**CHILD FACE SHEET/ BACKGROUND INFO FORM**

**CHILD’S NAME**: DATE: \_\_\_\_\_ \_\_\_\_\_

ADDRESS:

AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

GRADE:\_\_\_\_\_\_\_\_\_\_\_TEACHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ETHNIC BACKGROUND:\_ RELIGION:

**1. PARENT’S NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:

PHONE (HOME): (WORK):\_ (CELL):

EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ETHNIC BACKGROUND: RELIGION:

EDUCATION:

OCCUPATION: EMPLOYER:

MARITAL STATUS:

\_\_\_Single \_\_\_Living together \_\_\_Engaged \_\_\_Married \_\_\_Separated \_\_\_Divorced \_\_\_Remarried \_\_\_Widowed

Number of yrs married/living together: \_\_\_\_Previous marriage(s)?: \_\_\_\_\_ How many? Duration of each:

**2. PARENT’S NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:

PHONE (HOME): (WORK):\_ (CELL):

EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ETHNIC BACKGROUND: RELIGION:

EDUCATION:

OCCUPATION: EMPLOYER:

MARITAL STATUS:

\_\_\_Single \_\_\_Living together \_\_\_Engaged \_\_\_Married \_\_\_Separated \_\_\_Divorced \_\_\_Remarried \_\_\_Widowed

Number of yrs married/living together: \_\_\_\_Previous marriage(s)?: \_\_\_\_\_ How many? Duration of each:

WHO IS LIVING IN YOUR RESIDENCE?

Name Age Relationship

CHILDREN NOT LIVING AT HOME:

Name Age Relationship

PREVIOUS TREATMENT:

Has your child been previously evaluated or received mental health or behavioral services at this practice or another practice or agency?

If yes, where and for what reason(s)?

Has any other member of your family received services at the Family Center?

Name(s) and Approximate Dates:

WHY YOU’RE HERE:

What are your goals for your child in therapy?

What, if any, would your child state as their goals in therapy?

What factors have led to you/your child seeking therapy at this time?

Please describe important developments in your child’s background:

Any unusual events and/or reactions to events (i.e. prolonged separation from parents, divorce

of parents, deaths in family, hospitalization of family member):

DEVELOPMENTAL HISTORY:

Was this a planned pregnancy?

Were there any problems during the pregnancy? If yes, what and when?

Length of labor: Birth Difficulties:

Breast or bottle fed? Any feeding problems during the early years? If yes, what?

Child’s health during first year, including allergies?

When did your child achieve the following milestones:

Talk: Any difficulties?

Walk: Any difficulties?

Toilet trained Any difficulties?

MEDICAL HISTORY:

Has your child had any medical problems (i.e. accidents, high fevers, childhood diseases,

surgery, hospitalization)? If yes, what and when?

Child’s Physician’s Name: Phone:

Is your child taking any medications? If yes, please list Medications and Dosages:

Medicating Physicians or Psychiatrist: Phone:

PRE-SCHOOL YEARS:

Relationship with brothers and sisters:

Relationship with friends:

SCHOOL:

Which school does your child attend and when started:

School performance- academic:

School performance- social:

Other pertinent information:

Name of person filling out form:

Relationship to child: Date:

In case of an emergency, whom can we notify?

Name: Relationship:

Address:

Phone: (Home) (Work) (Cell)

**THE FAMILY CENTER SERVICE AGREEMENT**

Welcome to The Family Center. The following sets forth the policies under which we operate. Please read this carefully and feel free to ask your therapist any questions you might have. Please sign the agreement and either bring it with you to your next appointment, or email it back prior to your next session.

