**CLIENT INFORMATION**

Client Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_

Client Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Parent Marital Status: S M D Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

I agree to be contacted in the following manner (check all that apply):

Cell phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Detailed message ok \_\_\_\_\_\_ Detailed message ok

\_\_\_\_Text message ok \_\_\_\_\_\_ Text message ok

\_\_\_\_\_ Name and call back number only \_\_\_\_\_\_ Name and call back number only

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I wish to receive appointment reminders by \_\_\_ email and/or \_\_\_ text message. (check one or both)

\_\_\_\_ I do not wish to receive appointment reminders.

How were you referred to me?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:** I do not currently accept insurance. I accept cash, credit/debit HSA. (Please ask for sliding scale if needed.)

Acknowledgement of HIPAA/Privacy Policy: I have received a copy of this office’s Notice of Privacy Practices. (see attached in this packet) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is the responsibility of the client (or guardian) to keep this office informed of any changes in residency &/or phone number as soon as possible.

**CONSENT FOR SERVICES**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Guardians (for minor client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychotherapy Services:** Participation in therapy includes both risks and benefits, including the risk that symptoms or distress may increase during treatment. Benefits can include decreased emotional distress, greater insight and awareness, more adaptive coping skills and behaviors, and improved communication and interpersonal relationships. Therapy cannot be guaranteed and effectiveness of treatment depends on a variety of factors, including the client’s level of participation and effort. The client should be aware that they have options for treatment, including no treatment at all. Attending therapy is voluntary, and client may end treatment at any time. If the client decides that they would like to seek another provider for therapy, I will provide referrals to other providers. Length of Treatment: Length of treatment will be determined by therapist and client together and will vary based on the client’s needs and severity of symptoms.

**Fees:** All sessions are 45-55 minutes. Payment is due and payable at the time of service. I accept cash, check, or credit card for payment. Returned checks will incur a $15 fee. For additional services, such as documentation, attending meetings, providing consultation, or phone calls longer than 15 minutes, I may charge a pro-rated amount, based on our standard session fee. In cases of failure to pay fees, I may enlist the services of a collection agency to collect outstanding debt if necessary. Fees may increase at a future date, and you will be notified in advance if fees are raised.

Session rate is $80.

**Parental Involvement for Minor Clients:** When a minor is the client, parents may be requested to participate in treatment through family sessions or parenting sessions. A parent/guardian is required to remain on-site during all individual sessions of a minor client.

Parents have a legal right to request information and records about their child’s treatment; however, privacy allows children and adolescents to better benefit from the therapy process as they can more openly express themselves. By consenting to services with me, you are agreeing that I may hold your child’s therapy disclosures confidential. I will inform parents of any significant safety concerns that the minor may disclose.

**Cancellation Notice:** All cancellations of appointments should be made at least 24 hours in advance. If appointments are cancelled in advance there is no fee for the cancelled session. Cancellations may be left on my voicemail at (314-649-0655). An administrative fee of $25.00 will be charged if you give less than 24-hour notice or no-show for a scheduled appointment. If you cancel or no-show for two consecutive sessions or stop attending therapy for two weeks without prior arrangement, your reserved appointment time may be released.

**Court:** I do not testify in court as a witness and do not provide court testimony for marital or custody disputes. If I am required to testify in civil court, due to court order or subpoena, I will require payment in advance of my standard fee of $80.00 per hour during the entire time at the court or at the depositions, including travel time.

**Confidentiality:** Information that you discuss with your therapist is usually confidential and will not be discussed with anyone not covered under the HIPAA regulations (see Notice of Privacy Policy). This means that under most circumstances what is told in a therapy session will not be reported to anyone, even to other family members (except for therapeutic purposes, in case of a minor). If you wish for information to be disclosed, you may sign a request to release information.

There are limits to confidentiality under any of the following circumstances:

1. If you are a serious danger to yourself

2. If you threaten serious harm to others

3. If I have reasonable suspicion or am told of abuse or neglect of a child, elder, or dependent adult

4. If I am ordered by a court to release records or as otherwise required by law

5. If you are using a mental health insurance policy to pay for your visits, I may be required to provide certain diagnostic and treatment information in order to obtain payment for services

6. To coordinate services with your primary care provider, your psychiatrist, your referring doctor and/or other relevant providers as stated in the HIPAA regulations All treatment records are the property of this therapist and will be stored in a secure electronic health record. You may submit a written request for your records, and I will determine whether it is appropriate to release these records.

**Therapist Contact Between Sessions:** You may call or email me between sessions for brief questions, concerns, or scheduling matters. I am not always able to answer the phone, so please leave a voicemail and I will make an effort to return your call within 48 hours. In the case of a psychiatric emergency or crisis , call Behavioral Health Response at 314-469-6644. In case of immediate emergency, please call 911.

Email: Email should not be used for a crisis or emergency situation as you may not receive an immediate response. Security of email cannot be guaranteed, and you may wish to avoid the transmission of confidential information in email. If you choose to email me, you are accepting this risk. Text Messages: Text messaging should be used for scheduling issues only. If you need to discuss anything else between sessions, please call and leave me a voicemail.

