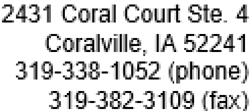

Katie Barreras, LISW
Farrah Bonde, LISW

Child Intake Assessment

Information provided by:			
Relation to child:			
Information for child seeking treatment			
Child's First Name:		Last Name:	
Date of Birth:	Age:	Gender Identity:	Today's Date:
Legal Guardianship			
[ ] Biological Parents [ ] State County:____________________________________ [ ] Other: ____ [ ] Did Termination of Parental Rights (TPR) occur? Date of TPR: ____________________ [ ] Is there a plan for reunification with parent(s)? ______________________			
Parent(s)/ Guardian information			
Parent/Guardian's First Name:		Last Name:	
Relation to Child:			
Date of Birth:	Age:	Gender Identity:	
Home Address:			
Cell Phone:	Home Phone:		May we identify ourselves? [ ] Yes [ ] No
Work Phone:	Email Address:		May we identify ourselves? [ ] Yes [ ] No
Highest level of education:		Current employer:	
Parent/Guardian's First Name:		Last Name:	
Relation to Child:			
Date of Birth:	Age:	Gender Identity:	
Home Address:			

Cell Phone:	**Home Phone:**	**May we identify ourselves?** [ ] Yes [ ] No
Work Phone:	**Email Address:**	**May we identify ourselves?** [ ] Yes [ ] No

Highest level of education:	**Current employer:**

***INFORMATION SHOULD PERTAIN TO THE CHILD SEEKING TREATMENT**
Coralville Family Counseling respects your right to not disclose the following information. Please use your discretion and level of comfort when answering the following questions. We have provided a self-identify (Self-ID) option in each relevant category to allow for the child's unique identity to be included.

Race/Ethnicity (check all):	**Relationship Status:**	**Sexual Identity:**
☐ African American/Black	☐ Single	☐ Lesbian
☐ Asian/Pacific Islander	☐ Dating	☐ Gay
☐ Caucasian	☐ Partnered, not married	☐ Heterosexual
☐ Hispanic/Latino(a)	☐ Married	☐ Bisexual
☐ Native American	☐ Divorced/separated	☐ Questioning
☐ Self-ID: ________________	☐ Widowed	☐ Self-ID: ______________
	☐ Self-ID: _____________	
Cultural preferences:	**Language preference:**	**Religious Affiliation/Spiritual Identity:**

Child's School:	**Grade:**	**Address:**

Circle any that apply: **Special Education** **Resource** **AEA** **IEP** **504 Plan**

Child's Primary Care Physician:	**Clinic:**
Child's Current Psychiatrist's Name:	**Clinic:**
Is the child being seen by another behavioral health clinician?	**Clinic:**

Behavioral/Mental Health Treatment History- Do Not Leave Blank

Agency/Professional's Name:	**Date of Treatment:**

Outcome/Response to Treatment:

Interventions used:

Client Name ____

Agency/Professional's Name:		**Date of Treatment:**
Outcome/Response to Treatment:		
Interventions used:		
List of Mental Health Diagnoses for Child:		
Child's Medical History		
Medication and prescriber:	**Dose (per day):**	**Date prescription initially started:**
Medication and prescriber:	**Dose (per day):**	**Date prescription initially started:**
Other medication(s) taken:		
Is the medication regime followed? [ ] YES [ ] NO **Is the medication working? [ ] YES [ ] NO** **Any problematic side effects?**		
List all allergies, adverse reactions/sensitivities to food, drugs, and other substances:		
List previous dates and providers of medical treatment:		
List child's current medical interventions and responses:		
List all previous medical conditions and current medical concerns:		
List all relevant family medical history concerns/issues:		

Developmental History- Do Not Leave Blank

Prenatal Events (Prior to birth):

Perinatal Events (within one month of birth):

Past Concerns with Social Interaction:

Educational Strengths and Areas of Concern:

Past concerns with Learning, Intellectual, or Academic Performance:

History:	Yes	No	Uncertain	Explanation:
Has this child ever been in trouble legally, or are there legal issues impacting the child or family now?				
Any family history of chemical dependency?				
Any family history of mental illness?				
Has this child ever had problems due to gaming or gambling?				
Has this child ever been physically abused?				
Has this child ever been sexually abused?				
Has this child ever been emotionally abused?				
Has this child ever abused someone else?				
Has this child ever experienced a traumatic event?				
Has this child been diagnosed with a disability?				
Has this child had a change in sleeping patterns or energy levels?				
Has this child ever been hospitalized for psychiatric issues?				**Date(s) and reason:**
Has this child ever been hospitalized for substance use reasons?				**Date(s), substance type, and outcome:**

Client Name ____

	Yes	No	Uncertain	
Has this child ever seriously considered/attempted harming himself/herself?				**Date(s), method, and severity/lethality:**
Has this child ever seriously considered/attempted harming someone else?				**Date(s), method, and severity/lethality:**
Has this child had a decreased enjoyment in activities in the last 30 days?				
Has this child recently had a change in appetite?				
Has this child recently become withdrawn?				
Has this child had recent changes in ability to concentrate?				

Substance use:	Yes	No	Amount	Has this child in the past?
Does this child currently use alcohol?				
Does this child currently use nicotine?				
Does this child currently use caffeine?				
Does this child currently abuse non-prescription medication?				
Does this child currently abuse prescription medications?				
Does this child currently use illicit drugs?				

Who uses nicotine in this child's place of residence?

If this child is an active smoker, describe child's readiness to reduce or quit tobacco:

Substance Abuse Treatment History (if applicable):

Date(s) and type of treatment(s) participated in:

Length of current relapse, if applicable:

Sexual Behavior History (Adolescents, ages 12-17)

Do you believe this child is sexually active?
Are this child's sex partners male, female, or both?
Do you believe your child or your child's partner(s) use protection against STDs?
Do you believe your child uses any contraception or practices any form of birth control?

Adoption History

History of placements prior to adoption:
Age of placement in adoptive home:
What has the child been told regarding adoption?

Other people residing in the child's home?

Name: ___________________________________ Gender identity:__________ Age: ________________ Relation: _________________________	Name: ___________________________________ Gender identity:__________ Age: ________________ Relation: _________________________
Name: ___________________________________ Gender identity:__________ Age: ________________ Relation: _________________________	Name: ___________________________________ Gender identity:__________ Age: ________________ Relation: _________________________

Describe each parent's/ guardian's relationship with the child:
What event(s) prompted you to seek treatment at this time?
List additional family stressors or concerns at this time (Mental, physical, emotional health of other family members, employment, housing, financial, recent losses, etc.):

Client Name ____

What changes would you like to see in the child seeking treatment?	
What changes would you like to see in your family?	
Please list child's strengths, skills, and abilities.	
What is the child's current motivation level?	

Please check all concerns that apply to the child:

[ ] **Noncompliance with treatment**
[ ] **Number of multiple behavioral diagnosis**
[ ] **Prior behavioral health inpatient admissions**
[ ] **Immediate risk of harm to self**
[ ] **Immediate risk of harm to someone else**
[ ] **Other, Please explain:**
[ ] **Immediate risk of harm to animals**
[ ] **Immediate risk of harm to small children**
[ ] **Suicidal/ Homicidal thoughts**
[ ] **Substance abuse**
[ ] **Running away/elopement potential**

Emergency Contact- Do Not Leave Blank

Name:	
Cell/Home Phone:	**Work Phone:**
Home address:	

Resources and Referrals

List current resources (e.g. family, friends, non-profit organizations, support groups, social services, school based support, government assistance, etc.):

Referrals needed (e.g. housing, food, psychiatry, support groups, academic, relapse prevention, stress management, wellness programs, lifestyle changes, etc.):