**Patient/Client Consent to Treatment**

Participating in therapy can result in a number of benefits including greater insight, less emotional distress, and resolution of specific emotional, psychological, or behavioral concerns. Benefits may also include improved social skills, increased capacity for intimacy, decreased negative thoughts and behaviors, and improved ability to achieve personal goals. Psychotherapy requires active participation and openness. You are encouraged to give feedback and input about the course of therapy as it proceeds. For the best results, it is often ideal for therapist and patient to collaborate in good faith to meet the patient’s goals. Occasionally your therapist might consult with other professionals including other Family Center clinicians, are also bound by rules of strict confidentiality, regarding ideal practice and treatment to enhance effectiveness and quality of services. In this event, names and identifying information are concealed to protect confidentiality. If at any time your therapist believes that they are unable to help you reach your therapeutic goals, they will discuss this with you, and if appropriate, develop a plan for termination and referral to another provider. You have the right to terminate treatment at any time. Therapy never involves social, sexual or business relationships or any dual relationshipthat may impair the effectiveness of treatment.

**Communication: Phone, Email, Texting, TeleHealth, and Emergency Contact**

During your first session please be sure to discuss with your therapist the best way for you to get in touch with each other should you need to outside of your regularly scheduled appointment times, including the best phone number, email address, and whether or not through text messaging.

**TeleHealth**: Presently, The Family Center is conducting most services via a HIPAA compliant TeleHealth platform, which enabling patients and therapists to see and speak with each other from remote locations. Telehealth involves delivery of healthcare services including assessment, treatment, diagnosis, and education using interactive audio, video, and data communications. Prior to your first appointment, your therapist will provide you with a unique link to click at the time of your weekly appointment. This will connect you to our patient TeleHealth portal. The same link may be used weekly. Even if you meet with your therapist in person, TeleHealth might be an appropriate option on occasion in the case of inclimate weather or for other reasons as determined by you and/or your therapist.

**Emergencies**: If you are experiencing an emergency and cannot reach your therapist, please contact 9-1-1 or your local emergency/crisis center, or go directly to the nearest hospital emergency room and ask for the psychiatrist on-call. If possible once you are safe, then leave your therapist a message that you have done so.

**Confidentiality**

**Confidentiality.** Confidentiality is a key component of effective therapy. Knowing that what you share will be kept confidential helps most people to feel more comfortable and develop greater trust in their therapist and the process. With little exception, information that you share in therapy will be kept confidential.

**Written Consent Exception**. One exception to confidentially is when you have given express written consent to disclose certain information. This would involve you signing a Release of Information Form that sets clear parameters regarding which information may be disclosed to whom. As noted above, our therapists do from time to time collaborate with each other and other professionals in order to provide you with the highest quality treatment. With respect to communications with other Family Center therapists, names and identifying information will be concealed. With respect to communications with professionals outside of The Family Center, you will be asked to sign a Release of Information Form, which you may subsequently revoke at any time as desired.

**Safety Exceptions.** There are additional exceptions to confidentiality that are important for you to understand before you share information with your therapist. Exceptions to confidentiality are described in greater detail in our Informed Consent for Treatment Form. In essence, any information that you share regarding a plan to inflict harm on yourself or on someone else will require an exception to be made to confidentiality. Please make sure to read and ask any questions you have about confidentially and related exceptions prior to signing the Informed Consent for Treatment. In the event that your therapist is required to break confidentiality, they will make every reasonable effort to talk with you and inform you before doing so.

**Policy of Minors in Treatment.** Clients who are younger than eighteen years are considered minors and parent(s) or legalguardian(s) sign must sign an informed consent for their treatment As minors, thelaw may give parents and legal guardians the right to examine treatment records. The Family Center encourages and values open communication and a collaborative approach toworking with minors. At the same time, confidentiality is vital in helping minors feel safe toexplore feelings they may not be comfortable sharing with other adults. With minors’involvement, therapists will provide parents/legal guardians with general information aboutsessions, treatment goals, and progress. Further, therapists will work with minors on developing aplan for sharing confidential information with their parent(s) or legal guardian(s) when appropriateand beneficial for treatment progress. If at any time a therapist assesses that there is a high risk a minor may seriously harm themself or another person the therapist will notify the minor’s parent(s) or legalguardian(s) immediately of the concern.

