Phone: (480)704-3474 Fax: (888)221-2541

CONFIDENTIAL

Child Information Form

Name ____ **Today's Date**:_______________

Birthdate: _________________ **Age**: _______

Address: ____

City:________________ **Zip Code:**______________

Home Phone: ____________________ **Cell Phone:** ____________________

E-mail: ___________________________________

Primary Insurance:____

Policy Number/ID Number:_________________________**Group Number**:__________________

Policy Holder: ___________________________________

May I contact you by mail? *Yes*_____ *No*_____ **Cell?** *Yes*_____ *No*_____ **E-mail?** *Yes*_____ *No*_____

What is your preferred method of contact?____

Occupation: ______________________________________

Parent Guardian Names:_________________________________

In case of emergency, please notify the following:

Name	Relationship to You	Phone Number
1.		
2.		

What does your child currently do too often, too much, or at the wrong times that creates a problem? Please list all the behaviors you can think of.

____

____

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

____

What does your child do that you like? What does he/she do that other people like?

____

____

What are your child's strengths?

____

____

Are there any other concerns about your child or your family?

____

____

From your list of your child's behavior and your family concerns, what is your greatest concern?

____

____

Family History:

Mother's Name: ________________________________ **Lives with child?** *Yes*_____ *No*_____

Father's Name: _________________________________ **Lives with Child?** *Yes*_____ *No*_____

Who has legal guardianship of your child?__________

Who are other household members with your child?

Name	Relationship to You	Age
1.		
2.		
3.		

Has your child received counseling before? Was it helpful?

____

____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _________ **if yes, please describe:**

____

Education History:

What school does your child attend? _______________________________

Address:____

Current Grade: _____________

What does your child's teacher say about him/her?

____

____

Does your child like or dislike school? (Please explain):

____

____

Has your child ever repeated a grade? If so which one(s)?

____

____

Has your child ever received special education services?

____

____

Has your child experienced any of the following problems at School? (*check all that apply*)

____Fighting	**____Lack of friends**	**____Drug/Alcohol**
____Behavior problems	**____Suspension**	**____Learning Disabilities**
____Poor attendance	**____Poor grades**	**____Gang influence**
____Incomplete homework	**____Detention**	**____School Refusal**

<u>Medical History</u>

What is the name of your child's primary care physician? __________________________

Address: ______________________________________ Phone: _______________

Date of your child's last medical examination: _____________________________

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones: ____

Did the child's mother have any problems during the pregnancy or at delivery?
If so, please describe them: ____

Has your child experienced any of the following medical problems?

- ☐ Serious accident
- ☐ Head injury
- ☐ Eye/Ear problems
- ☐ Allergies
- ☐ Hospitalization
- ☐ High Fever
- ☐ Meningitis
- ☐ Loss of Consciousness
- ☐ Surgery
- ☐ Convulsions/Seizures
- ☐ Hearing problems
- ☐ Asthma
- ☐ Other:_______________

Please list any current medical issues:

____

____

Please list any medications your child takes on a regular basis:

____

____

Do you have concerns about your child's eating or sleeping? If " yes" please explain:

____

____

Has your child ever experienced any type of abuse (physical, sexual, or verbal)? If " yes" please explain:

____

____

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else? If " yes" please explain:

____

____

Has he/she ever purposely hurt himself or another? If " yes" please explain:

____

____

Has your child ever experienced any emotional losses (ex. Death or separation from a loved one)? If yes, please explain:

____

____

Are there any current stressors in your child's family life?

____

____

Consent and Agreement to Treatment

Please read the following and initial each section as a notation that you have read and fully understand the information. Please sign at the end of this agreement to state that you are in full agreement with this Consent and Agreement toTreatment.

CLIENT/THERAPIST RELATIONSHIP: The relationship between you and your counselor is a professional relationship exclusive for therapeutic treatment. The therapeutic relationship is most effective when it remains strictly professional and therapeutic. _____________*(client initials)*

AVAILABLE SERVICES: Paper Cranes Healthcare offers a wide array of Behavioral Health Services including individual counseling, family counseling, couples counseling, group therapy, consultative services, and wellness workshops. You have the opportunity for a free initial 20 minute consultation with our provider. ___________*(client initials)*

RISKS AND BENEFITS: There are benefits to counseling and psychotherapy, as well as inherent risks. Risks and benefits come with all forms of treatment. Throughout counseling, uncomfortable emotions, feelings and thoughts may surface due to the discussion and encounter of personal issues. Overall, the benefits of counseling outweigh the risks and those may include improved personal relationships and emotional regulation, conflict resolution and overall enhanced wellness and life enjoyment. Your counselor will "walk with you at your pace" towards the attainment of your personal goals. _____________*(client initials)*

COUNSELING: Paper Cranes Healthcare Behavioral Health Services provides outpatient counseling services and wellness programs intended to focus on many of the personal and life issues our clients encounter. The completion of initial paperwork prior to appointment is recommended however if the client chooses to complete at the initial appointment then the first session will allow for about 10 minutes of paperwork and a 40 minute session. The initial session consists of a discussion on what has brought you to counseling and what you would like to accomplish. Some questions will be asked about your current circumstances, life history and counseling goals. A treatment plan will be established. The counseling schedule will be planned and the next appointment will be set.
Counseling sessions will then be 50 minutes and will focus on your goals and issues that you would like to address. This is a time for you to safely talk and explore issues and experiences that are important to you. With your counselor, you will move in the direction of your goals at a pace that you are comfortable with. Factors that influence the session style and duration of therapy include:

