THE CENTER for Psychological Services

CHILD/ADOLESCENT INTAKE PACKET

Dear Client:

Welcome to The Center For Psychological Services Ltd. Your registration packet which includes the following forms:

I. BIOGRAPHICAL INFORMATION

II. AGREEMENT FOR SERVICES (*parent/guardian must sign*)

III. HIPAA: NOTICE OF PRIVACY PRACTICES (*signature page)*

IV. ADDENDUM CONSENT FOR SERVICES (*child/adolescent)*

V. ELECTRONIC COMMUNICATIONS STATEMENT

Please take time to read over the information and sign where necessary. *Be sure to ask your doctor or therapist any questions you may have.*
We look forward to working closely with you on making changes that you and/or your family members hope to make as a result of the therapy process. We have found that those who experience the most successful outcomes here have:

1. **Clearly defined as goals** what they hope to achieve. Usually this is done during the first or second session and revised as necessary.
2. **Formed an effective working relationship** with their therapist or doctor. Be sure to talk over any concerns or questions you have about the therapy process with your therapist or doctor.
3. **Kept appointments as scheduled**; each visit builds on the ones before.
4. **Done any recommended "homework"** between sessions. In many ways, what you do at home, work or school can have a profound effect on your progress.
5. **Have discussed expectations** that may exceed the scope of private practice behavioral health services.

The Center is deeply committed to providing you with the highest quality comprehensive state-of-the-art behavioral health services for children, adolescents, adults, couples, and families. We utilize a variety of therapeutic approaches and services to help you successfully adapt and balance life's stressors and challenges as you move toward a fuller, richer life. We thank you for placing your confidence in us and look forward to meeting with you.

Sincerely,
Victoria L. Williams, MSN, Psy.D., LCP
Licensed Clinical Psychologist
Director, The Center for Psychological Services, Ltd.

THE CENTER for Psychological Services

SECTION I: BIOGRAPHICAL INFORMATION

Date: _____ Therapist here to see: _____

CLIENT NAME: _____ DOB: _____ AGE: _____

SEX: __M __ F__ MARITAL STATUS: __ single __ married __ divorced __
Preferred Pronoun: _____ __ separated __ widow __ minor

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

Home #: (___) ___ - _____ List Family Members / Ages: _____
Cell #: (___) ___ - _____ _____
Work #: (___) ___ - _____. _____

Please indicate preferred contact # _____ May we leave a message: ___ yes ___ no

Our system generates automatic reminder calls or texts to your preferred #.
Please check to choose format: **Call** - _____ **Text-** _____ **No Reminder-**_____

If you have any special direction concerning mail delivery to your stated address please note here:
_____

EMPLOYER: _____ OCCUPATION/POSITION:_____

EMERGENCY CONTACT: _____ RELATIONSHIP TO CLIENT: _____
EMERGENCY CONTACT PHONE #:(___) ___ - _____.

If there should be a need for us to contact your emergency contact person, we will only disclose any information that is related to the emergency situation. Please initial here that you understand this.

I understand that in an emergency situation, relevant information will be disclosed. _____
initial

If client is a minor, please complete the following:

WHO DOES MINOR RESIDE WITH: _____RELATIONSHIP TO CLIENT:_____
NAME OF RESPONSIBLE PARTY: _____ SCHOOL/GRADE:_____

How did you hear about us?

___ website: ___ friend: ___ relative: ___ school: ___ physician: ___ other: _____

FOR OFFICE USE:
DX: _____ Session fee: _____ Agreement for Services form read & signed __ Yes __ No
copy of insurance card ___ Driver's license ____ Credit card on file ____

