***Family Christian Counseling Center Inc.***
*9950 Cypresswood Drive, Suite 260, Houston, TX 77070 Phone: 281-890-6234 Fax: 832-369-7679*

*Gary R. Lynn, M.Ed., LPC, NCC ~~~ Rosalinda Orta , M.A., LPC*

# Minor Intake Form

Minor Counselee Name: _____ ____/____/_____
(Last) (First) (Initial) (Nickname) (Date)

Address: _____
(Street) (City) (State) (Zip)

Social Security Number: _____-_____-_____ Male Female Age: _____ Birth date: ____/____/_____

Parent/Guardian Name: _____SS#: _____-_____-_____ Birth date: ____/____/_____

Phone Numbers: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

E-mail: _____ Marital Status: Single Married Divorced Separated Other

Employer: _____ Full Time Part Time Self Unemployed

Spouse's Name: _____ Birth date: _____/_____/_____

Spouse's Employer: _____ Spouse's SS#: _____-_____-_____

Referred By:_____ Home Church: _____ _____Do not attend at this time

**********

Why have you decided to seek counseling for your child? _____

_____

_____

_____

What goals do you hope to accomplish?_____

_____

_____

***Previous Counseling***

Counselor Name:_____ From Mo.____Yr.____ to Mo.____ Yr.____ Number Sessions: _____
Counselor Name:_____ From Mo.____Yr.____ to Mo.____ Yr.____ Number Sessions: _____
Counselor Name:_____ From Mo.____Yr.____ to Mo.____ Yr.____ Number Sessions: _____

***Current Doctors***

Family Doctor: _____ Date of First Visit:_____ __ Date of Last Office Visit:_____
Psychiatrist: _____ Date of First Visit:_____ __ Date of Last Office Visit:_____
Specialist: _____Date of First Visit:_____ __ Date of Last Office Visit:_____
Specialist: _____Date of First Visit:_____ __ Date of Last Office Visit:_____

***Current Medications***

Name:_____ Treatment for:_____ Dosage:_____ per_____ Date Began: _____
Name:_____ Treatment for:_____ Dosage:_____ per_____ Date Began: _____
Name:_____ Treatment for:_____ Dosage:_____ per_____ Date Began: _____
Name:_____ Treatment for:_____ Dosage:_____ per_____ Date Began: _____
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# Background History

**(Please share any information you consider important)**

Describe any major physical or emotional problems: _____

_____

_____

Traumatic life events:_____

_____

_____

Personal alcohol and/or illicit drug sage? _____

Physical, emotional, and/or sexual abuse during developmental years? _____

_____

_____

Share your religious upbringing and current religious status: _____

_____

_____

Describe your current family status and support network? _____

_____

_____

Briefly share your employment history including any military service:_____

_____

_____

**Are you experiencing any of the following physical symptoms?**
**(A - Always B - Often C - Sometimes)**

_____ Depressed
_____ Restlessness
_____ Overeating
_____ Confusion
_____ Nausea
_____ Hallucinations
_____ Upset bowels
_____ Heart Racing
_____ Lack of energy
_____ Racing thoughts
_____ Stomach troubles
_____ Indecisiveness
_____ Dizziness
_____ Self mutilation
_____ Poor memory
_____ Chest pains

_____ Violent behaviors
_____ Guilty conscience
_____ Seizures or convulsions
_____ Anxiety or nervousness
_____ Feelings of unreality
_____ Heart irregularities
_____ Feelings of sadness
_____ Addicted to pornography
_____ Feelings of worthlessness
_____ Suicidal thoughts/attempts
_____ Always “on guard”
_____ Excessive guilt or shame
_____ Unusual sexual behavior
_____ Feelings of sadness
_____ Headaches
_____ Periods of “going blank”

_____ Sleeping to much
_____ Outbursts of anger
_____ Inability to sleep
_____ Shortness of breath
_____ Financial difficulties
_____ Difficulty making choices
_____ Uncontrolled crying spells
_____ Loss of consciousness
_____ Weight loss/gain
_____ Involuntary body trembling
_____ Loss or decrease of sex drive
_____ Tingling or numbness
_____ Excessive sweating
_____ Sensitivity to criticism
_____ Fear of “going insane”
_____ Fear of being alone