- ~Your therapy goals and what you would like to accomplish in therapy.
- ~Action-oriented sessions vs. space to talk openly and honestly
- ~Individual acceptance and transparency in therapeutic process

If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs. The goal of our services are to provide our community with a place for a positive integration of their mind, body, and life in effort of optimal health and well being _____________*(client's initials)*

FEE SCHEDULE: Counseling session fees are as follows : $65 for 30 minutes, $125 for 50 minutes and $185 for 90 minutes. All session fees will be paid at the time of service. We ask that all cancellations are communicated to Paper Cranes Behavioral Health by the end of business day prior to your appointment otherwise you will incur a fee of $50 depending on length of session. ________(*client's initials)*

ADDITIONAL FEES: An additional fee will occur for client initiated or requested time outside of a counseling session and beyond the normal scope of direct counseling practice, including but not limited to: phone or email consultations, documentation review and preparation, time required for court hearings, legal proceedings, IEP meetings. The fee incurred will be billed at $100/per hour in 15 minute increments. I understand that I will be billed for these services and it is at the discretion of Paper Cranes Behavioral Health ______(*client's initials)*

AUTHORIZATION TO TREAT/RELEASE INFORMATION: I hereby give my permission to Paper Cranes Healthcare to administer treatment and to perform procedures that may be deemed necessary in the diagnosis and treatment of my health. I also hereby assign to the above-named practice all benefits provided by my insurance company policy or policies for medical care. **I understand that I am financially responsible for any balance due on my account.** I also authorize the above practice to release all of my information in the processing of my claims. ______(client's initials)

EMERGENCY SERVICE LIMITATION:: PaperCranes Healthcare Behavioral Health Services does not offer emergency services. If you are experiencing increased difficulty, please contact us during regular business hours to schedule an appointment with our Nurse Practitioner and/or Counselor. If you are experiencing an emergency, please call 911 or head to the closest Emergency Room. If you are in Crisis and need support prior to your next appointment, please call the Maricopa County Crisis Line at 1-800-631-1314._________ (*client's initials)*

SUPERVISION OF CLINICAL CARE AND RECORDS: Paper Cranes Behavioral Health's service providers receive clinical supervision towards independent licensure.The supervision includes clinical case, counseling plan and clinical notes. The purpose of clinical review is for professional training purposes and support of excellent services. Please speak to your counselor regarding any further questions about their individual clinical supervisor and supervision. I understand that their name and contact information is available per my request to my counselor or the office manager of Paper Cranes Behavioral Health _________ (*client's initials)*

PERMISSION FOR VIDEOTAPING THERAPY SESSIONS: The videotaping of therapy sessions for the purpose of continued practice improvement on the part of our clinical staff under the direction/supervision of the Clinical Director of Paper Cranes Behavioral Health.

I AGREE to the videotaping of sessions __________(*client's initials)*

I DECLINE the video taping of therapy sessions. _______________*(client's initials)*

DISCHARGE CRITERIA:

1. When you and your counselor identify that your counseling goals have been met and you decide to end the therapeutic relationship.

2. When you request counseling to end, and your counselor offers a closing session or referrals as clinically recommended.

3. If there is no contact or communication from you for a period of 30 days, after 2 missed appointments, or after 2 attempted contacts; I will assume that you no longer intend to remain active in this therapeutic relationship and your case will be closed. You can return to therapy in the future if you decide to continue treatment. _____________
(*client's initials)*

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Parent/ Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given an appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive a behavioral health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

Print Name:_________________________Signature:______________________________Date:___________

Print Name:_________________________Signature:______________________________Date:___________

Provider Name:______________________Signature:______________________________Date:___________

Client’s Rights

The counseling services are confidential. This means that your information is not shared or released to any persons or agencies regarding the fact that you are receiving counseling nor the nature of your concerns without your written consent. Couples or families seen as clients maintain that the therapeutic process requires that information shared individually with the client may not remain confidential from the other partner/ family members, as the therapeutic process requires open communication between both partners and all family members in a safe environment. Danger to self or others (i.e., suicide or homicide) may necessitate the breaking of confidentiality. In addition, by law I must report suspected child abuse and/or neglect.

Client’s Rights: You, the client, have the right to:

- have your personal dignity, privacy, and freedom of choice respected
- receive respectful treatment that is beneficial to you in a safe setting
- ask questions about counseling techniques and strategies
- participate in the establishment of your goals and the evaluation of your progress
- request and receive information on professional qualifications or your Behavioral Health Provider
- an explanation of services offered, time commitments, fee scales, billing policies and cancellation policies prior to receipt of services
- to refuse the disclosure of information
- know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others
- report unethical and illegal behavior by a provider
- be informed of clinical supervision provided specific to your care
- request and in most cases receive, a summary of your file, including a diagnostic impression, your progress, and type of treatment
- request the transfer of a copy of your file to any therapist or agency you choose
- receive a second opinion regarding your counseling and/or a referral to another provider

My signature below indicates that I,________________________________ have read and understand the Clients Rights and Confidentiality Statements. If I have any questions at any time regarding these statements and rights, I will speak to the Behavioral Health Provider of Paper Cranes Healthcare.

Print Name:________________________Signature:____________________________Date:__________

Provider Name:_____________________Signature:____________________________Date:__________