**Questions and Other Rights:** If you have any questions about the above information or other questions related to your treatment, please feel free to discuss this with me. If you are unhappy with your treatment at any time, I hope that you will talk with me so that I can address your concerns. You have the right to considerate, safe, and respectful therapy, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

Client Signature/ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Conservator Signature (if applicable) / Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian/Conservator Signature (if applicable) / Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist/Witness Signature /Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Credit Card Use**

It is the policy of this office to keep a credit card on file for all clients in order to ensure payment for services. I authorize Paula Heller to charge the credit card provided below for the following fees if I do not pay them in person when attending treatment: - Therapy session fee ($80/session unless otherwise negotiated) - No-show and late cancellation fees ($25/session) -requests for records, or collateral support services. I agree to pay for these purchases in accordance with the issuing bank cardholder agreement.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Type: \_\_\_\_\_ Visa \_\_\_\_\_ Mastercard \_\_\_\_

Number on card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Identification Number: \_\_\_\_\_\_\_ (last 3 digits located on the back of the credit card)

Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I wish to receive a receipt for any payments by email. \_\_\_\_\_\_ (initial) Send receipt to the following email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child Psychosocial Inventory:**

Parents, please complete the following information regarding your child prior to your first appointment and bring it with you to the session. Completing this form in advance will help the assessment process go more quickly. During the initial session, we will review the provided information together.

You may complete this form by typing in the fields provided or by printing and completing by hand. If you are unsure of an answer or feel that a question does not apply, you may leave it blank. All information will be kept confidential.

Date:

Form completed by:

Presenting Concerns:

What are the main concerns that bring you to therapy?

How long has this been a concern?

What have you already tried to address the problem?

Has anything been helpful so far?

What do you hope to get from therapy and what are your goals for therapy?

Have you noticed any changes or problems with your child’s sleep, appetite, or hygiene? (Please describe)

Is there any history of trauma or upsetting life events (such as abuse, life threatening accidents or medical concerns, family conflict, bullying, divorce, death or loss of loved ones, or natural disasters)?

Yes No (If yes, please describe.)

Has your child ever had psychotherapy or counseling before? Yes No (If yes, please describe.)

Has your child been given a previous psychological diagnosis? Yes No (If yes, please describe.)

Is your child currently taking any medications for emotional or behavioral reasons?

Yes No (If yes, please list name of medication, dosage, and reason prescribed. )

Has your child taken any other medications in the past for emotional or behavioral reasons?

Yes No If yes, please list name of medication, dosage, and reason prescribed.

Has your child ever been hospitalized for emotional or behavioral concerns? Yes No (If yes, please describe reason and provide name of hospital.)

Has your child ever made suicidal statements, made suicide attempts, or self-harmed (including cutting)? Yes No (If yes, please describe.)

Do you have concerns that you child may be using drugs or alcohol? Yes No (If yes, please describe.)

**Medical History:**

Primary Care Doctor or Pediatrician:

Date of last physical exam:

Does your child have any allergies?

Yes No (If yes, please describe.)

Please describe any past and present medical concerns or serious illnesses:

Are you aware of any sensory processing issues that your child has?

Yes No (If yes, please describe.)

Has your child ever received speech therapy or occupational therapy?

Yes No (If yes, please describe.)

**Developmental History:**

Term of pregnancy: months Birth weight:

Were there any complications with the pregnancy or delivery? Yes No (If yes, please describe.)

During pregnancy, was there any use of drugs/alcohol, exposure to domestic violence, major illnesses/accidents, or significant stressors? Yes No (If yes, please describe.)

Age 0-3:

Were there any delays in reaching major milestones, such as sitting up, crawling, walking, talking, and toilet training? Yes No (If yes, please describe.)

Were there any problems with feeding or sleeping? Yes No (If yes, please describe.)

What was your child’s temperament and personality like as a child?

Please describe any significant stressors or events age 0-3:

Ages 4-6

Were there any concerns regarding developmental milestones? Yes No (If yes, please describe.)

How did your child adjust to beginning school? How were your child’s social relationships?

Please describe any significant stressors or events ages 4-6

Age 7-12:

Were there any concerns regarding development or social relationships? Please describe any significant stressors age 7-12:

Age 13-18:

Were there any concerns regarding development or social relationships?

Please describe any stressors are 13-18:

**Family Information:**

Please list family members that live in the home with child, including names and ages:

Other immediate family members that live outside of the home (i.e., parents or siblings):

Primary caregivers’ relationship status: Married Single Engaged Divorced Living together

Partnered, living separate Separated Divorced Widowed

Caregivers’ occupations and education level:

Are there family members or others that you consider part of your family’s support system? Please describe.

**Family religious/spiritual identification:**

Does your family actively participate in religion/spirituality? Yes No

Does your family consider religion/spirituality to be a source of support? Yes No

Do you have any concerns related to family relationships/interactions, parenting/discipline, or family communication? Yes No (If yes, please describe.)

What methods do you generally use for discipline of your children?

Is there any family use of alcohol or drugs? Yes No (If yes, please describe.)

Is there any history of Department of Children’s Division involvement, including abuse/neglect reports, investigations, or removal of child from home? Yes No (If yes, please describe.)

Has your child ever lived in another family situation (e.g., foster family, other caregivers, grandparent or kinship care, group home or residential placement)? Yes No (If yes, please describe.)

Is there any family history of mental illness (including extended family)? Yes No (If yes, please describe.)

What do you consider to be your family strengths?

What do you feel that you need to improve or change as a family?

**School Information:**

Current School: Grade:

Does your child have an IEP or other special services at school? Yes No (If yes, please describe.)

Has your child been diagnosed with a learning disorder or other educational impairment? Yes No (If yes, please describe.) Do you have any concerns about your child’s behavior or academics at school? Yes No (If yes, please describe.)

Does your child participate in an afterschool program or other extracurricular activities? Yes No (If yes, please describe.)

Additional Information: What are some of the strengths and positive qualities of your child?

Is there any other information that I should know regarding your child or family?