Intake Assessment Child/Adolescent

Please use the back of this form if need more room to complete questions

Date: _____ Client name: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Address _____ City _____ Zip _____

Home phone _____ Work phone _____

Cell phone _____ Other_____

Mother's Name_____ Employer _____

Address _____ City _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Father's Name:_____ Employer _____

Address _____ City _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Child's School Name_____ School Phone_____

Pediatrician_____ Phone#_____

Emergency Contact (Nearest relative or friend)_____ Phone _____

Person Financially Responsible _____SS# _____

Employer _____ Address_____

Preferred Language of Patient:_____

Family Members (living in home):

1._____ Date of Birth _____Relationship_____

2. _____ Date of Birth _____Relationship_____

3. _____ Date of Birth _____Relationship_____

4. _____ Date of Birth _____Relationship_____

Referral Source:_____Victom's Compensation County: _____

Please describe in detail why you are pursuing therapy at this time including background regarding the primary concern.

Check all symptoms that apply past or present to client:

- ❏ **Anxiety:** ☐ excessive worry ☐ fear of impending harm ☐ panic attacks restlessness ☐ sweaty hands ☐ nightmares ☐ school anxiety ☐ difficulty with transitions ☐ separation anxiety ☐ racing heart ☐ difficulty breathing
- ❏ **Appetite:** ☐ eats too much ☐ eats too little ☐ overweight ☐ underweight ☐ restrictive diet
- ❏ **Nutrition Problems:** ☐ unhealthy choices ☐ cravings ☐ large portions
- ❏ **Attention:** ☐ Attention Deficit/ Hyperactivity ☐ poor attention ☐ disruptive ☐ easily description easily distract ☐ forgetful ☐ does not listen ☐ in impulsive ☐ hyperactive ☐ fidget ☐ unable to stay on task ☐ excessive talking ☐ poor follow-through tasks ☐ avoidance of tasks that require sustained mental effort ☐ difficulty with organization ☐ interrupts or intrudes on others ☐ impatient ☐ loses things
- ❏ **Autism:** ☐ Abnormal Body Posturing or Facial Expressions ☐ Abnormal Tone of Voice ☐ Poor Eye Contact ☐ Behavioral Disturbances ☐ Deficits in Language Comprehension ☐ Delay in Learning to Speak ☐ Flat or Monotonous Speech ☐ Inappropriate Social Interaction ☐ Intense Focus on One Topic ☐ Lack of Empathy ☐ Lack of Understanding Social Cues ☐ Learning Disability or Difficulty ☐ Not Engaging in Play With Peers ☐ Preoccupation With Specific Topics ☐ Problems With Two-Way ☐ Conversation ☐ Repeating Words or Phrases ☐ Repetitive Movements ☐ Self-Abusive Behaviors ☐ Sleep Disturbances ☐ Social Withdrawal ☐ Unusual Reactions in Social Settings ☐ Odd Words or Phrases
- ❏ **Conduct Problems:** ☐ aggressive ☐ oppositional ☐ defiant ☐ assaulted ☐ explosive temper ☐ disobeys rules ☐ argumentative ☐ threatens others ☐ bullies/ intimidates ☐ blames others for Behavior ☐ deliberately annoys others ☐ easily annoyed ☐ angry ☐ resentful ☐ excessively negative ☐ difficult to manage
- ❏ **Depression:** ☐ depressed mood ☐ sad ☐ irritable ☐ mood reactivity ☐ low self-esteem ☐ cheerfulness ☐ energy/ fatigue ☐ poor concentration ☐ hopelessness ☐ restlessness ☐ decreased energy ☐ hopelessness ☐ worthlessness
- ❏ **Dissociative:** ☐ stairs off ☐ periods of not answering questions when talked to ☐ amnesia ☐ not feeling connected to your own body ☐ developing different identities
- ❏ **Energy:** ☐ low energy ☐ high energy
- ❏ **Mania:** ☐ high energy/activity ☐ excessive talking ☐ increased goal-directed behavior ☐

