CHILD

LIFE in BALANCE
COUNSELING & WELLNESS CENTER
Enriching Mind, Body & Spirit

NEW CLIENT PACKET CHECKLIST

Welcome to Life in Balance Counseling & Wellness Center!

Full completion of this packet will enable us to provide you with the best possible service. This packet will take approximately 45 to 60 minutes to complete.

To enable us to provide you with the best care possible, please be sure to complete and initial each page.

Please have the following with you at your first appointment. These documents are required for insurance and medical records compliance:

- ☐ Insurance Card
- ☐ Driver's License or Photo ID
- ☐ Any additional medical records or notes you may have from previous practitioners
- ☐ Copay or other payment required by your insurance company

Please note the following:

- The child's legal guardian must sign all forms. If there is a custody agreement in place, a copy of the agreement must be provided to our offices prior to the first appointment. Written consent must be given by both custodians, if required in the custody agreement, for the child to receive services. If services are court ordered, a copy of the court order must be provided prior to the first appointment.
- Client registration (next page) must be filled out completely. The date of birth and social security number of the Insurance Policy Holder is required to submit insurance claims. If you do not have this information, we cannot bill your insurance. You would then be held responsible for charges that your insurance may otherwise cover.
- Please complete this packet as completely and detailed as you can. This will help your practitioner understand more about your visit.
- The Authorization to Release Protected Health Information (PHI), is page 23. Please fill in your name and date of birth, the name of the practitioner that you will be working with at **Life in Balance** on the line next to Clinician's Name, and the name and demographic information of the person or entity that you wish to share your information with. Please wait to sign and date this sheet until you check-in with the receptionist at the front office so they can witness your signature.
- **Please check and review that <u>each page</u> has been <u>signed (where indicated) and initialed</u>.**

Thank you for your cooperation and patience in filling out these forms to help us better understand your needs and bill your insurance correctly.

WE APPRECIATE THE OPPORTUNITY TO SERVE YOU

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CLIENT REGISTRATION

Today's Date: _____

CLIENT INFORMATION:

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Sex: ☐Male ☐Female

Gender Identity: ☐Transgender Male ☐Transgender Female ☐Transgender (as non-binary)

☐Non-Binary ☐Two-Spirit ☐Questioning/Not Sure ☐Other: _____

Marital Status: ☐Married ☐Single ☐Partnered ☐Separated ☐Divorced ☐Widowed

☐Annulled ☐Interlocutory ☐Polygamous ☐Polyamorous ☐Other: _____

Child's Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mailing Address (if different than above): _____

City: _____ **State:** _____ **Zip Code:** _____

Do we have authorization to send mail to the address listed above: ☐Yes ☐No

Child's Parent/Guardian: _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:** _____

School Name: _____ **Grade Level:** _____

Family Physician: _____ **Phone:** _____

Referred By: ☐Returning Patient ☐Social Media ☐Healthcare Provider ☐Health Insurance ☐Word of Mouth

Emergency Contact: _____ **Phone Number:** _____

Is there a custody agreement in place? ☐ Yes ☐ No

If yes, please explain: _____

_____

Initial Here: _____

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INSURANCE INFORMATION

All items in this section must be completed to bill your insurance.

POLICY HOLDER'S INFORMATION:

Full Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Phone Number:** _____

Relationship to Client: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Employer: _____ **Phone:** _____

Employer's Address: _____

City: _____ **State:** _____ **Zip Code:** _____

PRIMARY INSURANCE: _____ **ID Number:** _____

Group Number: _____ **Mental Health Phone Number:** _____

SECONDARY INSURANCE: _____ **ID Number:** _____

Group Number: _____ **Mental Health Phone Number:** _____

WELCOME!

Thank you for choosing Life in Balance Counseling & Wellness Center. The initial appointment will take approximately 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of what to expect, our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you may need. All the Clinicians in our practice has earned a Graduate Degree (Masters or Doctorate) from an accredited University. All Life in Balance Clinicians is Licensed to practice in the State of Virginia or are Resident Clinicians who have completed a Graduate Degree and are pursuing licensure under direct supervision of a Licensed Clinician. The clinical supervisor's name and credentials may be obtained upon request. Our Clinician's only practice within their scope of training and experience. During our training and previous employment, we have had experience in treating a wide variety of individuals, including children, adolescents, adults, individuals, couples, families, and groups. Your counselor will have his or her own primary specialty areas of expertise. Treatment practices, philosophy, plan limitations and risks, will be discussed with you today.