THE CENTER for Psychological Services

SYMPTOMS

Check the box beside each concern experienced recently

☐ Anxiety	☐ Depression	☐ Sleeping Problems	☐ Thoughts of Suicide
☐ Panic	☐ Unusual thoughts	☐ Anger Outbursts	☐ Weight Change
☐ Crying Spells	☐ Memory Problems	☐ Sexual Problems	☐ Relationship Issues
☐ Treated Unfairly	☐ Frequent Pain	☐ Low Energy/Lethargic	☐ Concentration problems
☐ Restlessness	☐ Nausea	☐ Eating Disorder	☐ Legal Difficulties
☐ Drug Use	☐ Alcohol Abuse/Heavy	☐ Boredom	☐ Hopelessness
☐ Stress	☐ Shyness	☐ Work Problems	☐ Confusion
☐ Feelings of Guilt	☐ Suspicion	☐ Loneliness	☐ Violent Thoughts
☐ Compulsions	☐ Worry	☐ Financial Problems	☐ Difficulty with decisions
☐ Specific Fears	☐ Mourning	☐ Physical Illness	☐ Lack of Motivation
☐ Feeling Abandoned	☐ Meaninglessness	☐ Perfectionism	☐ Unusually Sensitive
☐ Irritability	☐ Social Withdrawal	☐ Feeling Misunderstood	☐ Troublesome Thoughts
☐ Religious Concerns	☐ Disappointment	☐ Impulsive Behavior	☐ Hearing strange voices
☐ Feelings of Inferiority	☐ Irrational Thoughts	☐ Mood Swings	☐ No Present Concerns

Enter any additional concerns or symptoms in the blank space below:

_____

_____

_____

What stresses or life changes have you experienced recently?

_____

_____

_____

10735 S. Cicero Avenue . Suite 208 . Oak Lawn, IL 60453 . 708.424.0001 . Fax 708.424.1394

THE CENTER for Psychological Services

Have you seen a therapist in the past?

Year	Problem	Therapist or Clinic	Treatment Duration

Where are you currently living?

- ☐ Dorm/Campus Apartment
- ☐ Apartment
- ☐ House
- ☐ Health Care Facility
- ☐ Other
- ☐ With Relatives

Who lives with you now?

_____

Childhood

Check the box beside issues experienced in childhood:

☐ Happy Childhood	☐ Neglected	☐ Moved Frequently
☐ Physically Abused	☐ Few Friends	☐ Sexually Abused
☐ Weight Problems	☐ Popular	☐ Parents Divorced
☐ Family Fights	☐ Poor Grades	☐ Conflict with Teachers
☐ Drug/Alcohol Use	☐ Good Grades	☐ Sexual Problems
☐ Depressed	☐ "Spoiled"	☐ Anxious
☐ Not Allowed to Grow-Up	☐ Attention Problems	☐ Anger Problems

THE CENTER for Psychological Services

Enter any additional childhood experiences or symptoms in the space below:

_____

_____

_____

Education and Occupation

Are you currently - (circle one) Working Unemployed in school

Highest level of education completed?

_____

What is (or was) your major or favorite subject? _____

How many hours per week are you working? _____

In what field do you usually work? _____

Briefly describe what you like and dislike about your employment or school:

_____

_____

Home Life

How do you spend personal time? (hobbies, sports, clubs, groups, family activities, etc.)

How many contacts do you have each month with friends outside of work or school?

Who can you talk with about personal feelings or private matters?

Are you satisfied with your romantic life?

Briefly describe what you like and dislike about your current romantic relationships and friendships:

_____

_____

_____

Health

Check each accident or illness you have experienced:

- ☐ Recent surgery
- ☐ Head injury
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Drug/alcohol abuse treatment
- ☐ Neurological disorder

THE CENTER
for Psychological Services

- ☐ Chronic pain
- ☐ Headaches
- ☐ Diabetes
- ☐ Hormone problems

List any other chronic health problems you may have:

_____
_____
_____

How many hours do you sleep in an average night? _____

How many drinks (containing alcohol) do you consume in an average week? _____

Which recreational drugs have you used in the last year? _____

List any prescription or over-the-counter medications you may take, along with the purpose of medicine?

_____
_____
_____

Do you exercise? How? How often?

_____

Do you use tobacco? How much?

_____

Who is your primary physician? (Include phone number if known.)

_____
_____
_____

When was your last physical? _____

Are you concerned about your physical health?

