Pediatric and Adolescent Behavioral Counseling

ADULT CLIENT REGISTRATION FORM

Client Name: _____ Date: _____
(first) (last) (middle initial)

Address of Client:_____

Sex: _____ Birth Date: _____ Home Phone: _____

Highest Level of Education: _____ Email: _____

Family Physician: _____ Physician Phone: _____

Address: _____

Spouse Name: _____
(last) (first) (middle initial)

Emergency Contact: _____
(last) (first) (middle initial)

Referred by: _____

Name of Siblings: _____ Age: _____ Living in Home? ☐ Yes ☐ No
_____ Age: _____ Living in Home? ☐ Yes ☐ No
_____ Age: _____ Living in Home? ☐ Yes ☐ No
_____ Age: _____ Living in Home? ☐ Yes ☐ No

Any history of mental health services (counseling, psychiatric services, group therapy, etc.): ☐ Yes ☐ No

Have you ever been prescribed psychiatric medicine? ☐ Yes ☐ No

If Yes, please list and provide dates: _____

Have your ever been hospitalized for psychiatric treatment? ☐ Yes ☐ No

Please list dates of psychiatric hospitalizations: _____

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (self, father, mother, grandmother, uncle, etc.

Alcohol/Substance Abuse	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Domestic Violence	☐ Yes ☐ No
Sexual Abuse	☐ Yes ☐ No
Eating Disorders	☐ Yes ☐ No
Obesity	☐ Yes ☐ No
Obsessive Compulsive Disorder	☐ Yes ☐ No
Schizophrenia	☐ Yes ☐ No
Suicide Attempts	☐ Yes ☐ No

Suicide Success ☐ Yes ☐ No

ADD/ADHD ☐ Yes ☐ No

Currently employed? ☐ Yes ☐ No Do you drive? ☐ Yes ☐ No Involved in activities: ☐ Yes ☐ No

Who do you socialize with (family, friends, neighbors, etc.):_____

Do you have any concerns about behavior, attendance or performance in school or work? ☐ Yes ☐ No

If so, please describe: _____

_____

Any current or history of legal issues? ☐ Yes ☐ No

How would you rate your physical health: ☐ Unsatisfactory ☐ Satisfactory ☐ Good

How would you rate sleeping habits: ☐ Unsatisfactory ☐ Satisfactory ☐ Good

Please list any specific sleep concerns: _____

Please list any specific appetite or eating concerns: _____

Are you currently experiencing any of the feelings below? (**circle** any that apply)

Depression Rage Grief Anger Jealousy Worry Suicidal Ideation

Stress Fear Anxious Regret Frustration Panic Hate Hopelessness

Remorse Sadness Heartbroken Trapped Confused Embarrassment Left Out

Fatigue Disconnected Annoyed Pain Tense Overwhelmed

Other: _____

Approximately how long? _____

What triggers these feelings? _____

What helps you feel better? _____

Any current history of self-harm, suicidal thoughts, suicidal attempts or plan? ☐ Yes ☐ No

If so, please describe: _____

_____

How often do you experience crying spells: ☐ Daily ☐ Weekly ☐ Monthly ☐ None

Do you currently experience anxiety or panic attacks? ☐ Yes ☐ No How often: _____

Do you experience any chronic pain, headaches or stomachaches? ☐ Yes ☐ No How often: _____

Do you drink alcohol? ☐ Yes ☐ No Do you engage in recreational drug use? ☐ Yes ☐

Do you have any questions regarding your sexuality? ☐ Yes ☐ No

What significant life changes or stressful events have you experienced recently or in the past?

_____

_____

Do you have any history of trauma? If so, please describe:

_____

_____

What do you like the most about yourself? _____

What would you like to improve on? _____

What would you like your therapist to know about you that may be helpful?

_____

_____

_____

_____

What are your goals for therapy (learn coping skills, increase self esteem, etc.):

1. _____
2. _____
3. _____

PEDIATRIC AND ADOLESCENT BEHAVIORAL COUNSELING
Terms and Agreement

I, _____, acknowledge that I am voluntarily seeking mental health counseling treatment rendered by Dennielle M. McIver, MS LPC., and Professional Counselor.