**The Family Center Hourly Rates**

\* *indicates services not able to be submitted to insurance*

Individual Psychotherapy Session…………………………….………………...$225.00

Initial Psychotherapy Intake Session...………………….………………………$285.00

Couples and Family Sessions………….………………….…………………….$285.00

Group Psychotherapy ………………….………………….…….........................$140.00

Forensic Evaluations & Court Appearances ……………….….…………...........$610.00

Psychological-Educational Assessments………………………...........................$300.00

\*Family Mediation …………………….…………………....…….….................$325.00

\*Parenting Coordination ……………………………...........…….…....................$365.00

\*Parental Guidance/Coaching ………………………….…….…………………. $210.00

\*School Visits …………………………………...………….…….……………...$210.00

\*Executive/Accountability Coaching ……….………………………….………...$250.00

\*Correspondence/related professional services outside of regularly scheduled sessions...$200.00

*Billed in 15-minute increments. Examples: reviewing and responding to lengthy email or texting correspondence, lengthy or frequent telephone conversations, non-assessment related report writing, consulting with other professionals (as authorized by the patient/client), preparation of records and treatment summaries, and other miscellaneous services performed at your request*.

Payment is due at the time of service. As limited by healthcare insurance providers, certain services are eligible to be billed to insurance. Services that fall within this category are (a) listed above *without* an asterisk (\*) and (b) provided by one of our licensed psychotherapists or supervisees who are also paneled with your insurance (i.e., **in network**). Where this applies, our office will submit in network claims on your behalf as a courtesy.

For patients with **out of network** insurance benefits, the full hourly rate is due at the time of service. Patients with out of network insurance benefits, your therapist will provide you with a detailed billing statement that includes a clinical diagnosis and standard billing code to be submitted to your insurance provider. Patients with out of network insurance benefits are responsible for submitting claims directly to their insurance provider.

All Patients and Clients are ultimately responsible for knowing their own insurance benefits including effective dates and all copay, deductible, out of pocket maximum amounts. In the event that a patient’s insurance provider denies any insurance reimbursement, the ***PATIENT IS RESPONSIBLE FOR THE FULL BALANCE ON THEIR ACCOUNT***.

Some therapists are open to discussing a sliding scale fee arrangement. If you need to discuss payment plan options, please let your therapist know as soon as possible.

In legal proceedings of patients that require therapist or mediator participation, patients are responsible for all professional time and costs, including preparation and transportation costs, and any necessary professional attorney fees, even if the therapist or mediator is called to testify by another party. Because of the complications and difficulty of legal involvement, the hourly professional rate is $500.00, billed in 15-minute increments for preparation, travel, and attendance at any legal proceeding.

Please be aware that practice fees tend to increase between 5-10% every few years, as necessary to offset to increasing cost-of-living expenses and various other practice operating expenses. If and when the practice finds it necessary to raise fees, you will be informed at least one month in advance in order to offer an opportunity to discuss the increase. Please let your therapist know if you feel the increase would cause financial hardship.

**Cancellation/Missed Session Policy.** In contracting for psychotherapy, you are responsible for the weekly appointment time(s).Advanced notice of 24 hours prior to a canceled session is required to avoid a full feecharge for that session. Cancelled sessions are not billable to insurance. Sessions canceled at the last moment due to illness or emergencywill not be charged if the client can make up the missed appointment within 10 days. Asa courtesy, group psychotherapy members are allowed to miss 2 sessions at no costduring each semester. Any absences from group beyond 2 missed sessions will becharged at the full fee in order to maintain the client’s space in the group. In order toenroll in group, clients must commit to participate for a semester at a time.

**Billing and Payments.** Patient bills areprinted and insurance is submitted, both once monthly. Payment is expected within 20 days of receipt of the bill. Many patients opt to provide on file credit card information so that their copay amount can be run weekly. In circumstances of unusual financial hardship, please let your therapist know to discuss negotiated fee adjustment or installment payment plan.