_____

10735 S. Cicero Avenue . Suite 208 . Oak Lawn, IL 60453 . 708.424.0001 . Fax 708.424.1394

THE CENTER for Psychological Services

Accomplishments & Additional Information

List your personal strengths and important accomplishments:

_____

_____

_____

SECTION II- AGREEMENT FOR SERVICES

Please read this document carefully as it outlines our professional service policies. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychological testing, evaluation and psychotherapy can have benefits and risks. These services often lead to better relationships, significant reductions in feelings of distress, and better performance in school or work. On the other hand, since these services often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings (e.g., sadness, shame, guilt, anger). You may even feel worse for a period of time.

One of the best predictors of success in achieving your goals is the "goodness of fit" between you and your therapist. If you have any doubts about working with your therapist for any reason, we welcome you to share your concerns. Your therapist will do likewise, including if your needs go beyond the scope of this private practice. We are fortunate to have a large team of therapists at our Center, as well as connections within the community, so that we can offer additional recommendations better suited for you.

The beginning of services will involve an evaluation of your needs and goals, reasons for seeking testing or therapy services at this time, and a brief family and life history. In the first few meetings we will discuss initial impressions, treatment plan, and methodologies that are most likely to be useful for you.

APPOINTMENTS

Appointments will ordinarily be once per week as agreed upon. Typically sessions become less frequent as you gain traction in achieving your goals. It is important to be on time for your scheduled appointments since sessions will end on time regardless of your arrival time.

Should you need to cancel or reschedule a session, **please give at least 24 hrs notice**. Insurance companies do not provide reimbursement for canceled sessions. If you miss a session without canceling or cancel with less than 24 hrs notice, **our policy is to collect $50 per missed therapy session or $150 for missed testing sessions** (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, we will try to find another time to reschedule your appointment.

PROFESSIONAL FEES

The standard fee is $168 per hour. It is our practice to charge this amount on a prorated basis for sessions that require more time (e.g., Emergency Evaluations or Wellbeing Checks), other professional services that you may require such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings or consultations which you have requested, or the time required to perform other services which you may request.

THE CENTER for Psychological Services

PAYMENT TERMS AND INSURANCE

We strongly believe that part of a **healthy working alliance involves staying current with your account** here at The Center for Psychological Services. This enables us to pay your therapist/counselor for services rendered.

When you initiate services, our Billing Office will obtain a **quote of benefits from your insurance company** and will share that information with you. ***(as a reminder, this is a quote of benefits, not a guarantee of payment)***

If your insurance carrier or coverage should change, you are responsible for notifying us of this fact. If this results in an increase of your session fee, you are responsible for this additional payment; should it reduce your fee, we will adjust on our end.

If our Center is not a participating provider for services in your insurance plan, we will supply you with the invoice necessary to submit to your insurance company. We also offer a "fee for service" option.

Your portion of the session fee is due at the point of service. Please check in with our Front Desk to pay fees before your session; should our Front Desk not be available, kindly pay your therapist by the end of your session. If someone from your family is receiving services and not responsible for payment, please be sure payment arrangements are made before the session. We welcome credit cards, cash or check; there is a $30 charge for returned checks. Future appointments are scheduled when accounts are current.

CONTACTING YOUR THERAPIST

We check our voicemails throughout the business day at the Center and return calls typically within 24 hours except weekends and holidays. When leaving a voicemail or electronic communication, please be specific and brief.

If for unseen reasons, you do not hear from your therapist or there is difficulty in reaching you, and safety is a concern for you or your child, please go to your nearest Emergency Room or call 911 and ask to speak to the mental health worker on call.

Your therapist will let you know in advance of planned absences, and provide you with contact information of a mental health professional to contact if necessary.

_____

Signature of parent/guardian (responsible party) Date **Printed name** of parent/guardian

Therapist signature: _____ **Date:**_____

10735 S. Cicero Avenue . Suite 208 . Oak Lawn, IL 60453 . 708.424.0001 . Fax 708.424.1394

THE CENTER for Psychological Services

SECTION III - HIPAA- NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) - *notice of policy and practices to protect the privacy of your health information.*

Please review the HIPAA policy document located under "Forms" on our website *cpstherapy.com* **and sign & date below that you have read it: (if you're in the office filling this out, please refer to the HIPAA document attached to the clipboard.**

By reading and signing this document, I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax:

I fully understand and accept the terms of this consent.