I understand that fees are as follows for in office mental health counseling and **to be paid beginning or ending of each session**:

1. Initial consultation: $150.00
2. Individual counseling 45 minutes: $100.00
3. Individual counseling 60 minutes: $135.00
4. Family counseling 45 minutes: $135.00
5. Family counseling 60 minutes: $170.00

CONFIDENTIALTIY:
All information shared will be kept confidential with the following exceptions: if I believe you are a danger to yourself or someone else, if someone is abusing you, if you give me written permission to disclose information, if the information is court ordered, in case of medical emergency, if accusations of misconduct are brought up. PABC complies with all regulations of HIPPA and state regulations.

TERMS OF NO SHOW AGREEMENT:
I understand and agree to pay for those scheduled appointments in full which are not kept or cancelled within twenty-four (24) hours prior to the appointment time, except for extreme emergencies at the full rate of the appointment.

TERMINATION OF TREATMENT:
I understand that the successful termination of treatment is determined when the therapist and I agree that the goals of treatment are substantially achieved. However, I also understand that I am free to discontinue treatment at my own discretion at any time.

Client Name: _____ Date: _____

Signature: _____ Date: _____

Therapist: _____ Date: _____

PEDIATRIC AND ADOLESCENT BEHAVIORAL COUNSELING
INFORMED CONSENT FORM

Privacy of Information Shared in Counseling/Therapy: Your Rights and My Policies

What to Expect
The purpose of meeting with a Therapist is to get help with your problems that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to receive support. When we meet, we will discuss these concerns, however my main interest is your personal mental health. I will ask questions, listen to you, and together I will help you devise a plan to improve your situations. It is important that you feel comfortable talking with me about issues that are bothering you. I want you to know that your privacy, also your confidentiality, is an important and necessary part of good counseling. As a general rule, I will keep the information you share with me in our sessions confidential. There are, however, important exceptions to this rule that I must abide by the law to disclose information, whether or not I have your permission. Except for situations mentioned below, I will not break confidentiality of discussions disclosed in our private therapy session, unless by professional judgment decide it is necessary to keep you or others safe from harm.

Confidentiality cannot be maintained when:

- You disclose you plan to cause serious harm or death to yourself
- You disclose you plan to cause serious harm to someone else whom can be identified
- You are doing things that could cause serious harm to yourself or others, even if you do not intend to harm yourself or another person
- You tell me you are being abused (physically, sexually, or emotionally), neglected or that you have been abused in the past. In this situation, I am required by law to report abuse.
- You are involved in a court case and request is made for information about your counselor or therapy. You will be notified of what will be disclosed.

If you are a serious risk to yourself or others, I am mandated by the State of Michigan to help you obtain a higher level of care.

Please be advised that any communication sent via text or email is not secure or protected by HIPPA. It is strongly encouraged to communicate via phone or face to face.

Client Name: _____Date: _____

Client Signature: _____ Date: _____

Therapist: _____ Date: _____

Pediatric and Adolescent Behavioral Counseling HIPAA Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW TREATMENT INFORMATION ABOUT YOU:

A. MAY BE USED AND DISCLOSED AND

B. HOW YOU CAN GET ACCESS TO THIS INFORMATION SHOULD YOU SO DESIRE. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR "PROTECTED HEALTH INFORMATION" ("PHI").

A. By law we are required to insure that your PHI is kept private.

B. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health (including mental health) or condition, the provision of health care (including counseling) services to you, or the payment for such health care.

C. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI.

Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice;

PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice.

Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Should I make any significant changes to my policies, I will immediately change this Notice and post a new copy of it on our website, pabcounseling.com. You may also request a copy of this Notice at any time.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations that Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment.

2. For health care operations.

3. To obtain payment for treatment.

B. Certain Other Uses and Disclosures that Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.

2. If disclosure is compelled or permitted by the fact that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

3. If disclosure is mandated by the Michigan Child Abuse and Neglect Reporting law. For example, if we have a reasonable suspicion of child abuse or neglect.