Initial Here: _____

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OUR PRACTICE CONSISTS OF THE FOLLOWING CLINICIANS

Andrew Burns, LPC
Dr. Alan Forrest, LPC, LMFT
Angela Cardenas, LPC
Angela McGoldrick, LPC
Cynthia Blevins, LPC
Deanna Bailey, LCSW
Donna Wagner, LPC
Erin Sullivan, LCSW
Jennifer Merritt, LPC
Lisa Kirkner, LPC
Elizabeth Kates, LPC
Melissa Blau, LCSW
Sarah Trenis, LPC

RESIDENTS IN COUNSELING

Erin Justis, MSW	Under the Supervision of Angela McGoldrick, LPC	(540) 381-6215 Ext. 303
Anda Ben Senior, MS	Under the Supervision of Cynthia Blevins, LPC	(540) 381-6215 Ext. 307
Chloe Muttart, MS	Under the Supervision of Angela Cardenas, LPC	(540) 381-6215 Ext. 308

Office Hours

Monday—Thursday:	9:00 a.m. — 5:00 p.m.
Friday:	9:00 a.m. — 4:00 p.m.
Saturday—Sunday:	CLOSED

You may reach our office by phone at (540) 381-6215 to schedule an appointment. If we are unavailable, you may leave a message on our confidential voicemail box, and someone will return your call as soon as possible during normal business hours. Most practitioners have confidential voicemail boxes.

DO NOT LEAVE A MESSAGE IF YOU HAVE A PSYCHIATRIC EMERGENCY. PLEASE CALL:

- **ACCESS: (540) 961-8400**
- **DIAL 911**
- **Proceed to the nearest Emergency Room**

Initial Here: _____

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COMMUNICATION

It is our standard practice to communicate with you about health matters, such as appointment reminders, using the home address and daytime phone number you provided when you scheduled your appointment. You have the right to request that our office communicate with you in a different way.

Please DO NOT provide phone numbers if you do not wish for us to leave messages. If a phone number is provided as a form of contact, the front office will leave a message at that number.

You may contact me and leave a message at: (Select all that apply)

☐ Home: _____ ☐ Work: _____ ☐ Cell Phone: _____

☐ Please contact me ONLY AT: _____

☐ Please DO NOT leave a message

Would you like to receive appointment reminders? ☐ Text Message ☐ Phone Call ☐ No

---

FINANCIAL | INSURANCE

As a courtesy, we will bill your insurance company. **All payments, co-payments and/or co-insurance payments are due at the time of your appointment.** If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If the balance is not paid after 45 days, 1.5% interest/month (18% APR) will be applied. If the account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for collection fees charged to our office to collect the debt owed.

We accept the following forms of payment:

- Personal Checks
- Cash
- Discover
- Visa
- MasterCard

A returned check fee of $38.00 will be charged. If we receive a returned check from an individual, we may refuse future payment by check.

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FEES FOR SERVICES

Initial Assessment & Diagnosis	(45-55 Minutes)	$ 175.00
Individual Therapy Session	(55 Minutes)	$ 165.00
Individual Therapy Session	(45 Minutes)	$ 140.00
Individual Therapy Session	(30 Minutes)	$ 110.00
Family Therapy	(45-55 Minutes)	$ 165.00
Phone Consultation	(15 Minutes)	$ 55.00
Phone Consultation	(30 Minutes)	$ 110.00
Phone Consultation	(45 Minutes)	$ 140.00
Group Therapy Session	(50 Minutes)	$ 65.00
Deposition or Appearance in Court	---	$500.00 + $100.00/hr.
Records and Document Review	($30.00 Minimum Required)	$ 95.00/hr.
Written Correspondence	(Documentation Type Varies)	$50.00/pg.
Record Printing Fee	Charges as per Virginia Code §8.01-413 Section B2	$0.50 per page up to 50 pages; $0.25 per page thereafter
Search and Handling Fee	---	$ 20.00
No Show Appointment	---	$ 65.00
Late Cancellation Fee	---	$ 65.00
Returned Check Fee	---	$ 38.00

NO SHOW | LATE CANCELLATION POLICY

Please contact the office within 24 Hours if you are unable to make your appointment. If you do not show for a scheduled appointment, or cancel with less than 24 Hours' notice, a **NO SHOW and/or LATE CANCELLATION FEE of $65.00** will be charged for the cost of the missed appointment, if permitted by your insurance company. This cost is **not covered by insurance** and is your responsibility. This fee must be paid in full before your next appointment. If a second appointment is missed without cancelling with a 24-Hour Notice, your counselor will speak with you about future appointments. If a third appointment is missed, your counselor may not be willing to reschedule with you depending on your situation.

