The Adolescent Center and Mental Health
3730 Kirby Dr. Ste. 904
Houston, Texas 77098
T: 832-484-2635 F: 832-202-2497

Monarch Family Service
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Texas 77098
T: 281-236-3989 F: 832-202-2497

Date file opened: _____
Chart#: _____

CHILD INTAKE FORM

Please complete on behalf of your child

Name of person completing this form: _

Your relation to the child: _____

Phone:_____Email: _____

Name of other parent/legal guardian: _____

Phone:_____Email: _____

Child's first name:_____Last name:_____

Age: _____ Birthday: _____ Month: _____Year: _____

Ethnicity:_____Religion:_____Sex/gender: _____

Home address: _____

Who does your child live with? _____

Are both parents living in the home?_____ If not, please list the name and number of the other parent:_____

Is the requested service in relation to a child custody case? Yes No

If yes, please specify: CPS Divorce

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ACADEMIC INFORMATION:

Name of child's school:_____ Grade/Year:_____

Program:_____ School Performance (grades): _____

Is your child involved in any below special education services:
504
If yes, please describe modifications:

Gifted and Talented
If yes, please describe modifications:

1:1 mentor

If yes, please describe modifications

HOW YOU FOUND THIS CLINIC:

☐ Word of mouth ☐ I'm a former client ☐ Psychology Today

☐ Rate MDs ☐ Google, using these words: _____

Other:_

THE REASONS FOR YOUR CHILD'S VISIT:

_____

_____

_____

_____

_____

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How intense is your child's emotional distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe: _____

_____

Overall, how much do the problems affect your child's ability to perform school, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe: _____

_____

When did these problems start? What was going on in your child's life at that time?

_____

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PSYCHIATRIC AND MEDICAL HISTORY

Please list any ***psychiatric or "mental"*** problems your child has been diagnosed with:

_____

_____

_____

Please list any ***medical or "physical"*** problems that your child has been diagnosed with:

_____

_____

_____

Please list any **medications your child currently takes**, and what they are taken for:

_____

_____

_____

_____

Name of **Family Doctor:** _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

Results: _____

_____

Name of **Psychiatrist:** _____ Phone: _____

Last visit was during the month of: _____ Year: _____

Results: _____

_____

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MENTAL HEALTH TREATMENT HISTORY

Has your child ever been hospitalized for psychological or psychiatric reasons? ☐ No ☐ Yes

If yes, please describe when and where, and for which reasons.

_____

_____

DEVELOPMENTAL HISTORY

Birth weight:
Did your child meet all developmental milestone on time (crawling, walking, talking, etc.): Yes No
If no, please explain:

Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

_____

_____

CURRENT HABITS

Please describe your child's **current habits** in each of the following areas:

Smoking:
Drinking:
Drug use:
TV use:
Internet use:
Video game use:
Caffeine intake:
Exercise:
Eating:
Sleeping:
Fun and relaxation:
Chores and responsibilities:

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RELATIONSHIPS

Please describe your child's relationships with each of the following people, if applicable:

Biological Mother:

Biological Father:

Step-parents:

Legal guardians:

Siblings:

Extended family:

Your children:

Friends:

Romantic partner(s):

Colleagues or classmates:

Total number of close, supportive relationships:

STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that your child has been experiencing:

	No	Yes	If yes, please describe
A recent move or change in school?			
Abuse or neglect?			
Bullied or ignored by peers?			
Academic difficulties?			
Weight control issues?			
Sexual orientation concerns?			
Self-injury?			
Death or Illness of a loved one or pet?			
Family conflict?			
Separation or Divorce?			
Domestic Violence			
Community Violence			
Other?			

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What are your child's positive qualities and skills? What do you like about your child? What qualities have helped your child to succeed at coping with life stressors in the past?

Please tell us about your child's interests (sports, hobbies, talents, etc.)

Does your child agree that the problem that she or he is seeking help for is problematic?

What are some goals for your child's therapy? What would you like them to achieve by attending therapy?

What concerns do you have about your child attending therapy or working on these problems?

Does your child have any legal issues? Yes No If so, what county:
# of charges # of detentions
Please describe nature of legal issues:

Is there anything else that you would like to mention?