Provide Insurance Information or Insurance Card(s) to Our Staff

Primary insurance:	**Insurance Phone #:**
Policy Holder Name:	**Policy Holder's Employer:**
Policy Holder DOB:	

Insurance ID#:	**Group#:**
Secondary Insurance:	
Policy Holder Name:	
Policy Holder DOB:	**Policy Holder's Employer:**
Insurance ID#	**Group #**

In consideration of the health care services provided to the client, I ______________________ assign and authorize my insurance company, or other third party payor to make payments directly to Coralville Family Counseling.

Specific authorization for release of information

I specifically authorize Coralville Family Counseling to submit medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to my insurance company, or other third-party payor or its authorized agents or representatives for the purpose of determining benefits and facilitating payment. I may revoke this specific consent to release information at any time by sending a written notice to Coralville Family Counseling, 2431 Coral Court, Suite #4 Coralville, Iowa 52241. I understand that the information to be released may include mental health related information unless I specifically deny the release.

Print Client's Full Name:	**DOB:**
Signature of Parent/Guardian/Legal Representative:	**Today's Date:**

Acknowledgment of Notice of Privacy Practices

I acknowledge that I am aware the Provider's Notice of Privacy Practices is available in the lobby at Coralville Family Counseling for me to review. The Notice of Privacy Practices describes how identifiable health information may be used and disclosed and states my rights with respect to my medical information.

I understand that Coralville Family Counseling has the right to revise these polices and to amend the Notice of Privacy Practices. I understand that in the event that the notice is revised, the revised notice will be available at Coralville Family Counseling. At any time, upon request, I may obtain a copy of the Privacy Practices.

If for a child, your signature indicates that you have legal guardianship to sign for this minor.

Print Client's Name:	Date of Birth:
Signature of Client/Guardian/Legal Representative:	Today's Date:

Client Name ____

Staff Member/Witness:	Today’s Date:

2431 Coral Court Ste. 4
Coralville, IA 52241
319-338-1052 (phone)
319-382-3109 (fax)

Katie Barreras, LISW
Farrah Bonde, LISW

Separated, Divorced or Never Married Parents

Beginning the therapeutic process for your child is a significant change for you and your family. We want to ensure that the helping relationship proceeds with ease for you and your family. In our experience, there are frequently unique circumstances that arise when parents do not live together. We offer this information to clarify our policies and procedures regarding alternative family arrangements.

Permission for Treatment:
Parents with joint legal custody have equal rights concerning therapeutic treatment, unless otherwise noted in a legal decree. It is critical that both parents agree that mental health treatment is necessary for their child and agree on a provider.

Confidentiality:
Your child is considered the "patient" in the helping relationship and has confidentiality with his or her therapist. Therefore, matters discussed during individual sessions will, for the most part, remain confidential between the therapist and child. We appreciate that it is very important to include parents in the treatment process and they are typically consulted during appointments to discuss treatment progress, interventions, and concerns regarding the child.

Regardless of whether or not parents reside together, it is important for all of us to work together in assisting your child. When concerns arise about a particular household they are typically not shared with the other parent. However, if one parent indicates that he or she is not satisfied with the therapist or services provided to the child, the other parent will be informed.

It is very common for children to have multiple family members involved in their lives. In the circumstance that step-parents, partners, grandparents or other supportive individuals bring your child in for treatment, you will be asked to sign a release of information permitting the therapist to speak with such individuals regarding your child.

Custody and Visitation:
The therapist cannot make any recommendations regarding custody or visitation. If concerns arise in these areas, the therapist may refer you to a mediator or another therapist who can perform a custody evaluation. The therapist will not provide records to attorneys or testify in court for custody/visitation disputes.