Signature of Parent/Guardian: _____

Initial Here: _____

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AUTHORIZATION

I authorize treatment deemed necessary by Life in Balance Counseling & Wellness Center Practitioners. I authorize Life in Balance Counseling & Wellness Center to release my health plan and all information which is deemed necessary regarding my care and treatment to ensure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to Life in Balance Counseling & Wellness Center for any and all charges incurred in connection with services provided to me. I consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Life in Balance Counseling & Wellness Center for all charges not paid by either my insurance companies and/or employer, subject to the rules of any Federal or State health insurance program, such as Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due at the time of the appointment or within thirty (30) days of receipt of a statement.

Signature of Client (or person acting for client): _____

Initial Here: _____

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AUTHORIZATION

To ensure that the best care possible is provided to my child, I, _____ (parent/guardian)

of (child's name): _____ agree to comply with the following guidelines:

(Please initial each line to indicate that you have read, understand and accept each statement)

_____ I understand that all phone consultations MUST be scheduled by calling the front office. These consultations are not insurance billable and must be pre-paid at the time of scheduling. They can be scheduled in 15-, 30- and 55-minute appointments.

_____ I understand that unscheduled phone calls are not possible due to the Practitioner's schedule and that emergencies will be directed to emergency services and followed up on by the practitioner as soon as possible.

_____ I understand that all written correspondence requires pre-payment and is not insurance billable.

_____ I understand that written correspondence must be requested 7 business days prior to the date it is needed by contacting the front office.

_____ I understand that if I would like for my child's practitioner to attend school meetings, court dates, or any other out of office appointment I MUST contact the front office no less than 10 days prior to the date of that appointment to allow time to clear your practitioner's schedule.

_____ I understand that all out of office appointments require pre-payment and are not insurance billable.

By signing, I agree to comply with the above guidelines in order for my child to receive the best care possible. I acknowledge that my failure to comply so will lead to the discontinuation of services at **Life in Balance.**

X _____

PARENT/GUARDIAN SIGNATURE

Date: _____

X _____

WITNESS SIGNATURE
LIFE IN BALANCE

Date: _____

Initial Here: _____

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UNDERSTANDING PSYCHOTHERAPY AND INFORMED CONSENT

It is important for you to understand what counseling is about and what you may expect during therapy. Please read this material carefully and ask the therapist to explain anything that is unclear to you.

What is Counseling and Psychotherapy?

"Counseling" and "Psychotherapy," or simply "therapy," are words used for the same process which is: using proven methods, to assist people in changing how they think, feel and behave. Legitimate therapy is practiced by professionals licensed (or license eligible under supervision) by the State in the areas of Clinical Social Work, Professional Counseling, Psychology, or Psychiatry.

The Risks of Counseling:

Research has shown that competent therapy provided by trained and licensed professionals is helpful to most people. At the same time, therapy is not guaranteed to result in a successful outcome every time for everyone. It is important that you understand this before you invest time and money in counseling. The greatest risk of counseling is that it may not, by itself, resolve your problem or concern. Unexpected emotional strain, stress and life changes may happen during therapy. Other people in your life may not respond how you might like them to with the changes you make during therapy.

How does therapy work?

Therapy at Life in Balance Counseling & Wellness Center will involve several steps. Therapy sessions are usually 45 to 50 minutes in length and are typically held one time per week to start.

First, your counselor will listen to the concerns that you brought to counseling. He or she will get to know you and how you view your life and yourself. You will probably understand your situation better as you and your counselor talk. After you and your counselor explore your concerns, you will choose specific goals and objectives for therapy. Next, you and your counselor will work together to develop a plan for meeting those goals.

You and your counselor will define and work toward accomplishing your goals using research-proven methods. These methods include, for example, accessing your inner strengths and resources, changing thoughts that affect how you feel and what you do, or homework assignments in which try new behaviors to see how they fit. You and your counselor may decide to involve other family members in your session. Please know that any work in the sessions will occur only with your permission. It is very important to your counselor to see that your limits are respected. Your specific needs and concerns will determine what is done.