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This consent form explains the nature of the psychological services that your child is about to receive. As consent is an ongoing process, any changes that may influence your consent will be discussed with you.

Nature of treatment: (i) Evaluation and treatment planning: Approximately 1-3 sessions, (ii) Intervention: Depends on many factors, such as the nature of your child's difficulties and readiness for change, (iii) Termination: Approximately 1-2 sessions, involves developing a "toolbox" of strategies that may be used to help your child maintain treatment gains and reduce the likelihood of relapse and/or reoccurrence. Treatment effectiveness varies from person to person. Discussing, working with, and changing thoughts, feelings, and behaviours may be painful and challenging at times.

Approach: Your therapist will complete an intake assessment to understand how the current difficulties may have developed and are maintained within the various contexts of your child's life. The results of this assessment may be shared with you, and a treatment plan will be developed including some potential goals for therapy, and the strategies that may be used to help your child reach the goals. Throughout the therapy you are invited to share any concerns or questions that you may have about the therapy process. This helps the therapist to personalize the treatment strategies to better match your child's unique needs. *Services are by appointment only; in an emergency please call 911 or go to the emergency room.*

Fees and payment: Sessions are approximately 45-55 minutes in length. Every attempt is made to see clients on time. To work towards this goal, payment is due at the *start* of each session, and sessions are to end no later than 5-minutes to the hour. Payments can be made by cash, debit, or credit card. **TWENTY-FOUR (24) hours' notice *is required to* CANCEL OR RESECHEDULE *an appointment to avoid being billed for the full fee of the missed session*. THE ONLY EXCEPTIONS ARE UNEXPECTED ILLNESS OR EMERGENCIES.**

Confidentiality: Psychological records may include items such as personal information, progress notes, and evaluations, and will be shredded 7 years after your file has been closed. No information can be released to a third party without your prior written consent, or verbal consent in the case of an emergency. Exceptions include: (1) when children are under 14 years of age, and their parents/legal guardians want access to the file, (2) risk of imminent danger, such as suicide, death, risk of a child running away, or serious bodily harm to an identifiable person or group, (2) suspected or known abuse or neglect of a child or older adult, (3) unsafe operation of a motor vehicle, (4) requests ordered by a court of law or (5) access is required by other personnel (e.g., administrative staff) to carry out their professional duties. Therapists must, as soon as the interest of their client so requires, receive supervision, consult another therapist, a member of another professional order, or another competent person. Disclosure of identifying information will be minimized, and names will not be released without consent.

Mutual rights and responsibilities: The relationship must remain limited to a respectful therapeutic framework. You/your child may refuse any therapeutic suggestions offered, or to suspend or cease treatment at any time without penalty. *If you decide to stop treatment for any reason, please notify your therapist so that the file can be closed and/or a referral can be referred to another resource. If you stop treatment without an explanation, the file will automatically be closed after 30 days.*

Consent to treatment: I have read and understood the above information, and any questions that I had have been answered. I agree with the above consent form, and freely consent to have my child receive psychological services.

Name of child client:_____ Today's date: _____

Name of parent/guardian:_____ Signature:_____

Name of parent/guardian:_____ Signature: _____

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Informed Consent for Telehealth Services

The Adolescent Center and Mental Health

Monarch Family Services

PATIENT NAME: _____ LOCATION OF PATIENT: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
PHYSICIAN NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____		DATE CONSENT DISCUSSED: _____

Introduction

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

Improved access to mental health care by enabling a client to remain in his/her home (or at a remote site) while the clinician obtains assessment information and provides therapeutic services. Telehealth may also include consults from healthcare practitioners at distant/other sites.

More efficient medical evaluation and management.

Obtaining expertise of a distant Licensed Psychiatrist, Licensed Psychologist and/or Licensed Psychotherapist.

Possible Risks:

As with any medical/mental health remote process, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

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In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images or sound) to allow for appropriate assessment by the clinician;

Delays in assessment/evaluation and treatment could occur due to deficiencies or failures of the equipment;

In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

Please initial after reading this page: _____

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By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

I hereby authorize ***The Adolescent Center and Mental Health/Monarch Family Services*** to use telehealth in the course of my diagnosis and treatment.

