Paper Cranes
BEHAVIORAL HEALTH

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?

;_____

_____

What are your child's biggest supports? (parents, siblings, coach, friend, faith, etc.)

_____

_____

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 has legal medical/mental health decision making for your child? _____

Who are other household members with your child?

Name	Relationship to You	Age/Date of Birth
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:

_____

Has the child ever used 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**

Medical History

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 state when the loss occurred and explain:

_____

_____

Are there any current stressors or changes in your child's family life? (moving, loss, finances, etc.)

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. Paper Cranes Healthcare and their providers do NOT participate in testimonies or dispositions for custody cases. _____*(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: For providers that accept insurance, you will be responsible for the amount determined by your insurance provider. Copays and balances are due at the time of service. Fees for insurance billing providers will vary based on your insurance plan. 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. If you are more than 15 minutes late to your appointment, your appointment will be cancelled and you will be subject to the cancellation fee. _____*(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, 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: Paper Cranes 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 report 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:

Should you choose to discontinue your counseling services with Paper Cranes Healthcare, or if you are discharged based on the criteria below, a list of referrals and resources is available in office and on our website (www.papercraneshealthcare.com). It can also be emailed to you at any time.

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, but may be subject to current waiting lists. _____ **(***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:_____