**Late Fee ($25).** All bills are due the 20th of each month. A $25.00 late fee will be added for each bill notreceived by the 20th, and an additional $25.00 will be charged for each billing cycle a balance remains unpaid.

**Coordinating with physician and psychiatrists.** Physical and psychological symptoms often interact. You are encouraged to seek medicalconsultation as needed. Medication can be helpful for some

psychological concerns. Please let your therapists know of any medical and/or psychiatric concerns you have and a referral can be made where appropriate.

**Patient Rights.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with the following rights: to request certain amendments to your record; to restrict what Protected Health Information (PHI) information is disclosed to others; to request an accounting of disclosures that have not required your consent; to determine the location(s) where PHI is sent; to have complaints you may make about therapist procedures and policies recorded in your record; to request copies of this notice and the HIPAA notice form. You have a right to review your PHI, except in limited legal and emergency situations, including situations where releasing the information to you might be harmful to you. In this event, it may be appropriate for to provide records to an appropriate mental health professional of your choice to review with you.

**Counseling Agreement Consent**

Your signing below indicates that you have read in its entirety and understood this Therapy Agreement, that you have had an opportunity to ask questions, and are agreeing to enter into a professional relationship with The Family Center and agree to abide by the terms of this agreement. In the event that a person other than you is responsible for paying the bill, please also have the party read this document and sign. Thank you!

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Date: \_\_\_\_\_

*(please print)*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Date: \_\_\_\_\_

*(parent/guardian’s signature, if applicable)*

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ \_

**CONSENT FOR TREATMENT - CHILDREN**

Child’s Name:

It is important that you understand the policy and procedures regarding the treatment of minors at the beginning of service so that you can make an informed decision about receiving services.

This information is in addition to the Family Center Therapy Agreement.

• Parents/Guardians are expected to be involved in their child’s therapy sessions. All children must initially be brought to therapy sessions by a parent or guardian and that person must remain in the office during the time your child is being see. If an alternate accompanying adult is desired for future sessions, it is important to discuss this option prior to the session.

• A parent or guardian who has legal authority to do so must consent to their child’s treatment. A court order to verify that you are the legal parent or guardian may be necessary.

• Virginia Law allows for either parent to have access to their child’s records or information, unless there is a court order limiting access or terminating parental rights. If and when a parent makes a request, I will make attempts to notify the other parent. Please understand that I must comply with legitimate requests.

• By signing this statement you agree not to involve this therapist in any type of legal proceedings against a parent or family member. It is important to recognize the importance of the relationship that your child will be developing with their therapist. The trust that is built into the sessions is the foundation for change and growth in your child.

By requesting participation in legal proceedings, you would be asking your child’s therapist to betray the trust and relationship that was built/is building with your child.

I acknowledge that I have read and agree to all of the above provisions about seeking

services for my child. I certify that I am the legal parent/guardian and have the authority

to consent to services

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

Parent/Legal Guardian Signature Date

**INFORMED CONSENT FOR TREATMENT**

PATIENT NAME:

I (We) , hereby give permission and

*(Patient or Legal Guardian)*

consent to for treatment. I (We)

*(Psychotherapist)*

understand that this will encompass the intake, diagnostic assessment, and treatment processes.

I (We) understand and acknowledge that strict confidentiality is practiced and assured, with the following exceptions:

1. I/We have signed a Release of Information Consent Form for specified individuals or agencies;

2. There is an active court order signed by a duly appointed or elected judge for the release of my records or my/our child’s records;

3. I am/My child is perceived to be a danger to myself/themselves/or others.

4. I am/My child is suspected of abusing children or other vulnerable individuals

5. Representatives of a funding source for my(our)/my child’s services require that

my(our)/my child’s record(s) be made available with my(our) written consent.

\*HIPAA Privacy Rule allows for release to insurance carriers of Protected Health Information (PHI), namely treatment dates, modalities, results of tests, diagnoses, symptoms, treatment plan, prognosis, and progress. PHI does not include Psychotherapy Notes, which may include the content of our conversations and therapist analysis of these conversations. These Notes are the possession of the therapist, and are not released by the therapist. When requested, a summary of Psychotherapy Notes will be provided to the patient, or another party with written consent of the patient or their representative.

