Daisy Mountain Family Therapy PLLC
Client Information Sheet – Child or Adolescent

Child's Name: ______________________________________ Date of Birth: ________________

Address: ____

City: ____ State: ______ ZIP: _______________

Home Phone: ____________________________ Mobile Phone:__________________________

Parent/Guardian: ________________________________ Phone:_________________________

Preferred Method for Courtesy Appointment Reminders:

☐ Call to Home Phone ☐ Call to Mobile Phone ☐ Text Message to Mobile Phone ☐ Do Not Remind Me
☐ Email: ____

Note: You are responsible for appointments you schedule whether you receive a courtesy reminder or not.

Emergency Contact: ______________________________ Phone: ________________________

____
Therapist's Signature Date

Daisy Mountain Family Therapy PLLC
Child and Adolescent Intake Form

This information is considered confidential and will not be released without written permission of parents and/or guardian. Please complete the form and provide details where possible.

PART I: Identifying Information

Child's Name: _______________________________________ D.O.B.: _________________________
Gender: _________________ Telephone number: ____________________________________
Address: ____
Place of Birth/Hospital: ____
Mother's Name: _________________________Phone: H: ______________W: _________________
Father's Name: __________________________Phone: H: ______________W: _________________
Parents' marital status: Circle one: Married Divorced Separated Never Married Living Together Who is the major caretaker of the child?____
Private Insurance: _______________________Group #: _______________ Policy #:_____________
Medicaid #, if applicable: ____
Person Completing From:____________________ Relationship to Child: _________________________
Who referred you ? ______________________
May we send you information about our upcoming programs by mail or email? Circle: Yes No
If yes by email list email address: ____

PART II: Reason for Referral

What is the main concern and what are some of the behaviors you observe that make you suspect there is a problem ?____
____
____
Does the present problem occur at home? ________ school? ______ other?______________________
Are there other concerns?____
Social and Behavioral Questions:
Place a check to any behavior or problem that your child currently exhibits:
_____Has difficulty with speech (articulation or producing sounds)
_____Has difficulty with hearing
_____Has difficulty with language
_____Has difficulty with vision
_____Has poor bowel control
_____Has difficulty with coordination
_____Wets bed
_____Is much too active
_____Is distractible/short attention span
_____Is fearful
_____Has frequent tantrums
_____oppositional/defiant
_____Has frequent nightmares
_____Has trouble sleeping
_____Has poor appetite

_____Has memory problems
_____Has attachment problems
_____Is aggressive
_____Is slow to learn
_____Is impulsive
_____Does not get along with peers

Please use this space to describe any problems in more detail:____
____
____
____

__ Does he/she have a problem controlling his temper or with controlling anger? (describe)
____
____

__ Does he/she ever get sad or withdrawn? (describe)
____
____

__ How does this child react to stress and frustration? (describe)
____

__ Does the child seem more clumsy than other children?
____

Does the child have a hard time sitting still and paying attention to things? (describe)____
____

Does the child have any problems interacting with peers out side the home? (describe)
____
____

__ How does the child get along with other family members?
____

Does his/her behavior cause difficulty within the family?
____

When was the problem first observed and by whom?
____

What was done at that time?
____

Has the child been evaluated for the current problem before? Circle: Yes No

If yes, when and by whom?
____

Has the child seen a therapist or psychologist previously? Circle: Yes No

If yes, who___________ May I contact them for additional information? Circle: Yes No If yes, list contact information ____
Please sign here giving authorization to contact this person:______________________________
Was it in reference to this or another problem? Same: _____ Different: _____
If different, please explain: ____

PART III: Family Information Please list those persons who are important in your child's life.

Has your family ever had genetic studies done? Circle: Yes No
Where and Why/Results:____
Are there any other family members with similar problems to those discussed on this form?
____

Is the child adopted? Circle: Yes No
How long has the child lived in the current home?_____
When was the child initially placed outside the birth home? _______
How many placements has the child had? ______
What were you told about the child's history?
____

PART IV: Prenatal, Birth and Developmental History

During pregnancy, did the child's mother use any of the following: ____Tobacco ____Alcohol
____Medications ____Drugs
Weight at Birth: ______________________
Length at Birth: ______________________ Length of Labor: ______________________
Type of Delivery: Vaginal_____; C-Section_____
Any problems during the birth?: Y or N ____
Full Term: Y or N
If not, how many weeks' gestation? __________________
Did the child breathe on his/her own at birth? Y or N Was Oxygen required? Y or N
Explain: ____

This is a list of developmental milestones. Please give the approximate age when your child did reach the following. If the child cannot accomplish the item please indicate that by writing "no" in the space.
Finger fed ______
Undressed completely _______
Tie shoes _________
Toilet trained ________
Rolled over _________
Sat unassisted_______
Crawled _________
Walked_____
cooed_____
Understood "no"_____
Laughed aloud_____
Gestures (waving bye, pat-a-cake)_____
Followed one command (without you pointing)_____
Said First Words _____
Put Two Words Together_____
Points to 5 body parts (where are your eyes, etc.)_____