Your counselor will frequently take time to examine your progress toward your goals to make sure you both are on the right track. You and your counselor will decide together when your therapeutic goals are met and when to move toward completing therapy. Your therapy may be terminated if you fail to maintain regular attendance or if your therapist feels you are not making progress. You will be notified in advance of any possible termination of services.

Initial Here: _____

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CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for situations covered in the Notice of Privacy Practices. Please note that confidentiality cannot be guaranteed if you use electronic communication(s) with practitioners or office staff. This includes e-mail, instant messages, social media and text messages. In addition, we will protect your privacy in public. We will not communicate with you in public unless you initiate contact, nor will we disclose that you are a client.

If any Emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to:

- **Contact ACCESS: (540) 961-8400**
- **Contact CONNECT: 1-800-284-8898**
- **Dial 911**
- **Proceed to the nearest Emergency Room**

Life in Balance Counseling & Wellness Center Clinicians are not on-call outside of their office hours. Our Clinicians will follow up those emergency services with standard counseling and support to the client or the client's family.

You Have the Right:	**You Have the Responsibility**
• To be treated in a humane and dignified way. • To be informed of your treatment options, risks, and benefits. • To take an active role in treatment planning. • To have questions answered fully. • To have confidentiality and privacy within legal/ethical guidelines. • To facilitated review of your clinical information.	• To be honest in providing information. • To keep your appointments, to be on time, and to give a 24-Hour Notice if you should need to cancel your appointment. • To be free of alcohol and drugs during your therapy session. • To respect the therapist and facility. • To respect the privacy and rights of others. • To know your insurance requirements, deductibles, and co-pays. • To pay your co-pay, deductible, or full charge at the beginning of each appointment.

In the unlikely event that your clinician is unable to provide ongoing services, another clinician within the group practice can provide those services. Our office will maintain your records for a period of 7 years. Please contact the Executive Director, Angela McGoldrick, LPC, for any questions pertaining to this.

Signature of Parent/Guardian: _____

Initial Here: _____

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COORDINATION OF TREATMENT

It is important that all Health Care Providers work together. As such, we would like your permission to communicate with your Primary Care Physician and/or Psychiatrist. Your consent is valid for one year. If you prefer to decline your consent, no information will be shared. However, we do need your Physicians name and demographic information for insurance billing.

Please check one:

☐ You may inform my physician(s) ☐ I decline to inform my physician

Physician's Name: _____ **Clinic:** _____

Phone Number: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I/We have reviewed and received a copy of the Notice of Privacy Practices if so requested. The Notice of Privacy Practices is available on our website at www.lifeinbalancecenter.com or through request at the Front Office.

Signing the acknowledgement does not mean you have agreed to any uses or disclosures of your protected health information outside the purposes outlined in the Notice of Privacy Practices.

Signature of Parent/Guardian: _____

Initial Here: _____

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CHILD SUPERVISION

Children's Name	Children's Age

Life in Balance Counseling & Wellness Center strives to maintain a peaceful therapeutic environment to enhance well-being and healing. This includes keeping noise and activity levels to a minimum to avoid disrupting services. Many of our services such as meditation, message, yoga, and hypnosis are best provided in a quiet environment.

We would prefer that children always be supervised by a responsible parent or other adult at all times while at Life in Balance Counseling & Wellness Center. However, we do understand that sometimes it may be necessary to leave children in the waiting area and/or play area. Please keep the following in mind:

- Life in Balance Counseling & Wellness Center will neither provide supervision nor assume liability for your children's safety while they are unsupervised.
- Children under the age of 5 should **never** be unsupervised.
- You must let the front desk staff know you are leaving your children in the waiting and/or play area. Staff will need to know the children's name and ages, as well as which practitioner you are seeing.
- Please inform your children that they must play or sit quietly.
- Rough play or disruption to other Life in Balance Counseling & Wellness Center services, guests, or practitioners will not be tolerated.