- ❑ **Obsessive/ Compulsive:** ☐ repetitive thoughts ☐ ritualistic behavior ☐ obsessive thinking/behavior
- ❑ **Psychosis:** ☐ delusions ☐ hallucinations ☐ paranoia
- ❑ **Somatic:** ☐ complaints of physical sickness ☐ frequent ailments
- ❑ **Sleep:** ☐ trouble falling asleep ☐ nocturnal awakenings ☐ nocturnal awakenings
- ❑
- ❑ **Suicide/Self-harm:** ☐ thoughts of suicide in the past ☐ current thoughts of suicide ☐ history of suicide attempt ☐ history of self-harm
- ❑ **Trauma:** ☐ victim of crime ☐ re-experiencing trauma ☐ sexual abuse
- ❑ **Grief:** ☐ crying ☐ lack of engagement ☐ recent loss
- ❑ **Relationship Difficulties** *describe:*_____

Previous Mental Health History:

- ❑ **Participated in counseling in the past (list provider(s) and dates attended)**_____
- ❑ **Previous psychological testing (describe)** _____
- ❑ **Previous diagnosis** _____
- ❑ **Previous Hospitalization(s)** _____
- ❑ **Suicidal ideation:** ☐ thought ☐ plan ☐ intent ☐ self-harm ☐ attempt ☐ hospitalization
- ❑ **Past Psychotropic Medications:** _____
- ❑ **Residential Treatment** _____
- ❑ **Outpatient Treatment** _____

Birth History:

- ❑ Age of mother at conception _____
- ❑ Concerns during the course of your pregnancy _____
- ❑ Medication or drug use (including non-prescription drugs) during pregnancy_____
- ❑ Was baby full-term _____
- ❑ Were there any indicators of fetal distress during labor or birth _____
- ❑ Weight and APGAR scores, if known _____

Developmental History:

- ❑ Were your developmental milestones met at appropriate ages _____
- ❑ Describe discipline used in the home _____
- ❑ What is the client disciplined for_____ _____
- ❑ How does the client respond to this discipline?_____
- ❑ List chores/tasks the client is responsible for _____
- ❑ List traumatic or frightening experiences the client has experienced _____

Medical History:

- ❑ List health concerns _____
- ❑ History of head injury with loss of consciousness _____
- ❑ History of Medical hospitalizations_____
- ❑ History of surgeries_____
- ❑ Medical diagnosis_____
- ❑ Date of last physical exam_____
- ❑ Weight fluctuations 10 lb within the last 3 months_____

- ❑ Special diet_____
- ❑ Food allergies_____
- ❑ Independent with bathing, dressing, and other self care _____
- ❑ Sleeps concerns:
  - ❑ Difficulting falling asleep _____
  - ❑ Nightmares _____
  - ❑ Wakes during the night _____
  - ❑ Number of naps in the day _____
  - ❑ Bedwetting _____
  - ❑ Goes to bed at _____
  - ❑ Wakes up at _____

Family History:

Client lives at home with:

Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____

List biological parents names _____
Were your parents separated/divorced _____
Describe times client has been separated from primary caregiver _____
List practicing religion _____
Describe your relationship with your biological mother_____
Describe your relationship with your biological father _____
Describe the your relationship with your siblings_____
Describe your relationship with your step-parents _____
List family members who have received therapy services _____
List family members who have mental health diagnosis _____
List family members who have a medical diagnosis_____
How long have you lived at your present location? _____

Interests/Activities:

Describe the client_____
Describe the clients friends_____
Favorite classes/ activities_____
Sports/extracurricular participation in school_____
Current employment_____
Hobbies_____
Hours/day of technology (TV, computer games, video games)_____
Weekly physical activities outside of school_____

Educational History:

Current grade_____
List school currently attend_____
List other schools and dates of attendance_____

Individualized education plan (IEP) special education designation or 504_____
Estimated grade point average _____
List learning difficulties_____
Does the client complete home work independently _____
Has the client experienced any traumatic experiences at school _____
Client's career aspirations _____

Sexual History:
Sexual orientation _____
Currently dating _____
Sexually active _____