PART V: Medical History

Have there been any health problems? ________ If yes, please explain __________________________
____
____
Has he/she ever been hospitalized?
____
____

Has he/she ever had surgery? ____

____
When was the last eye exam? ______________Results: ______________________________________
When was the last hearing exam? _____________Results:_________________________________
Does he/she have allergies? Y or N (please list) ______________________________________

____
Are his/her immunizations up to date? Y or N
Medications: Please list any medications your child currently takes regularly?
Name ____ ________________________

________________________ ________________________
Frequency ________________________ ________________________ ________________________

________________________ ________________________
Dosage _____________________ _____________________ _____________________

_____________________ _____________________
Physician name: ______________________________ Telephone number: __________________
Physician name: ______________________________ Telephone number: __________________
May I contact the physician to coordinate care if necessary? Circle: Yes No
If yes, please sign giving authorization to contact them: ____

PART VI: Educational History

Name of school:_____________________Grade:_______ Special Ed Services: Circle: YES NO
Has the child had any educational testing? Circle: YES NO
What grades does the child typically earn?_____________________________
Does the child receive: speech therapy_____ occupational therapy_____ physical therapy _____
If so, what type, where and when? (date of last assessment) ______________________________________

____
Has the child been held back in a grade? Circle: Yes No
Number of schools the child has attended_____________________________
Place a check next to any educational problem that the child currently exhibits
_____Has difficulty with reading _____Has difficulty with arithmetic _____Has difficulty with spelling _____Does not get along with classmates_____Has behavior problems _____Does not like school _____Has difficulty with writing

PART VII: Employment History

Has the child ever been employed? Circle: Yes No

If yes, give details

____

____
Has the child ever had difficulty with the police? Circle: Yes No
If yes, explain____________________

____

____
Has the child ever appeared in juvenile court? Circle: Yes No
If yes, explain ____

____

____

Has the child ever been on probation? Circle: Yes No

If yes, give dates, reason, and name of probation officer

____
____
____
____
____

To your knowledge has the child ever used drugs or alcohol? Circle: Yes No
If yes, explain

____
____

Part IX: Other Information

What are the child's strengths?

____
____

What are the child's favorite activities?

____

What is the child’s temperament like?

____

Please discuss anything else it would be important to know about the child: ___________________

____
____

*Thank you for completing this form. Please bring this to your first appointment.

Daisy Mountain Family Therapy PLLC

CONSENT for TREATMENT & OFFICE POLICIES

(effective 6/01/2012)

I, ______________________________ *authorize therapeutic services for* ________________________.
(*Parent/Guardian - please circle)* *(Child's full name)*

- **Custody/Guardianship Issues**
  - Consent for services can only be authorized by a current legal guardian.
  - If parents are separated, services are provided only with written consent of **both** parents. For divorced parents, consent may be given by the parent authorized to make medical decisions. If medical decisions are ordered to be made jointly, consent of **both** parents is required.
  - Copies of legal paperwork (relevant pages) are requested to document the above information.

- **Confidentiality & Release of Information**
  - At the family's request, Cynthia Spencer will contact other providers/staff to coordinate care.
  - *No information will be released about your child's therapeutic services without your written permission, except in the following cases:*
    - Insurance companies request dates of service and diagnosis codes. To authorize additional sessions, they request some details about treatment and progress.
    - The law requires Cynthia Spencer to report suspicions or evidence of child abuse, or child's/parent's expressed intention to harm oneself or others.
    - Child records in some circumstances may be subpoenaed. Cynthia Spencer will make every effort to protect confidentiality in these situations.
    - Consultation**:** I consult regularly with other professionals regarding my clients; however, my client's identity remains completely anonymous, and confidentiality is fully maintained. ________________ ***(please initial)***
    - E - Mails, Cell Phones, Computers and Faxes: Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality. ________________ ***(please initial)***
    - Julie Caldwell LMFT located at 39905 N Gavilan Peak Parkway, Anthem , AZ 85086, shall be named custodian of records to facilitate continued services or provide clients access to their records in the event that therapist is unable to provide this service due to death, disability, close of office or change of office location.

- **Fees:** ***Payment is expected at the time of service, unless other arrangements have been made.***
  - Accepted forms of payment: Cash or Check.
  - Insurance Charges: If Cynthia Spencer is on your insurance plan, the copay amount applies. Deductibles are paid down in increments of Cynthia Spencer's contracted rates with each plan.
  - Private Pay Charges : A discounted rate will be offered to families who need to pay out of pocket. Intake $140, Family visit $130.00, Individual child visit $120.00. Individualized private pay arrangements can be made at or before the 1st visit. Standard rates are Intake $200.00, Family visit $145.00 and Individual child visit $140.00.
  - No-show / Late cancel: $65.00 for no-shows and cancellations with less than 24 hrs. notice.
  - Delinquency: After 3 billing statements/contact attempts, unpaid charges are turned over to collections. Policy holder would also be responsible for collection agency's 30% commission.