4. If disclosure is mandated by the Michigan Elder/Dependent Adult Abuse Reporting law.

5. To avoid harm.

6. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.

7. For health oversight activities.

8. For specific government functions.

9. For public health activities.

10. Appointment reminders and health related benefits or services.

11. For Workers' Compensation purposes.

12. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

13. If disclosure is otherwise specifically required by law.

C. Other Uses and Disclosures of your PHI Require Your Prior Written Authorization.

In any other situation not described in Sections IIIA and IIIB above, we will request and must obtain your written authorization before using or disclosing any of your PHI.

Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures of your PHI by us.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

B. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. We may deny your request, in writing, if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than us. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. (We are not obligated to delete any information, only add corrections or additions.) Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.

C. The Right to Get a List of the Disclosures We Have Made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we give you will include disclosures made in the previous six years (if applicable) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no cost, unless you make more than one request in the same year, in which case we will charge you a reasonable sum based on a set fee for each additional request.

D. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. If we do not have your PHI, but we know who does, we will advise you how you can get it. You will receive a response from us within 30 days of our receiving your written request. Under certain circumstances, we may decide that we must deny your request, but if we do, we will give you, in writing, the reasons for the denial.

We will also explain your right to have our denial reviewed. If you ask for copies of your PHI, we will charge you not more than $2.00 per page. We may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

E. The Right to Choose How We Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as

well.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about our privacy practices, we will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint, please use contact information below:

Department of Licensing & Regulatory Affairs
Freedom of Information Coordinator
BPL / Legal Affairs Division
P.O. Box 30670 Lansing MI 48090-8170
Or fax written request to 517-241-2635

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on September 1, 2012.

Pediatric and Adolescent Behavioral Counseling HIPAA Acknowledgement Form

I am required to provide you with a copy of our Notice of Privacy Practices, which states how I may use and/or disclose your health information. Please sign this form to acknowledge **receipt** of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I can view HIPPAA Compliance Policies online at http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html.

Client Name: _____ Date: _____

Signature: _____ Date: _____

Therapist: _____ Date: _____

PEDIATRIC AND ADOLESCENT BEHAVIORAL COUNSELING
Coordination of Care with Physician Form

Clients Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Physician Information

Name: _____

Address: _____

Phone: _____ Fax: _____

A. ___ I DO authorize any information on my care, diagnosis, medications, labs and recommendations to be shared between the providers listed above to facilitate my treatment.
B. ___ I DO NOT authorize information to be share with my primary care physician or for ONLY limited information to be shared as specified below:

Please specify: _____

Parent Name: _____

Signature of Client: _____ Date: _____

Signature of Clinician: _____ Date: _____

Do not write under this line. To be filled out and sent to physician if authorized

Diagnosis/Presenting Problems(s)_____

Treatment Recommendations: _____

To be completed by Physician and return to Pediatric and Adolescent Behavioral Counseling

Current Medical Diagnosis: _____

Current Medications: _____

Treatment Recommendations or Referrals: _____

Any pertinent medical information to assist in coordinating care: _____

_____

_____

Please complete and send any documentation that would be helpful in assisting with mental health treatment to:

Pediatric and Adolescent Behavioral Counseling
36400 Woodward Ave. Suite 225, Bloomfield Hills MI 48304
Secured Fax: 972-323-7684

PEDIATRIC AND ADOLESCENT BEHAVIORAL COUNSELING
AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

Federal law states that I cannot share your health information without your permission except in certain situations. If you sign this form, you are giving Pediatric and Adolescent Behavioral Counseling permission to share and/or obtain information you indicate below. You may revoke this authorization at any time in writing except to the extent that action has already been taken to comply with it.

Clients Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I give permission to Pediatric and Adolescent Behavioral Counseling to

☐ **release** ☐**obtain** information from:

Name: _____

Address: _____

Phone: _____

☐ All ☐ Other (specify):_____

Signature of Client: _____

Name: _____ Date: _____