Trauma/Abuse:
Describe trauma/ abuse history_____

Legal Involvement:
- ❑ Legal history_____
- ❑ Current legal involvement_____

Substance Use History:
- ❑ Client currently uses substances (list) _____
- ❑ Client used substances in the past (list)_____
- ❑ When did substance abuse start _____
- ❑ How have you intervened _____
- ❑

Family Psychiatric History:
- ❑ Siblings_____
- ❑ Biological mother _____
- ❑ Biological father _____
- ❑ Other family members _____

Current Medications
- ❑ Over-the-counter medications, vitamin supplements (list all) _____
  _____
- ❑ Prescriber name and phone number _____

Other:
Describe any other information that is important to know
_____

THERAPY AGREEMENT

- Individual 50 minute in person therapy sessions are $165 per session or $145 for telehealth sessions. Eye Movement Desensitization and Reprocessing therapy (EMDR), if agreed upon, are $175 per session. Appointments without 24 hours cancellation are charged at the session rate and additional fees are prorated based on the session fee.

- Payment/Insurance: I understand that **ALL CHARGES ARE DUE AT THE BEGINNING OF EACH SESSION**, unless other payment schedules are agreed upon, and that payment is a condition of treatment. Payment is accepted in the form of cash or credit card. Clients take full responsibility for any and all payments and acknowledge that Anew Professional Counseling Services will not bill insurance companies but can upon request provide an itemized bill for clients to submit to their insurance company for reimbursement.

- Canceled Appointments: Cancellations must be made 24 hours prior to your appointment. If 24 hours notice is not given you will be charged the full fee for that session. If your appointment is scheduled on a Monday, then notice must be given the Friday before your appointment in order for you to avoid being charged.

- Additional Fees: You will be charged at an hourly rate ($100) for services rendered outside of your session, including but not limited to the following services: letters, reports, court hearings, collateral contacts. Client phone calls and emails (reading and response) longer than 5 minutes will also be charged. The fee for these services are based on the time incurred and will be rounded to 6-minute intervals.

- By signing this agreement you agree that if it becomes necessary your account balance will be forwarded to a collection agency and you will be responsible for reasonable costs associated with collection, including attorney's fees, in addition to the amount owed. If I do not call to cancel and fail to show for my appointment more than one time during the course of my treatment, or I do not keep my account at a zero balance, I am giving the impression that I am no longer interested in counseling and my case will be closed, unless other arrangements are made.

I give Terri Testa permission to share information necessary for billing purposes with the insurance company and/or Victim's Compensation.

YES_____ NO_____

By signing below I acknowledge the conditions of treatment as stated above and I understand that I am financially responsible for all services rendered:

Signature: _____ Date:_____
Guardian's Signature

PATIENT NOTIFICATION OF SERVICE POLICIES

All agreements and arrangements made are between the patient and Anew Professional Counseling Services.

APPOINTMENTS. Individual sessions are scheduled for 50 minute sessions. Sessions for children are 40-45 minutes.
HOURS OF SERVICE. Consultation is available by appointment only. The office telephone number provides for voicemails to be left 24 hours a day and messages are checked **during working hours only**. If you need to speak with your clinician during working hours please use his/her direct number to contact them regarding clinical issues. **There is not an emergency service available through Anew Professional Counseling Services, so if you have a life-threatening emergency please go to your nearest emergency room, at a hospital or crisis center designated by your insurance company.**
CONFIDENTIALITY. All information and records are kept confidential in accordance with the American Psychological Association standards and Colorado State law. General legal exceptions to confidentiality include: suicide, homicide, child abuse, and court-ordered testimony. Case consultation and review may occur when necessary. Your insurance company will also require some basic information about your diagnosis. Please address any concerns you may have in regard to this area.

INTERNET-BASED COMMUNICATION: Please be advised that e-mail communications may be conducted for the purpose of communication around clinical issues, but if you choose to communicate with this mode of technology your confidentiality cannot be guaranteed.