IIII. Insurance Matters

- *Check the Mental Health* benefits of your insurance plan.* While Cynthia Spencer provides assistance, ***it is the family's responsibility to verify eligibility, coverage, deductibles & co-pay.***

A. Authorization: Some plans require policy holder to obtain an authorization #**.** If authorization was required but not obtained by 1st visit, policy holder is responsible for session fee(s).

B. Coverage: If insurance coverage details are unclear at intake, full private will be charged. Any overpayment will be reimbursed to the family as soon as coverage is clarified.

C. Denials: Policy holder is responsible for any fees the insurance company declines to reimburse.

D. Primary Insurance: Cynthia Spencer will bill the primary insurance company only. If the policy holder wishes to bill a secondary insurance, a superbill is available upon request.

I have read this form, discussed my questions with Cynthia Spencer, and agree to its terms.

________________________________	______	________________________________	______
Parent/Guardian signature	*date*	*Parent/Guardian signature*	*date*

Daisy Mountain Family Therapy PLLC
Cynthia J. Spencer LPC

SERVICES & FEE SCHEDULE

Service	Fee
Intake	$ 200.00
(out of pocket discounted rate)	$ 150.00
Family Session	$ 145.00
(out of pocket discounted rate)	$ 130.00
Individual Session	$ 140.00
(out of pocket discounted rate)	$ 120.00
Telephone Consultations: *with parents, doctors, school staff, parenting coordinators, case workers & other professionals.*	$ 40.00 / quarter hour
Observation at school or daycare (1 hour visit)	$ 130.00 / hr
Attendance at school staffings / IEP meetings	$ 130.00 / hr
Travel time reimbursement (round trip)	$ 50.00
Court appearance (1 hour minimum)	$ 200/hr
Court report writing	$ 100/per report
Copy fee	$ 50.00/per request
"No Show" or late cancellation (less than 24 hrs notice) *(To cancel a Monday appt., please call prior Friday by 10am)*	$ 65.00
Returned Check Fee	$ 25.00 minimum

*all payments must be paid at time of service

Please sign to acknowledge receipt of this information.

______________________________ ____________________

Client Signature **Date**

Would you like a copy at this time?

Yes___ No___

PROTECTING YOUR PRIVACY

To increase your privacy, confidentiality and security:

The therapy relationship is a very personal one. By discussing very private and often sensitive issues with a trusted professional in a confidential setting, people are often able to free themselves from the difficulties that have inhibited their abilities for joy, happiness and success. The freedom to be open and honest about such difficulties is essential for therapeutic progress. For that reason, it is important that you are aware that every other person or entity that becomes involved in your treatment may put you at greater risk for having your privacy and confidentiality breached. These may include (but are not limited to) your insurance company, medical personnel, disability care managers, Workman's Compensation, or attorneys.

Risks may include:
• Your diagnosis impacting future insurance coverage should you change insurance carriers voluntarily or via job change;
• Increased potential for identity theft through the sharing of social security numbers or other personal information;
• Computer or other errors resulting in accidental release of information.

You are always welcome to use your insurance, sign Releases of Information, and/or ask for assistance in working with disability claims or Workman's Compensation paperwork. However, when you pay privately for therapy and/or leave other entities out of the therapeutic relationship, you eliminate or significantly reduce these risks. When only you and your therapist are involved in your treatment the situation is simplified: your therapist is legally and ethically bound to maintain confidentiality laws and you are in charge of with whom you choose to share information. (An exception would be legally mandated reporting of child/elder abuse, threats to harm self, or threats to harm others.)

The difference between the costs to you of using your insurance versus maintaining the most privacy possible through paying privately may not be significant. Talk with your provider for more information regarding reducing your risks.

NOTICE OF PRIVACY PRACTICES

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP, which you received along with this so refer to it for more information. However, we can't cover all possibly situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with *treatment*, to arrange *payment* for our services, and for some other business activities which are called, in the law, health care *operations.* After you have read this NPP we will ask you sign a *Consent Form* to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person

or organization which is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings. If a law enforcement official requires to do so.

3. If a law enforcement official requires to do so.

4. For Workers Compensation and similar benefit programs.There are some of the situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at certain place, which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. *You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important Information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell use the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing ad complaints will not change the healthcare we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Cynthia Spencer LPC
34406 N 27th dr suite 140
Phoenix, AZ 85085
480-235-3124

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you ________________________________ and Cynthia Spencer LPC. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here ________________________________.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and to send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Privacy Offices by calling 480-235-3124. **See Protecting Your Privacy handout for additional important information about your rights.**

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

1.____________________________________ ______________________
Signature of client or representative Date

____________________________________ ______________________
Printed name of client or representative Relationship to client

____
Description of representative's authority

2.________________________________
Witness