Joy Unlimited
COUNSELING CENTER

Child Intake Packet

Parent/Guardian, **complete the initial assessment**, **read** our policies, and **sign** the last page before the child's first appointment and bring it with you.

DIRECTIONS

Joy Unlimited Counseling Center (JUCC) is located at the Walnut Trail offices off Milham Road (6100 Newport Road, Suite 222, Portage, MI 49002). You will find our wait room on the second floor.

YOUR FIRST SESSION

The first session will be approximately 45 minutes - 1 hour. During this time, your child's counselor will assess your child's mental health concerns.

CONTACT INFORMATION

Phone: 269-488-5929
Fax: 833-599-7700
Email: charvey@joyunlimitedcc.com (Owner of JUCC)

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Initial Assessment

CLIENT INFORMATION

Last Name: _____ **First Name:** _____
DOB: _____ **SSN:** _____
Gender: ☐ Female ☐ Male ☐ Other
Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other
Sexuality: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other

CONTACT INFORMATION

Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone Number: _____
Email: _____
Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

COUNSELING PROCESS

Counseling goals:

_____

Anyone your child wants involved in counseling? _____

EDUCATIONAL HISTORY

Grade: _____ **School:** _____
# of schools attended: _____

Diagnosed with any of the following?:
☐ Learning disabled ☐ ADHD ☐ Sensory Integration
☐ Autism Spectrum ☐ Oppositional Defiant ☐ Emotionally Impaired
☐ Physical Impairment ☐ Pervasive Developmental Disorder

Academic performance: (including any suspension, expulsion, or threatening behaviors)

_____

Was the child ever held back? ☐ ☐ Explain: _____

In addition to school, does the child work?: (Where? How often?)

_____

LEGAL HISTORY

Has the child ever been involved with the legal system?: ☐/☐
If yes, please explain:

FAMILY HISTORY

Father's Name: **Age:** **Education:** **Job:**
Mother's Name: **Age:** **Education:** **Job:**
Marital Status of Biological Parents:
Step Father: **Age:** **Education:** **Job:**
Step Mother: **Age:** **Education:** **Job:**

Adoption or Foster Care?: **Age?:**

Sibling's Name	Age	Job	Marital Status

Child OR family experienced any addictions?: (Alcohol, drugs, food, gambling, sex/porn, relationship)

Child OR family experienced mental illness?: (Depression, anxiety, panic, obsessions, anger, suicide attempts, etc.)

Child OR family ever been hospitalized for any addictions or mental health crises?:

Child OR family members been victims of abuse of any kind?: (Physical, emotional, sexual, spiritual, witnessing violence)

PHYSICAL HISTORY

Pediatrician's Name:

Practice Name: **Phone Number:**

Date of Last Visit: **Reason:**

Did the client's birth parent have any complications during pregnancy or labor:

Current Medical Conditions:

Past Medical Conditions:

Surgeries OR Hospitalizations: (With dates)

Current Medications:

Allergies:

Sleep: (Total hours, any difficulties falling or staying asleep?)

Ever had a seizure? /

Ever had a head injury? /

Complain of frequent headaches? /

Current difficulties with wetting/soiling? /

Adequate hygiene habits? /

What age did the child: Walk? Talk? Potty Train?

Any changes in eating habits in the last 3 months?

___no change ___undereating ___overeating

___significant weight change___lbs.

___severe picky eating

Alcohol use? /

If yes, how much/often?:

Smokes Cigarettes or Vapes? /

If yes, how much/often?:

Cannabis Use? /

If yes, how much/often?:

Drinks Caffeine? /

If yes, how much/often?:

PSYCHOLOGICAL SYMPTOMS

In the last 2 weeks, has the child experienced ANY of the following?:

☐ Anxiety	☐ Anger	☐ Nightmares	☐ Compulsions
☐ Crying often	☐ Depression	☐ Irritability	☐ Violent thoughts
☐ Mood swings	☐ Loneliness	☐ Loss of hope	☐ Financial stress
☐ Obsessions	☐ Relation issues	☐ Low motivation	☐ Racing thoughts
☐ Sexual problems	☐ Panic attacks	☐ Weight loss/gain	☐ Trouble sleeping
☐ Irritable bowel	☐ Work issues	☐ Trouble concentrating	☐ Academic issues
☐ Headaches	☐ Low self-esteem	☐ Fatigue	☐ Back pain
☐ Picking	☐ Restlessness	☐ Isolation	☐ Suicidal ideation

Other:

Concern about suicidal statements or gestures with the child? ☐ ☐ Explain:

Concern about the child injuring others? ☐ / ☐ Explain:

Notable changes last 3 months: (Friends, moving, sports, etc.)

Significant losses: (Death, health issues, divorce, moves, etc.)

SOCIAL HISTORY

Forms friendships easily? ☐ / ☐

Closest friend:

Struggles with any of the following?:

☐ "late bloomer" ☐ bullying ☐ easy target

☐ extremely shy ☐ needs social reassurance

What does the child do well socially?:

Group or organization memberships:

Activities or hobbies:

List strengths:

SPIRITUAL HISTORY

Religion/Faith:_____ **Congregation:**_____
Involvement?:_____

COUNSELING PROCESS

Is child aware that they are coming to counseling? Y/N
Past counseling experience: (# of times, when, why, inpatient/outpatient, etc.)

TREATMENT PLANNING

What would you like to see occur from counseling services for the child?

How frequently would you like the child's counseling sessions to be scheduled?:
____Weekly ____Bi-weekly ____1x/month ___As-needed

Will the child need a letter to be excused from school to attend counseling?___/___

Is everyone in the child's family aware of the concerns?___/___
Is everyone in the family willing to participate in counseling?___/___

Anything else the child's counselor should know?