By signing below I agree to the above mentioned conditions to treatment:

Signature:_____ Date:_____
Guardian's Signature

DISCLOSURE STATEMENT

1. Dr. Terri Testa has a Doctor of Psychology Degree from California Southern University and a Masters degree in social work from the University of Denver. Dr. Testa is a Licensed Clinical Social Worker working at 6021 S Syracuse Way Suite 201, Greenwood Village 80111. Phone: 720 336-3227.

2. The practice of licensed or registered persons in the field of social work is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Social Work can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals:
   -Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
   -Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
   -Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.
   -Certified Addiction Counselor III (CAC III) must have a Bachelors degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
   -Licensed Addiction Counselor must have a clinical Masters degree and meet the CAC III requirements.
   -Licensed Social Worker must hold a Masters degree in social work.
   -Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
   -Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a Masters degree in their profession and have two years of post-masters supervision.
   -A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

3. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities.

   The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at:
   www.dora.colorado.gov/professions/registeredpsychotherapists.

4. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

5. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

6. I have read the preceding information and I understand my rights as a client or as the client's responsible party.

Guardian's Signature Date

COLORADO NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.
- *Adult and Domestic Abuse* – If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.
- *Health Oversight Activities* – If the Colorado State Board of Psychologist Examiners or an authorized professional review committee is reviewing my services, I may disclose PHI to that board or committee.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to me a serious threat of imminent physical violence against a specific person or persons, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.
- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therpist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will notify you by mail at the address you provide for me at intake.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Anew Professional Counseling Services, Dr. Terri Testa, Psy.D., LCSW, by telephone at (720)336-3227 or by mail at PO Box 932, Littleton, CO 80120.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on 9/1/2022. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

SIGNED ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received the "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information," which describes how psychological and medical information about me may be used and disclosed and how I can gain access to this information.

_____ _____

Guardian's Signature Date

Teletherapy Informed Consent

Definition of Telehealth: Telehealth involves the use of electronic communications to enable Anew Professional Counseling Services to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during my sessions is confidential, with the following exceptions, including, but not limited to, reporting child, elder, and dependent adult abuse; threats of harm to self; expressed threats of violence toward an ascertainable victim. Should you decide to have your mental or emotional state an issue in a legal proceeding your explicit signed waiver of release of information would allow for all of your treatment information to be disclosed. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent. In addition, I understand that my telehealth communications and appointments will not be recorded and will not be a part of my record.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.

3. I understand that there are **risks involved when using telehealth,** including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), my therapist will make that recommendation and make any appropriate referrals. And despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that Anew Professional Counseling Services will use the technology provided by Google Meet, which provides teletherapy services that are in accordance with HIPPA regulations. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Google Meet or that such information is current, accurate or up-to-date. I will not rely on my health care provider to provide all of this information in the Telehealth by Google Meet Service to me.

8. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

9. By signing this document, I agree that certain situations, including mental health emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in a mental health crisis or emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

10. I understand that different states have different regulations for the use of telehealth. Colorado is in allowance of telehealth services.

11. I give permission to be contacted for telehealth appointments at the following e-mail:_____.

I understand that a link will be sent prior to my appointment and that I will access that link to connect with my therapist at the appointment time.

Patient Consents to the Use of Telehealth, I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein by Anew Professional Counseling Services. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____ _____

Guardian's Signature Date

CHILD THERAPY CONTRACT

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient Notification of Service Policies and Therapy Agreement. Under HIPPA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however, I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children 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. By signing the agreement, you will be waiving your right to access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. If requested, at the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceeding, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if the appropriate releases are signed or a court order is provided), but I will not make any recommendations about the final decision. Furthermore, if I am required to appear as a witness, the party

responsible for my participation agrees to reimburse me at my normal session rate for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

By signing below I agree to the above mentioned conditions to treatment:

Signature:_____ Date _____
(Signature of Patient or Parent/Guardian)

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information]

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other_____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____ Cardholder ZIP Code: _____

I, _____, authorize _Anew Professional Counseling Servies_ to charge my credit card

above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Responsible Party's Signature Date