Signature of Parent/Guardian: _____

Initial Here: _____

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CHIEF COMPLAINT: PRESENTING PROBLEM AND PAST TREATMENT

Mother's Full Name: _____ **` Father's Full Name:** _____

Please briefly describe why you are seeking counseling for your child: _____

_____

HISTORY OF CURRENT PROBLEM:

How long has your child had this problem: _____

Did something happen before this problem started? ☐ Yes ☐ No

If your child has been diagnosed with a mental health disorder, please list it here: _____

_____

HISTORY OF OUTPATIENT TREATMENT:

Has your child received mental health treatment before? ☐ Yes ☐ No

If yes, please list when and where your child received treatment: _____

_____

If yes, please list the treating Therapist, Physician and/or Psychiatrist: _____

What was the reason for seeking treatment? _____

What was most helpful about your child's mental health treatment? _____

_____

What was least helpful about your child's mental health treatment? _____

_____

Has your child had psychological testing before? ☐ Yes ☐ No

If yes, please list when and where your child received testing: _____

Is your child receiving other mental health services, such as: ☐ Psychiatrist ☐ Substance Abuse Treatment

☐ Mental Health Supports ☐ Case Management ☐ Crisis Services ☐Other ☐ N/A

If yes, please list the Provider's Name, Agency, and Phone Number: _____

Is your child receiving services with the Department of Rehabilitative Services or other Agencies? ☐Yes ☐No

If yes, please list when and where: _____

Initial Here: _____

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HISTORY OF INPATIENT TREATMENT

Has your child ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please list when and where: _____

If yes, please briefly describe the reason: _____

SUICIDAL | SELF-HARM HISTORY:

Has your child ever had suicidal thoughts? ☐ Yes ☐ No **Has your child ever attempted suicide?** ☐ Yes ☐ No

If yes, please list when and what was going on that led to these feelings and/or thoughts: _____

_____

Does your child have a plan for suicide? ☐ Yes ☐ No

Does your child have an intention for suicide? ☐ Yes ☐ No

What has helped your child during this time? _____

Does your child have a history of self-harming behaviors? ☐ Yes ☐ No

If yes, what does your child do to self-harm? _____

How does these behaviors help? _____

How does these behaviors hinder your child? _____

HISTORY OF VIOLENT BEHAVIOR:

Does your child have a history of violent behavior? ☐ Yes ☐ No

If yes, please describe the behavior and what causes this behavior: _____

_____

Signature of Parent/Guardian: _____

Initial Here: _____

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CHILD SYMPTOMS SCREENER

Present	Past	
☐	☐	Change in appetite (more or less)
☐	☐	Feeling sad
☐	☐	Crying spells
☐	☐	Too little sleep (falling or staying asleep)
☐	☐	Sleep more than usual
☐	☐	Fatigue
☐	☐	Loss of interest and/or pleasure
☐	☐	Avoiding friends or family
☐	☐	Expect failure
☐	☐	Decreased concentration
☐	☐	Thoughts of death
☐	☐	Cutting or burning oneself
☐	☐	Suicide plan or attempt
☐	☐	Depression
☐	☐	Often sick
☐	☐	Loneliness
☐	☐	Slow moving
☐	☐	Hopelessness
☐	☐	Confusion
☐	☐	Worthlessness
☐	☐	Friendly
☐	☐	Lack of confidence/Low self-esteem
☐	☐	Guilt
☐	☐	Reckless or dangerous behavior
☐	☐	Racing thoughts
☐	☐	Pressured speech
☐	☐	Inflated self-esteem
☐	☐	Obsessive thoughts
☐	☐	Compulsive or repetitive behavior
☐	☐	Marital/family problems
☐	☐	Sexual problems
☐	☐	Relationship problems
☐	☐	Long term memory problems
☐	☐	Short term memory problems
☐	☐	Wound up or tense more days than not
☐	☐	Panic attacks
☐	☐	Irritable
☐	☐	Anxiety
☐	☐	Easy going
☐	☐	Muscle tension
☐	☐	Irrational fear of something or someone
☐	☐	Talking/acting w/out thinking
☐	☐	Fidgety, restless, overactive
☐	☐	Difficulty paying attention

Present	Past	
☐	☐	Frequent daydreams
☐	☐	Bored easily
☐	☐	Learning difficulties
☐	☐	Often lose things
☐	☐	Excessive dieting/exercise
☐	☐	Obsessed with losing weight
☐	☐	Use of laxatives
☐	☐	Engage in self-induced vomiting
☐	☐	Eating things that are not food
☐	☐	Vandalism
☐	☐	Fire-setting
☐	☐	Lack of remorse for wrongdoing
☐	☐	Selfish
☐	☐	Bullies/gets in fights
☐	☐	Lying
☐	☐	Truancy
☐	☐	Theft
☐	☐	Argumentative/sudden anger
☐	☐	Defiant of authority
☐	☐	Temper tantrums
☐	☐	Stubborn
☐	☐	Avoid adults
☐	☐	Afraid to leave a loved one
☐	☐	Easily embarrassed
☐	☐	Upset by minor changes
☐	☐	Feeling detached from one's body
☐	☐	Feelings of unreality
☐	☐	See or hear things others don't
☐	☐	Believe things others tell you aren't true
☐	☐	Fear of strangers
☐	☐	Difficulty trusting
☐	☐	Believe others are out to get you
☐	☐	Intrusive thoughts
☐	☐	Avoid things related to traumatic event
☐	☐	Startle easily
☐	☐	Flashbacks
☐	☐	Nightmares