Signature of Patient (or person authorized): _____ *Date:* _____

*Witness:*_____ *Date:* _____

I have been offered a copy of this consent form (patient's initials) ____

Consent for Treatment

Please read carefully

Psychotherapy is a working cooperative relationship between you and your counselor. Each member of this cooperative

relationship has certain responsibilities. Your counselor will contribute their knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.

I. Fees and Appointments

1. Appointments Psychotherapy and assessments are 55- 240 minutes in length, and take place on a weekly, biweekly or monthly basis. Your counselor holds your specific hour for you each week. If you are unable to keep an appointment, please cancel as soon as possible. Any cancelled appointment less than 24 hours will be charged a $25 no show fee. We ask that you pay the receptionist prior to your session each week. We reserve the right to suspend therapy if services are rendered and not paid for after three sessions.
2. There is a $25.00 service fee for any returned checks or insufficient funds. If determined that therapy will continue, you must agree in writing to a specific payment plan to reduce your overdue balance to zero, while continuing to pay the weekly agreed upon fee.

II. Confidentiality

1. Communication between you and your counselor is confidential. This means that your counselor will not discuss your case orally or in writing without your expressed written permission (please see the following section on “Training and Supervision”).
2. Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:
   a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
   b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
   c. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
   d. If <u>you</u> introduce your emotional condition into a legal proceeding.
   e. If there is a court order for release of your records.

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III. Training and Clinical Supervision

1. The Adolescent Center and Mental Health is a training center for Master's and Doctoral level counseling and psychology interns. All counselors at MFS/TAC are under the supervision of licensed mental health professionals.
2. In order to ensure that counselors receive the best possible training, and that clients are well served, a licensed clinician will attend each session.
3. Counselors are generally on a time-limited contract with MFS/TAC. Therefore, it is possible that your counselor may leave MFS/TAC prior to the end of your therapy. If this occurs we will take reasonable steps to ensure a smooth transition.

IV. Counselor Availability and After Hours Emergencies

Our administrative staff will check for voice mail messages during normal business hours. Messages left outside of normal MFS/TAC hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department or by calling 911.

V. Child Care Release

MFS/TAC does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room.

VI. Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

MFS/TAC reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or re-evaluation by MFS/TAC of your therapeutic needs, MFS/TAC's ability to address those needs, or other circumstances that lead MFS/TAC to conclude in its sole and absolute discretion that your counseling needs would be better served at an another counseling facility. Under such circumstances, MFS/TAC will suggest an appropriate counselor(s) or counseling agency.

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to MFS/TAC to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

Print Name:_____ Date: _____

Signature of Client #1: _____

Print Name:_____ Date: _____

Signature of Client #2: _____

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CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Patient Phone Number: _____

In the course of providing services to you, we may create, receive, and store individually identifiable information, including information that relates to health care and payment for health care ("Personal Information"). It is often necessary to use and disclose this Personal Information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practices that describes these uses and disclosures. As described in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment purposes not only includes care and services provided here, but also disclosures of your Personal Information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your Personal Information for purposes of payment may include, for example, the submission of this information to a billing agent for processing claims or obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your Personal Information to treat you, to obtain payment for our services, and to operate The Adolescent and Mental Health and Monarch Family Services. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You also acknowledge, by your signature below, that you have received a copy of our HIPAA Notice of Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature:_____ Date: _____

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If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____

Print Name:

Payment Information

*****NOT FOR CPS CLIENTS*****

*Our goal is to provide quality service to all of our clients in a timely manner. Failure to keep scheduled appointments ("no-show) is costly to our office and you. Patients who are unable to keep their appointments are requested to give more than **24 hours notice** prior to their appointments. We realize this is not always possible and the practice will consider each individual case. Providing such notice allows our office to offer other persons the opportunity to see our providers, thus using the time more efficiently.*

*If an established patient fails to provide notice of a cancellation of their appointment, a **$30 fee** will be billed to his/her account for each missed appointment*
*If a new patient fails to show twice they will incur a **$50 no-show fee**. A third missed visit will result in discharge.*

*Credit card number*_____*Expiry Date:* _____

*CVV Code:*_____ *ZIP:* _____ *Card holder:* _____

Client's signature: _____