_____ _____ _____

Signature of client (at least 12 yrs of age) Date **Printed name** of client

SECTION IV – Addendum Consent for Services (child/adolescent)

Prior to beginning treatment, it is important to understand some information about providing services to children and adolescents and agree about their confidentiality. We welcome any questions and concerns you or your child may have.

The General Course of Counseling: Risks and Rewards

The benefits of counseling for your child/adolescent includes gaining an increased understanding of themselves, their relationship with parents/guardians, and/or other family members, as well as learning practical tools to help them thrive within those relationships and other situations in their life. Developing insight and practical application is intended to help your child/adolescent feel more prepared to deal with conflicts as they arise and to experience more fulfillment with their relationships as a whole.

One potential risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, we strive to listen carefully to understand your perspectives and fully explain our perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether or not therapy will continue. If either parent decides that therapy should end, your decision will be honored, unless there are extraordinary circumstances. However, we ask that you allow the option of having a few closing sessions with your child's therapist to appropriately end the treatment relationship.

Some additional risks of counseling include the possibility of increased stress for your child/adolescent, and/or other family members when experiencing uncomfortable emotions during counseling sessions and at home. As a result, they can begin to rethink and experience aspects of their life, relationships and consider change.

THE CENTER for Psychological Services

Authorization for Minors Mental Health Treatment

In order to authorize mental health treatment for your child, **you must have either sole or joint legal custody of your child**. If you are separated or divorced from the other parent of your child, please provide us with a copy of the most recent custody decree that establishes your and the other parent's custody rights, or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is our policy to notify the other parent that your child will be receiving services here. This policy often eliminates the alienation of the other parent, which compromises your child's therapy. **We believe it is important that all parents have the right to know that their child is receiving a mental health evaluation or treatment, unless there are truly exceptional circumstances.**

Individual Parent/Guardian Communications

In the course of treatment, you (child's parents/guardians) may meet either separately or together with your child's therapist. Please be aware, **your child is the client** – not the parents/guardians nor any siblings or other family members of the child.

If your child's therapist meet with you or other family members in the course of your child's treatment, notes of that meeting will be taken and be included in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Communicating with other adults:

School: Sometimes it may be beneficial for your child's therapist to speak to someone at their school in an effort to support them. If it is appropriate to contact their school, or if someone at their school wants to contact your child's therapist, this will be discussed with your child/adolescent and written permission will be necessary.

Doctors: Sometimes your doctor and therapist may need to work together; for example, if your child/adolescent takes medication in addition to seeing a therapist. Written permission is required to share information with their doctor.

Children, Adolescents, & Confidentiality

Counselors who work with children and adolescents have the difficult task of protecting the minor's right to privacy while at the same time respecting the parents or guardians right to information. Therapy is most effective when a trusting relationship exists between the counselor and child/adolescent. Privacy/confidentiality is especially important in securing and maintaining that trust.

One goal of treatment is to promote a stronger and better relationship between children/adolescents and their parents. However, it is *often necessary for children/adolescents to develop a "zone of privacy"* whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is our practice's policy for your child's therapist to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to their therapist without your child's

agreement. This includes activities and behavior that you may not approve of – or might upset by – but that do not put your child at risk of serious or immediate harm.

If it is important for you to know about a particular situation that is going on in your child's life, your child will be encouraged and supported to tell you. However, if your child's risk taking behavior becomes more serious, then your child's therapist will need to use their professional judgment to decide whether your child is in serious and immediate danger or harm. If the therapist decides that your child is in such danger, the therapist will communicate this information to you.

Exceptions to Confidentiality

In some situations, therapists are required by law to disclose information whether or not they have permission. However, they will make every attempt to talk this over with the child/adolescent prior to talking with the parent/guardian, so that they are aware of next steps. The therapist and child/adolescent are a team, yet the therapist has a duty to support the safety of your child/adolescent.