Client Services Agreement

This agreement contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights. HIPAA requires that I provide you with a Notice of Privacy Practices. **When you sign this packet it will also represent an agreement between us**. You may revoke this Agreement in writing at any time.

That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under our policy; or if you have not satisfied any financial obligations you have incurred.

COUNSELING SERVICES

Counseling varies depending on the personalities of the counselor and client, and the problems you are experiencing. **For counseling to be most successful, you will have to work on things we talk about both during our sessions and at home**. Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, counseling often leads to better relationships, solutions to specific problems, and reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs and the development of a treatment plan if you decide to continue with counseling. During this time, you should decide whether you feel comfortable working together. If you have any questions about our procedures, we should discuss them whenever they arise. If your questions persist, I will be happy to make a referral to another professional.

SESSIONS

Counseling will usually consist of one, 45-60-minute session per week at a time we agree on, although this schedule may vary. Once a session time is scheduled, you will be expected to pay for it unless you provide **24 hours notice** of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for canceled sessions. If possible, I will try to find another time to reschedule the appointment.

FEES

My hourly fee is $205 for the initial appointment and $180 for each subsequent session of 53 minutes. This fee, prorated for periods less than 45 minutes also applies to other professional services you may need, such as report writing, phone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, and preparation of records or treatment summaries. (These are usually not covered by insurance.) If you become involved in legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparation and transportation costs, even if I am called to testify by another party. (Because of the difficulty of legal involvement, I charge $180 per hour for preparation and attendance at any legal proceedings.)

CONTACTING ME

Due to my schedule, I am often not immediately available by phone. Email is preferred. I will make every effort to return your call within the next business day. **If you are experiencing an emergency, please contact 911**. If I am unavailable for an extended time, I will notify you of the name of a colleague to contact, if necessary.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is their name, the nature of services provided, and the amount due. (If such legal action is necessary, its costs will be included in the claim.)

INSURANCE REIMBURSEMENT

For us to set realistic treatment goals, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, **YOU (not your insurance company) are responsible for the full payment of my fees**. It is very important that you find out exactly what mental health services your insurance policy covers. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis.

Sometimes I am required to provide additional clinical information. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored on a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit if you request it.

By signing this packet you agree I can provide the requested information to your carrier.

FEDERAL ANTI-KICKBACK LAWS

Due to policy provisions in your insurance contract with your insurance carrier and under the terms of the federal anti-kickback laws, **we are legally prohibited from writing off deductibles, patient responsibility co-insurance as directed by your insurance carrier, or co-payments**. Also, **if your policy is an out-of-network policy with our office and the provisions of your insurance mandates that allowable benefits are to be issued to you**, the client, rather than the provider of service, we will require payment at the time of service.

We regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance, we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us regarding any questions you may have, or any assistance you may require to fully understand these provisions.

Assign and Release

CHARGES

Initial Assessment	**$205**
30-Minute Session	**$100**
45-Minute Session	**$140**
1-Hour Session	**$180**
Group or Testing	**Charges Vary**
No payment for 120+ days	**$5 Per Month**

FINANCIAL ARRANGEMENTS

No Insurance: Client agrees to pay $_____ per session.
Opting Out of Insurance: Client agrees to pay $_____ per session.

CANCELATIONS AND NO-SHOWS

If you **cancel less than 24 hours in advance, you may be subject to pay up to 50%**. For 1st No Show: $50, 2nd no show: $75, and 3rd no show: $75 AND I reserve the right to discontinue. For Medicare/Medicaid, 1st no-show: warning, 2nd no-show: I reserve the right to discontinue.

Notice of Privacy Practices

NOTICE OF COUNSELOR'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR MENTAL 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**.

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.

- "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.
  - Payment is when I obtain reimbursement for your healthcare.
  - Health Care Operations are activities that relate to the performance and operation of my practice.
- "Use" applies only to activities within my practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.

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 authorization from you before releasing this information. I will also need to obtain authorization before releasing your psychotherapy notes. 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.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

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

- **Child Abuse** – If I have reasonable cause to suspect child abuse or neglect, I must report this suspicion to the appropriate authorities as required by law.

- **Adult and Domestic Abuse** – If I have reasonable cause to suspect you have been criminally abused, I must report this to the appropriate authorities as required by law.
- **Health Oversight Activities** – If I receive a subpoena or other lawful request from the Department of Health or the Michigan Board of Psychology, I must disclose the relevant PHI pursuant to that subpoena or lawful request.
- **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 privilege does not apply when you are being evaluated by a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- **Serious Threat or Health or Safety** – If you communicate to me a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, I may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If I believe that there is an imminent risk that you will inflict serious physical harm on yourself, I may disclose information to protect you.
- **Worker's Compensation** – I may disclose protected health information regarding you 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 provide benefits for work-related injuries or illness without regard to fault.

CLIENT'S RIGHTS AND COUNSELOR'S DUTIES

Client's Rights:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information. 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 receiving counseling. On your request, I will send 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 your 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 the 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 processing.
- **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.

Counselor'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.

COMPLAINTS

If you are concerned that I may have violated your privacy right, or you disagree with a decision I made about access to your records, you may contact: Carol Harvey, LMSW, Privacy Officer, (269-961-8589), 6100 Newport Rd, Suite 222, Portage, MI 49002. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed can provide you with the appropriate address upon request.

CHANGES TO PRIVACY POLICY

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 in-person, by mail, or email.

Signatures

I have received and read ALL of what is expected as a client of Joy Unlimited Counseling Center in this packet and give consent to Joy Unlimited Counseling Center to render professional counseling services for the child that is indicated on this form:

Parent/Guardian Signature:_____ **Date:**_____

Therapist Signature: _____ **Date:** _____