Medical Records:
Confidentiality is the cornerstone of every child's treatment relationship and a key part of confidentiality is guaranteeing the privacy of the child's records. It is assumed that each parent appreciates their child's need for a confidential relationship and will therefore not ask for copies of treatment notes. The therapist will be pleased to speak with parents about treatment and concerns or to provide a written summary of treatment upon request.

Payment:
The parent bringing the child in for therapeutic services will be responsible for payments at the time of each visit.

Court Fees:
I understand that Coralville Family Counseling doesn't testify in court, and if the therapist does testify it may be harmful to my child. In the event that the therapist receives a subpoena to testify in a court matter, the party issuing the subpoena will be responsible for a minimal appearance fee of $300.00 plus the cost of mileage.

I am the parent with the authority to consent for treatment, and I have reviewed and agree to abide by the above guidelines.

Client's Name: ______________________________ Date of Birth: ____________

Parent Signature: ______________________________ Date: ____________

Parent Signature: ______________________________ Date: ____________

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Consent for Treatment

Before you start counseling there are some things that you should know. Legally this information is called "Informed Consent." Informed Consent will help you understand better what to expect and will explain some limitations about what we will be doing.

Confidentiality

Of course, all of our work together—our conversations, your records, and any information that you give us—is protected by something called privilege. Our office respects your privacy, and we intend to honor your privilege. However, there are some limits to your legal privilege, some expectations you should understand before we start. If we believe there is a risk that you might harm yourself or someone else, we may be required to contact the authorities or the other person to give them the opportunity to protect you or the other person. If you are abusing children or elderly people, we are required by law to notify the authorities, so they can protect others from harm. Also, if you become involved in any lawsuit in which your mental health is an issue—for example, a child custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering –then the court or the lawyers may insist upon, and may obtain your information from us. Similarly, you would lose the protection of your privilege if you file a complaint against our office with the state licensing board.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. If we find ourselves in a dispute with you over billing, our office may only provide the information necessary to clarify and to collect any outstanding balance. Coralville Family Counseling will use good faith efforts to protect the patient's right to confidentiality in providing health information to payors.

Risks

You or your child may be suffering from a condition(s), which requires Mental Health services, diagnosis, and or treatment; you voluntarily consent to and authorize services, including psycho education, EMDR therapy, play therapy, cognitive behavioral therapy, narrative therapy, guided imagery, and services that the therapist may deem necessary. You acknowledge that as the patient or as the participant/guardian of a child in services you are aware that there are risks to participating in mental health treatment. You acknowledge that no guarantees have been made to you or anyone else on your behalf, as to the results of such services and procedures. You acknowledge that you have received information regarding the service(s) descriptions and have had all of your questions regarding the service answered to your satisfaction.

You should know that counseling is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate problems and improve level of functioning, but sometimes, especially at first, and as you get to the root of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel awkward or uncomfortable. Sometimes counseling requires trying new ways of doing things. You will always be free to move at your own pace. We will challenge you and your old ways of thinking and doing things, but we cannot offer any promise about the results you will experience. Your outcome will depend upon many things.

You acknowledge that during treatment, you/your child may have new insights and or new disturbing information may come to the patient's attention in the form of images, thoughts, affect, or sensations. You understand that it is your responsibility to share these reactions with the therapist and your physician.

If we believe that your problems require knowledge that we do not have, we may refer you for a consultation or treatment with someone with specific training or experience. We will discuss any such referral with you before we act. At the very beginning we will create a treatment plan with you. That is, we will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and how long it will take. Every now and again, we will review that plan to see if it needs to be updated.

By signing we are stating that we understand and agree to the process and to the above mentioned information.

