the date of service.

Credit Card Number:_____

Expiration Date:_____ Security Code Number:_____

Cardholder Billing Address of Credit Card Account:

Street Number _____

Zip Code _____

Notification Information:

Cardholder Phone Number: _____

Cardholder Email: _____

_____

Client Signature Date

ALL CREDIT CARD INFORMATION IS SECURED IN LOCKED FILES AND WILL BE SHREDDED AFTER ACCOUNT IS PAID IN FULL.