I (We) understand that all treatment and evaluation with the Therapist is voluntary, and that I (We) may cease treatment or evaluation at any time. I (We) have read and agree to the Therapy Agreement. I (We) have read and/or had the above explained to me (us), and voluntarily give my (our) informed consent to treatment and/or evaluation.

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

Patient Signature Date

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

Parent or Legal Guardian Signature Date

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

Parent or Legal Guardian Signature Date

**ACKNOWLEDGEMENT OF CHILD THERAPY**

Client/Patient Name:

This release is an acknowledgement that is seeing my child in counseling

*Therapist Name*

and that I am aware of the invitation to participate in this counseling process.

\_\_\_\_\_\_\_\_\_\_ I am in agreement with this process

\_\_\_\_\_\_\_\_\_\_ I am not in agreement with this process

\_\_\_\_\_\_\_\_\_\_ I accept the invitation to participate:

\_\_\_\_\_\_\_\_\_\_ In person

\_\_\_\_\_\_\_\_\_\_ By phone

\_\_\_\_\_\_\_\_\_\_ In writing

\_\_\_\_\_\_\_\_\_\_ I decline to participate

Parent/Legal Guardian Signature Date

**INSURANCE FORM**

\*PATIENT' NAME: INTAKE DATE: \_\_\_\_ \_

\*DOB: SSN#: \_\_\_\_\_

PRIMARY NAME ON INSURANCE POLICY:

\*NAME: SSN#: \_\_\_\_\_

\*DOB: \*RELATIONSHIP TO PATIENT:

**INSURANCE INFORMATION**

\*INSURANCE ID #:

GROUP ID #:

\*INSURANCE CARRIER:

\*INSURANCE CLAIMS ADDRESS:

INSURANCE PHONE NUMBER:

\*EFFECTIVE DATE:

POLICY RE-STARTS BASED ON: ☐ CALENDAR YEAR (JAN-1) OR ☐ CONTRACT YEAR (EFFECTIVE DATE)

DEDUCTIBLE AMT: COPAY AMT: OUT OF POCKET MAXIMUM:

LIMIT ON NUMBER OF SESSION ALLOWED PER YEAR? NUMBER ALLOWED:

REFERRAL OR AUTHORIZATION REQUIRED?

The above information will be disclosed to your insurance carrier and their mental health carrier if applicable in order to obtain eligibility, benefits, authorization/certification, extension of a treatment plan, claim submission, and claims questions.

Your signature below signifies your consent to release this information.

SIGNATURE: DATE:

PRINT NAME: DATE:

**RELEASE FOR ELECTRONIC DELIVERY OF BILLING INVOICES**

I, consent to have The Family Center deliver my billing invoices to the email address provided below. I understand that email communications may not be considered confidential or privileged, and I accept all risk to confidentiality permitted by my consent. I further agree not to hold The Family Center or any of its therapists or office staff liable for any damages incurred as a result of electronic emailing of my billing statements.

Signature Date

Email Address for Billing Invoice (please print clearly)

**CREDIT CARD AUTHORIZATION**

Please complete this form even if you will not be charging your sessions on a regular basis. Because clients may occasionally forget to leave payment, we appreciate having a card on file, which will not be charged without notifying you.

\_\_\_\_\_\_\_\_\_(Initial) I authorize The Family Center to keep my signature on file and to charge my account for services rendered including copays, late cancellation fees, no show charges, and unpaid balances.

I understand that this form is valid for four (4) years unless I cancel the authorization through written notice to The Family Center.

Patient’s Name:

Card Holder’s Name:

Card Billing Zip Code: \_\_\_\_ Visa \_\_\_\_\_ MasterCard

Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVV: \_\_\_\_\_\_\_\_\_\_ (3 digits found on the back of the card in the signature line)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THANK YOU!!