Print Client's Name:	Date of Birth:
Signature of Client / Guardian/ Representative:	Today's Date:
Staff Member/ Witness:	Date:

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Client's Responsibilities & Rights

Client's Responsibilities: Regarding your care during mental health treatment, you are responsible for:

- Providing accurate and comprehensive information about all matters pertaining to your health, including medications and past or present medical problems.
- Reporting changes in your condition or symptoms to your therapist and primary care physician.
- Following the instructions and advice of your health care team.
- Identifying and discussing any safety concerns that may affect your care.
- Informing your therapist or physician if you do not understand information about your care or treatment.
- Informing your mental health therapist if you are not satisfied with any aspect of your care.
- Participating in the planning of your care, including discharge planning.
- Keeping your scheduled appointments or cancelling appointments with 24-hours advanced notice; patient may be discharged after two missed appointments without 24-hour advanced notice.
- By providing your e-mail address to our staff you assume risks regarding confidentiality that may arise by using electronic correspondence. You must provide written notice to Coralville Family Counseling if you do NOT want e-mail correspondence at your work or home e-mail accounts (when the e-mail address is given to staff or staff receives e-mails from you).
- Providing supervision or childcare arrangements to appropriately supervise any child that needs to wait in the lobby while the parent/legal guardian/legal representative is participating in services in another room.
- Paying all charges, copayments, deductibles and co-insurance not covered by insurance or third party payor or as a result of lack of insurance coverage.
- Paying for all non-covered services as a result of failure to obtain pre-authorization for treatment as required by your insurance.
- Paying for Therapist's attorney fees in the event you wish to resist a subpoena for your records.

Client's Rights:

- As a client, you have the right to receive information from your mental health therapist about that therapist's education, training, experience, and credentials. As a client, you have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.
- As a client, you have the right and responsibility to fully participate in all decisions related to your health care. Clients who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, legal representatives, or family members. You have the right to change your mental health therapist at any time. You have the right to a second opinion if you should choose to do so.
- As a client, you have the right to request and receive information about the methods you may use to submit complaints or grievances regarding provision of care by your mental health therapist. Clients using services, and their guardians, have the right to appeal the application of policies and procedures, or any staff action that affects the individuals utilizing the services. If you wish to appeal or file a grievance, you may file a written grievance or appeal to your direct mental health therapist. The Coralville Family Counseling staff has 30 days to provide a response to the appeal or grievance. Clients who express a concern or complaint, or file a grievance, will not have their future access to care compromised in any way. To share a concern or complaint, please contact any staff member or your direct mental health therapist who can speak with you about your concern.
- Recommendations regarding mental health treatment shall be made only by a licensed mental health therapist in conjunction with you and your family as appropriate. As a client, you have the right to make final decisions regarding your treatment. If a client misses a session and/or doesn't return for 30 days, we will assume your therapy has been terminated.
- Our telephone is answered twenty-four hours a day by a mechanical answering system. Through the day, we check messages regularly, and whenever possible we try to return phone calls the same day. If we have not returned your call within twenty-four hours, please try again as your message may have been lost. If you have an emergency and are unable to reach us, call 911, or go to an emergency room.
- Quality mental health services should be provided to you without regard to race, color, religion, national origin, gender, age, sexual orientation, or disability. You have the right to considerate, respectful care from all staff members of Coralville Family Counseling at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality treatment relationship.

Advanced Directives

- During the client's initial intake appointment, all clients/guardians/legal representatives of clients have been given the opportunity to discuss their desire for information regarding an Advanced Directive. All client's that wish to be given more information about advanced directives will be given information on how to develop or obtain an Advanced Directive.
- It is necessary for you to sign that you have read and received this notice of Responsibilities and Rights and return this form to us.

By signing this, I acknowledge receipt and understanding of the above stated information regarding my responsibilities and rights. If I need clarification on any item, I will contact Coralville Family Counseling at (319) 338-1052 for clarification, before signing.

Print Client's Name:	Date of Birth:
Signature of Client / Guardian/ Representative:	Today's Date:
Staff Member/ Witness:	Date:

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Farrah Bonde, LISW

CONSENT FOR TELEHEALTH & DIGITAL COMMUNICATION

I understand that my therapist has agreed to engage in telehealth sessions with me.