- When the child/adolescent tells the therapist that they plan to cause serious harm or death to themselves, and the therapist believes the child has the intent and the ability to carry out this threat in the very near future. The therapist must take steps to inform the parent/guardian or others of what the child has said and how serious the therapist believes this threat to be and try to prevent the occurrence of such harm.
- When the child/adolescent tells the therapist that they plan to cause serious harm or death to someone else, and the therapist believes the child has the intent and the ability to carry out this threat in the very near future. In this situation, the therapist must take steps to inform the parent/guardian or others, and may be required to inform the person who is the target of the threatened harm and the police.
- Child/Adolescent are doing things that could cause serious harm to themselves or someone else, even if they do not intent to harm themselves or another person. In these situations, the therapist will need to use their professional judgement to decide whether a parent/guardian should be informed.
- Child/Adolescent tell their therapist or their therapist otherwise learns that, it appears that a child including the client, is being neglected or abused – physically, sexually, or emotionally – or –that it appears that they have been neglected or abused in the past. In this situation, the therapist is required by law to report the alleged abuse to the appropriate state child protective agency.
- The therapist is required by a court order to disclose information.

Disclosure of Minor's Treatment Records

Under **Illinois** law, minors age 12 through 17 have the right to access and authorize **release** of their own **mental health** and developmental disabilities **records** and information, and their **parents** have such rights only if the minor does not object or the therapist does not feel there are compelling reasons to deny parental access.

***Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody* Litigation**

When a family is in conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although our responsibility to your child may require helping to address family conflicts, the focus is strictly limited to providing treatment for your child. In the event of any child custody/visitation proceedings, *you will agree to not subpoena records or ask the child's therapist to testify in court*, whether in person or by affidavit, or to provide letters or documentation expressing opinion about parental fitness or custody/visitation arrangements.

THE CENTER for Psychological Services

Although this agreement may not prevent a judge from requiring testimony, we will not do so unless legally compelled. If required to testify, we are ethically bound not to give an opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, your child's therapist will provide information as needed based upon appropriate releases. *Furthermore, the child therapist is required to appear as a witness or to* ***perform work related to any legal matter****, the party responsible for participation agrees to reimburse at the* ***rate of $150 per hour*** *for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.*

Obtaining Parental Consent (please check one):

- **Parent has sole custody and can give consent _____**
- **Parent share joint custody and either can give consent** *(consent from both is preferred)* **_____**
- **Court appointed Sole Guardian of minor can give consent _____**
- **Court appointed Joint Guardians of minor and either can give consent** *(consent from both is preferred)* **_____**
- **Other (***please describe***): _____**

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality.

Minor's Signature (*12years or older)* _____ Date_____

Parent/Guardian of Minor Patient:
Please read and initial below indicating your agreement to respect your adolescent's privacy:

___ I will refrain from requesting detailed information about individual therapy sessions with my child or their attendance in sessions without their knowledge and permission. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

___ I agree NOT to request therapy records without the consent of my adolescent in order to respect their confidentiality in treatment.

___ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality is up to the therapist's professional judgment and may include consultation with a consultant/supervisor.

Parent/Guardian Signature _____ Date_____
Parent/Guardian Signature _____ *Date*_____

Therapist Signature _____ Date_____

THE CENTER for Psychological Services

V - ELECTRONIC COMMUNICATIONS STATEMENT

Electronic Medical Records/Communication:
At The Center for Psychological Services, we use an electronic medical records system and patient portal messaging system that is HIPAA compliant.

Email Communication:
This form of communication is not advised. Please use the "message" feature via your Patient Portal.

Text Communication:
Should you have an agreement with your therapist to utilize texting as means to communicate, Please be advised that due to the nature of variable security measures and phone service providers, we do not encourage or promote a text exchange that goes beyond non-personal dialogue, i.e. rescheduling/confirming an appointment.

Social Media:
I do not communicate with, or contact, any of my clients through social media platforms like Twitter, or Facebook. In addition, if I have discovered that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

Website:
We have a website which we use for professional reasons to provide information to others about our practice. You are welcome to access and review the information that is on the website, and if you have any questions about it, we should discuss this during your therapy sessions.

_____

Signature of client (at least 12 yrs of age) Date **Printed name** of client

10735 S. Cicero Avenue . Suite 208 . Oak Lawn, IL 60453 . 708.424.0001 . Fax 708.424.1394