Other symptoms not mentioned above: _____

_____

_____

How do your symptoms affect your life? _____

_____

_____

Initial Here: _____

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HISTORY

Have you ever been told that your child may suffer from any of the following?

☐ ADD ☐ ADHD ☐ Anxiety ☐ Depression ☐Other, please explain: _____

_____

Do you feel that your child understands direction and situations as well as other children their age? ☐YES ☐No

If no, please explain: _____

How would you rate your child's intelligence: ☐ Below Average ☐ Average ☐ Above Average

Does your child primarily play with children: ☐ Their own age ☐ Older ☐ Younger

Describe any problems your child has interacting with other children: _____

_____

_____

Describe any problems your child has interacting with adults: _____

_____

_____

SUBSTANCE USE HISTORY

SUBSTANCE	HISTORY OF USE	DATE OF FIRST USE	DATE OF LAST USE
ALCOHOL	☐ Yes ☐ No		
MARIJUANA	☐ Yes ☐ No		
BARBITURATES	☐ Yes ☐ No		
KLONOPIN, ATIVAN, XANAX	☐ Yes ☐ No		
VALIUM	☐ Yes ☐ No		
COCAINE | CRACK	☐ Yes ☐ No		
HEROIN | OPIATES	☐ Yes ☐ No		
PCP, LSD, MESCALINE	☐ Yes ☐ No		
INHALANTS	☐ Yes ☐ No		
AMPHETAMINES, SPEED, UPPERS, CRYSTAL METH	☐ Yes ☐ No		
DESIGNER DRUGS, ECSTASY	☐ Yes ☐ No		
OVER THE COUNTER DRUGS	☐ Yes ☐ No		
CAFFEINE	☐ Yes ☐ No		
NICOTINE	☐ Yes ☐ No		
OTHER:	☐ Yes ☐ No		

Initial Here: _____

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SUBSTANCE USE HISTORY (Continued)

If your child is currently using any substances, please describe when and where they typically use: _____

_____

Please describe how your child's use affects family and friends, including how they perceive their use:

_____

How do you perceive your child's use? _____

Has your child ever received substance use treatment? ☐ Yes ☐ No

If yes, please list when and where your child received treatment: _____

_____

Has your child ever experienced any of the following due to substance use? ☐ Blackouts

☐ Hallucinations ☐ Seizures ☐ Tremors ☐Legal Charges ☐ DUI

☐ DWI ☐ N/A

MEDICAL HISTORY

Physician's Name	Specialty	Reason for treatment	Date(s) of treatment

Date of last Physical Exam: _____ Date of last Dental Exam: _____

Signature of Parent/Guardian: _____

Initial Here: _____

CHILD

Prescriptions

Name of Medication	Prescribed By:	Dosage Frequency	Helpful	Side Effects and/or Comments	Taken as Prescribed
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N

Please select if your child has ever had any of these conditions:

☐	Hypertension	☐	PMS/Painful Mensuration	☐	Environmental Sensitivity
☐	Heart Disease	☐	Easy Bruising	☐	Numbness
☐	Arteriosclerosis	☐	Skin Rash	☐	Stabbing Pain
☐	Arthritis	☐	Allergies: _______________	☐	Sensitive to touch/pressure
☐	Kidney Disease	☐	Asthma	☐	Abscess or open sore
☐	Varicose Veins	☐	Skin Sensitivity	☐	Thyroid ☐Hypo (High) ☐ Hyper (Low)
☐	Seizures	☐	Head Injury	☐	Headaches
☐	Back Pain	☐	Chronic Pain	☐	Fibromyalgia
☐	Chronic Fatigue	☐	Digestive Disorder	☐	Operations: ___________________________
		☐	Infectious Diseases	☐	Other: ________________________________