I acknowledge that the video conferencing technology that will be used to conduct therapy will not be the same as direct client/provider visits as I will not be in the same room as my therapist.

I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand there are potential risks to this technology, including but not limited to interruptions, unauthorized access, limits to confidentiality, and technical difficulties. I understand that my provider or I can discontinue the telehealth session if it is felt that the video connections are not adequate for the situation.

I understand telehealth is NOT an Emergency Service. In the event of an emergency, I will use a phone to call 911.

I agree to be in a quiet, private space that is free from distractions during the session.

I know I should use a secure internet connection rather than public or free Wi-Fi.

It is important to be on time. If I need to cancel, I will give at least 24 hours' notice to cancel or reschedule my appointment.

I understand that I should confirm with my insurance company that the video sessions will be reimbursed, if they are not reimbursed, I am responsible for the full payment.

I acknowledge, my therapist or myself may deem telehealth services as not appropriate and these services may be terminated and face to face sessions may be recommended instead.

I will not share my telehealth appointment link with anyone unauthorized to attend the appointment or record the session without the permission from the provider.

By signing this form, I certify:

That I agree to the above-mentioned policies and procedures.

That I fully understand its contents including the risks and benefits of these services.

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client Name: ______________________________ **Date:** ____________________

Signature of Client/Client's Legal Representative: ______________________________

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_______________________________ _______________

Name of patient *Patient Date of Birth*

I, _______________________________, hereby give permission to Coralville Family Counseling to:
Name of patient/legal representative

__ **Disclose information to:** AND/OR __**Obtain information from:**

____

(Name of agency, attorney, school counselor, therapist, etc.)

____

Street *City* *State* *Zip Code*

____

Phone

I do______ /I do not ______ authorize the release of my/my child's protected mental health information.

I authorize release of my and/or the patient's: ___ **ENTIRE RECORD; OR**
___ **Only the following information:** (Patient must initial each item to be released/obtained)
___ Substance Abuse Information
___ Treatment Recommendations
___ Attendance Records Only
___ Psychological Testing or Evaluations
___ Other (specify): ______________________
___ Diagnosis / Assessment
___ Treatment Plan
___ Progress Report of Treatment
___ Educational Reports/Testing

I understand that the time frame within which this release of information is applicable is one year from the date signed unless otherwise specified here: ____________

In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

I understand that no services will be denied to me and/or the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me and/or the patient. The information disclosed may be used in connection with my and/or the patient's treatment. I understand that I can request to view the information that is disclosed.

I have been informed of the risks to privacy and limitations on confidentiality of the use from electronic means of information transfer, and I accept these.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon request.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. I fully understand all of the above information and my consent on this form is freely given.

____

Signature of patient/parent or legal guardian Date

____

Witness Date

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from mental health records; the confidentiality of which may be protected by federal and/ or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Katie Barreras, LISW
Farrah Bonde, LISW

Credit Card Policy and Authorization

Our office policy is that a credit card is on file in our office as a backup for any unpaid charges. No charges will be made to your card if you pay in full during your appointment. Any charges incurred and not paid at the time of the appointment will result in a charge to your credit card. Additionally, if you "no show" to an appointment or fail to cancel two appointments with at least a twenty-four-hour notice, your card will be charged a fee of $50 for each missed session. You have a right to see a summary of charges to your account and will be provided a copy of the receipt upon request.

Client Name: ___________________________________ Date of Birth: ________

Card Type: ____ Visa ____ Mastercard ____ Discover
Card Number: ____________________ Expiration: ______ Security Code: _____
Name as it appears on card: ____
Billing Address: ____
State: ______________ Zip Code: __________ Phone: ______________________

I (printed name) ____ authorize Coralville Family Counseling to charge payments for services to the credit card indicated on this form.

This charge card will be used for the unpaid balance of the client charges unless other payment arrangements are made.

____ ______________________
Signature of Cardholder/Responsible Party Date