_____ Recurrent thoughts or worries
_____ Feeling compelled to do things
_____ Trouble getting along with others
_____ Avoiding people/social situations
_____ Neglected hygiene/appearance
_____ Weight loss by vomiting/laxatives
_____ Loss of interest in usual activities
_____ Difficulty thinking/distractions
_____ Preoccupation w/ bodily functions
_____ Difficulties at work or school
_____ Constant focus religious thoughts
_____ Moodiness, changeable moods
_____ Feeling as if reliving past trauma
____ Excessive fear of persons, places
_____ Feelings of doom or death
_____ Recurring distressing dreams

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# Payment/Cancellation Policies

It is required that payments or co-payments for appointments be paid at the time of service. If your insurance will cover the services, you must satisfy any deductible before payments can be reduced to your co-payment. For your convenience, we accept Visa, MasterCard, Discover and American Express. Any alternative arrangements must be discussed with the counselor.

**The cancellation of your appointment less than 24 hours prior to the scheduled time or failure to keep your will result in being charged a NO SHOW fee of $60.**

**Preferred Method of Payment: _____ Cash _____Check _____ Credit Card**

**Signature:** _____ **Date:** ____/____/____

***Please complete the below Credit Card Authorization <u>ONLY</u> if you intend to pay by credit or debit card on a continuing basis.***

## Credit Card Authorization

***I authorize this clinic to keep my signature on file and to charge my listed credit card for the:***
(Initial and fill in necessary information)

_____ Deductibles and co-payment for each appointment visit.

_____ Balance of charges not paid by insurance within 90 days and not to exceed $_____.

**I understand this form is valid for one year unless I cancel the authorization through written notice to this provider.**

Patient's Name:_____ Cardholder Name: _____

Billing Address:_____
(Street) (City) (State) (Zip)

___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ ___ ___ / ___ ___ ___ ___ ___
**(Account Number)** **(Expiration Date)** **(Security Code)**

**Cardholder Signature:** _____ **Date:** ____/____/____

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# Insurance Information

Do you have insurance that you want billed for this service? _____ Yes _____ No

## *Present your insurance card for photo copy or fill information below.*

***Primary*** Insurance Company: _____ Phone: (____) _____-_____

Insured's Name:_____ Social Security Number _____-____-_____

Birth date of Insured: _____/_____/_____ Relationship: Self Spouse Parent Other

Insurance ID Number: _____ Group Number: _____ Plan: _____

# Assignment of Insurance Benefits

I hereby authorize and request my insurance to pay directly to the clinic the amount due on my claim for services rendered to me and/or my dependents. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible for payment of the entire bill.
I also authorize the release of any medical information that may be requested by my insurance company in order to assist in processing any claim for payment.

Signature: _____ Date: _____
(Patient/Insured)

## Please <u>read</u> and <u>initial</u> the following statements indicating you understand them:

_____ I have sought counseling on my own initiative and am under no obligation to accept the counsel that I receive.

_____ I am aware that counseling sessions will address emotional issues and therefore, I may experience increase of emotional pain.

_____ I understand that counsel I receive will include **discussion and/or teaching of principles from the Christian Bible**.

_____ I assume complete responsibility for my health and well-being.

_____ I understand that my counselor assumes no responsibility for me or my emotional condition.

_____ I understand my responsibility in the payment process.

**Signed:** _____ _____ _____/_____/_____
(Patient) (Parent/Guardian/Insured) (Date)

FAMILY CHRISTIAN COUNSELING CENTER, INC. P.O. BOX 3475 CLEVELAND, TN 37320 | 9950 CYPRESSWOOD, SUITE 260, HOUSTON, TX 77070 |FAX: 832.369.7679 | EMAIL: OFFICE@MYFCCC.COM TENNESSEE - PH. 423.599.9347 | TEXAS - PH. 281.890.6234

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. AFTER YOU HAVE READ THIS NOTICE WE WILL ASK YOU TO SIGN A CONSENT TO LET US USE AND SHARE YOUR INFORMATION IN THESE WAYS. IF YOU DO NOT CONSENT AND SIGN THIS FORM, WE CANNOT TREAT YOU.**

**Our commitment to your privacy**

Our practice is dedicated to maintaining the confidentiality and security of your personal health information as part of providing professional care. We are also required by law to keep your information private. HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of protected health information and help the healthcare industry control administrative costs.