Signature of Parent/Guardian: ____

Initial Here: __________

CHILD

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MEDICAL

How do your child's medical conditions affect your life or theirs? _____

_____

Is your child on a special diet? ☐ Yes ☐ No ☐ Unsure

If yes, please explain:_____

What types of foods does your child usually eat? _____

What is your child's activity level? ☐ Chores Only ☐ 30 Minutes Moderate Exercise

☐ 1—2 times per week ☐ 3—4 times per week ☐ 5—7 times per week

What is your child's current weight? _____ **What is your child's highest weight?** _____

What is your child's lowest weight? _____

How many hours does your child sleep at night? _____

Does your child have trouble falling asleep? ☐ Yes ☐ No

Does your child have trouble staying asleep? ☐ Yes ☐ No

Has your child ever had a neurological exam or EEG? ☐ Yes ☐ No

Does your child have any trouble with: ☐ Hearing ☐ Sight ☐ Speech

Are your child's immunizations up to date? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Pregnancy: ☐ Planned ☐ Unplanned

Did the mother use drugs or alcohol while pregnant: ☐ Yes ☐ No

Did the mother have problems during pregnancy? ☐ Yes ☐ No

If yes, please explain:_____

Child's birth weight: _____ **Was the child premature?** ☐ Yes ☐ No

Was the child: ☐ Breastfed ☐ Bottle fed ☐ Both

At what age was the above feeding discontinued? _____

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DEVELOPMENTAL HISTORY (Continued)

Was the child: ☐ Colicky ☐ Active

Were there any problems with weight gain? ☐ Yes ☐ No

At what age did the child walk? _____ **Were there any difficulties?** ☐ Yes ☐ No

At what age was the child potty trained? _____

Were there any problems with wetting or soiling after potty training? ☐ Yes ☐ No

What form(s) of discipline do you use when correcting the child? _____

_____

FAMILY HISTORY

Is your child adopted? ☐ Yes ☐ No **Is your child a foster child?** ☐ Yes ☐ No

If you answered yes to a foster child, how long has the child been in your care? _____

Are the child's parents living together? ☐ Yes ☐ No

If no, when did they separate? _____

What is the living and/or custody arrangements? _____

_____

If there are visitation arrangements, please describe: _____

_____

Father's Name: _____ ☐ Living ☐ Deceased

If deceased, please list the age and cause of death: _____

Mother's Name: _____ ☐ Living ☐ Deceased

If deceased, please list the age and cause of death: _____

List all members of household, including the age and relationship to the child:

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

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FAMILY HISTORY

Have any of your blood relatives (parent, sibling, grandparent, aunt, uncle, etc.) ever had issues or been diagnosed with any of the following: ☐ Mental Illness ☐ Suicide ☐ Alcoholism

☐ Drug Problems ☐ Seizure Disorder ☐ Mental Retardation ☐ Bipolar Disorder

☐ Chronic Illness ☐ ADD ☐ ADHD

SCHOOL

Name of School: _____

Phone Number: _____

Address: _____

City _____ **State:** _____ **Zip Code:** _____

Current Grade: _____ **Teacher:** _____

Does your child have an Individualized Education Plan (IEP) or 504 Plan in place? ☐ Yes ☐ No

Has your child ever had to repeat a grade? ☐ Yes ☐ No

If you answered yes to the above question, please explain: _____

_____

Does your child's teacher report any concerns or problems at school? ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

Are there any additional comments or concerns you would like your child's therapist to be aware of?

_____

_____

_____

_____

_____

_____

Initial Here: _____

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SPIRITUAL

Would you say that your child or your family is spiritual or religious in anyway? ☐ Yes ☐ No

If yes, please explain religious or spiritual activities: _____

_____

Has your child had any loss or death in their life that is currently causing them distress? ☐ Yes ☐ No

If yes, please describe: _____

_____

How does your child cope with loss and/or death? _____

_____

CULTURAL

What language(s) are spoken in your household? ☐ English ☐ Spanish ☐ Chinese ☐ Tagalog

☐ Vietnamese ☐ Arabic ☐ French ☐ Korean ☐ Russian ☐ German ☐ Other: _____

How would you describe yourself ethnically or culturally? _____

_____

Does your child have any physical disabilities? ☐ Yes ☐ No

Does your child have any limitations: ☐ Speech ☐ Hearing ☐ Vision ☐ No

FINANCIAL HISTORY

What is your source of income? _____

Do you receive any assistance (Select all that may apply): ☐ Food ☐ Housing

☐ Other: _____

Do you struggle with your bills? ☐ Yes ☐ No

Do you have your own transportation? ☐ Yes ☐ No

Initial Here: _____

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HOUSING

Has your family been facing homeless? ☐ Yes ☐ No **Is your family currently homeless?** ☐ Yes ☐ No

Does any of the following apply to your family: ☐ Unsafe Housing: ☐ Unsafe Neighborhood

☐ Poor Relationship with Neighbors ☐ Poor Relationship with Landlord ☐ Does not apply

LEGAL HISTORY

Do your child have a legal history? ☐ Yes ☐ No

If yes, please describe: _____

_____

Has your child served detention time? ☐ Yes ☐ No

If yes, please describe for what crime: _____

_____

Does your child have current legal charges? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does your child have any involvement with Child or Adult Protective Services? ☐ Yes ☐ No

If yes, please describe: _____

_____

If there anything not listed that would be helpful to know? _____

_____

Thank you for the time and effort you have invested in completing this intake. This will help us to understand you more fully and to be better able to assist you on this journey together.

FOR OFFICE USE ONLY

REVIEWED ALL THE ABOVE CONTENT WITH CLIENT:

_____ _____

Therapist Signature Supervisor Signature (if applicable)

Date: _____ Date: _____

Initial Here: _____

CHILD

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I, _____, ☐ Parent ☐ Guardian

of (child's name): _____ Child's Date of Birth: _____

Give permission to: **LIFE IN BALANCE COUNSELING & WELLNESS CENTER**

and to **(Clinician's Name)**: _____

This permission grants the above to:

- Send and/or disclose confidential case records and/or test results;
- Send treatment summaries and diagnosis information to and receive confidential information from my PRIMARY CARE PHYSICIAN, PSYCHIATRIST, or OTHER PERSON/ENTITY listed below;

PLEASE LIST PRIMARY CARE PHYSICIAN, PSYCHIATRIST, or OTHER PERSON and/or ENTITY:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

I understand my service record is protected under Federal and State regulations and that information to be released by my signature may contain information pertaining to medical, psychiatric, substance abuse treatment and/or confidential HIV/AIDs related information.

This consent shall be in effect from: _____ **until:** _____ (No longer than one year)

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

Signature of Witness: _____ **Date:** _____

Initial Here: _____

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CREDIT CARD AUTHORIZATION

I _____ agree to allow **Life in Balance Counseling and Wellness Center** to keep my credit card on file. It is required by my insurance company for my co-pay to be paid prior to my appointment. Therefore, I agree and permit **Life in Balance Counseling and Wellness Center** to charge my credit card for mine or my minor child's co-pay in the event that prior to the appointment I am not able to be reached or should the front office be unavailable to take my payment. I understand that no one will contact me prior to making this charge as it is understood that if I owed a co-pay for an appointment that I have completed, the co-pay charge will be charged to my credit card. I also agree to allow my card to be charged for a no-show appointment or missed appointment without a 24-hour prior notice to the office if I have missed an appointment more than 2 times.

Signature of Cardholder: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Initial Here: _____

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TeleMentalHealth Consent Form

This form is to be completed I addition to **Life in Balance Counseling & Wellness Center** standard Consent and Services Agreement. It does not replace **Life in Balance Counseling & Wellness Center** standard Consent and Services Agreement.

I hereby consent to engaging in telehealth with a **Life in Balance** provider as part of my clinical treatment. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/behavioral health information, both orally and visually, to health care practitioners located and licensed in the Commonwealth of Virginia.

I understand that I have the following rights with respect to telehealth:

- I have the right to withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive expectations to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my behavioral or emotional state an issue in a legal proceeding.
- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- In addition, I understand that telehealth-based services and care may not be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.
- I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
- I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia Law.

Insurance Reimbursement:

I understand that my insurance may not cover telehealth with my **Life in Balance Provider.** I understand it is my responsibility to contact my insurance company to find out if my policy covers telehealth with my specific **Life in Balance Provider**. I also understand that **Life in Balance** will bill my insurance, but this does not guarantee that my insurance will pay for telehealth mental services with my **Life in Balance Provider**. If my insurance does not pay, I accept full responsibility for any payment due for services rendered by my Provider. If my insurance does not cover telehealth for my **Life in Balance Provider**, I understand that I can request face-to-face services or ask for a referral to a provider that my insurance covers.

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

Initial Here: _____