**Patients protected health information**

HIPAA protects an individual's health information and his/her demographic information. This is called "protected health information" or "PHI". Information meets the definition of PHI if, even without the patients name, if you look at certain information and you can tell who the person is then it is PHI. The PHI can relate to past, present, or future physical or mental hea1th of the individual. PHI describes a disease, diagnosis, procedure, prognosis, or condition of the individual and can exist in any medium- files, voice mails, email, fax, or verbal communications. HIPAA defines information as protected health information if it contains the following information about the patients, the patient's household members, or the patient's employers:

- Names
- Dates relating to a patient, i.e. birthdates, dates of medical treatment, admission and discharge dates, and dates of death.
- Telephone numbers, addresses (including city, county, or zip code) fax numbers and other contact information
- Social Security numbers
- Medical record numbers
- Photographs
- Finger and voice prints
- Any other unique identifying number

**How we use and disclose your protected health information with your consent**

We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask to you to sign an authorization for to allow this.

**How we use and disclose your protected health information without your consent**

There are some times when the law requires us to use or share your information. For example:

**1. Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. They will only share information with persons who are able to help prevent or reduce the threat.

**2. Abuse of Children and Vulnerable Adults:** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**3. Prenatal Exposure to Controlled Substances:** Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**4. Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records

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**5. Insurance Providers (when applicable):** Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes types of services, dates/times of services. diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. This includes workers' compensation and similar benefit programs.
**6. Judicial or Statutory Decree:** The mental health professional is required to disclose specific information when mandated in legal or court proceedings.

**Patients' rights**
A health provider can disclose an individual's PHI without the patient's authorization if the disclosure deals with treatment, payment, operations, or if the information is mandated by law. Otherwise, for most other uses, the patient will need to authorize the provider to make the disclosure. HIPAA stipulates the following patient's rights under its privacy rule:
 Patients have a right to receive a notice of the privacy practices of any health care provider, health clearing house, or health plan.
 Patients have a right to see their PHI and get a copy.
 Patients have a right to request that changes be made to correct errors in their records or to add information that has been omitted. These requests must be in writing and include reasons for the changes.
 Patients have a right to see a list of some of the disclosures that have been made of their PHI.
 Patients have a right to request that special treatment is given to their PHI.
 Patients have a right to request confidential communications and treatment records. Specifically,
o Upon release from a client or the clients authorized representative, the therapist or the therapist's representatives shall provide a complete copy of the client's records or summary of such records which were maintained by the provider;
o It shall be the .provider' s option as to whether copies of the records or a summary will be given to the client;
o Requests for records shall be honored by the provider in a timely manner; and
o The individual requesting the records shall be responsible for payment of a reasonable fee to the provider for copying and mailing of the records.
 Patients have a right to complain.
 Patients have a right to request us to communicate with them in a particular way or at a certain place that is more private for them. For example, a patient can ask us to call them at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
 Patients have a right to request that the health provider limit what information shared people involved in care or the payment for care, such as family members and friends.
 Patients have the right to file a complaint if they believe their privacy rights have been violated. All complaints must be in writing. Filling a complaint will not change the health care we provide to you in any way. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please call the office.
o Complaints can be made in writing to our corporate privacy officer:

Privacy Officer
P.O. Box 3475
Cleveland, TN 37320
o Complaints can be made with the Sec. of U.S. Department of Health & Human Services in writing:

U.S. Department of Health & Human Services
61 Forsyth Street, SW, Suite 3870
Atlanta, GA 30323
Or telephonically:
(404)562-7886; (404)331-2867 (TDD)
Or via facsimile:

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**LIMITS OF CONFIDENTIALITY AND HIPAA**

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

**1. Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

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I agree to the above limits of confidentially and understand their meanings and ramifications. I have also been given a copy my HIPAA rights and agree to these terms.

_____ _____

Client Name (Print Name) Date

_____ _____

Client Signature *(Client's Parent/Guardian if under 18)* Date

_____ _____

Signature of Witness Date