Charis Institute for Psychological and Family Services
21 Southgate Court, Suite 101
Harrisonburg, VA 22801
Phone: 540.568.1876

Children's Intake Form

Where did you hear about our services or who referred you_____

General Information

_____ _____/_____/_____ _____ - _____ - _____
Name Date of Birth Social Security Number

_____ _____
Mailing Address City, State Zip School/Grade

Person Responsible For Account

_____ _____ - _____ - _____ (____)_____
Name Social Security Number Home Phone

_____ (____)_____
Mailing Address City, State Zip Cell Phone

For your comfort and assurance of confidentiality we ask that you please read over the following and check your preferences.

- I give permission for Charis to call my home and leave a message on the answering machine or with anyone who answers the phone.
- I give permission for Charis to call my work number if I need to be reached.

_____ _____/_____/_____
Signature **Date**

Father

_____ _____/_____/_____ _____ - _____ - _____
Name Date of Birth Social Security Number

_____ (____)_____
Mailing Address City, State Zip Home Phone

(____)_____ _____ (____)_____
Cell Phone Employer Work Phone

Marital Status: Single Married Divorced Separated

Mother

_____ _____/_____/_____ _____ - _____ - _____
Name Date of Birth Social Security Number

_____ (____)_____
Mailing Address City, State Zip Home Phone

(____)_____ _____ (____)_____
Cell Phone Employer Work Phone

Marital Status: Single Married Divorced Separated

Person(s) Caring for Child other than Biological Parents

_____ (____)_____ (____)_____
Name Home Phone Cell Phone

_____ (____)_____
Mailing Address City, State Zip Work Phone

If the child has any brothers or sisters please list, including ages._____

Religious Background _____ Church Involvement: Active Moderate Inactive
Church Name

Counseling Experience Has child had previous counseling experience? Yes No _____
Name of Previous Counselor

*Please list family history of substance abuse or mental health problems:*_____

_____

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Insurance Information

_____ Insurance Company

_____ _____
Cardholder DOB Insurance Address

_____ _____/_____
Address City, State Zip Policy Number/Member ID Group Number

Medical Questionnaire

_____/_____/_____
Date of Last Physical Examination

*List any medical problems the child now has or has had in the past and describe them. (Also note accidents, hospitalizations, broken bones, periods of unconsciousness)*_____

_____

*List all medications the child is now taking, how often, and the amount the child is taking.*_____

_____

Method of Payment: ***Please check the method of payment that you will be using.***

Cash ___ Charge___ Payment Plan ___ Insurance/Co-Pay or Deductible___

We are more than happy to cooperate with individuals who are covered by insurance. We only ask that you read your policy to be sure that you are fully aware of any limitations of the benefits provided. Insurance is a contract between the patient and the insurance company for benefits. You should be aware that different insurance companies vary greatly in the types of coverage available. Be sure to check if your insurance requires you to pay a deductible before they pick up and pay a percentage of your remaining bill.

Some insurance requires prior authorization for treatment. Make sure that you find out if your insurance requires this. Most insurance companies will not go back and pick up charges if this authorization is not given prior to treatment. When prior authorization is required the insurance companies also require periodic treatment or service plans to be sent in. *If your insurance company requires these treatment plans, then you as the patient, are responsible for keeping up with them.* The insurance company will deny claims if the treatment plans are not sent in on or before the day services are rendered. Since we have no control in the selection of your insurance company (nor do we feel we should), we have no control over what they will pay or when they will pay for the services provided. Therefore, we ask that yo**u look upon your insurance realistically as a device which helps you pay for your care here at Charis Institute.** ***Please understand that assisting you with your insurance claim is done willingly but that regardless of the insurance coverage, the obligation for the fee for the services rendered is yours.*** All fees will be due on the day of treatment even if you have insurance unless arrangements are made in advance with our office.

Insurance companies typically limit their coverage to services that *they* consider medically necessary. ***In the event that you receive services and your insurance determines it did not meet their criteria, you understand that you are responsible for payment for these services.*** If you have a question about this you need to consult with your insurance company and the therapist before receiving the services.

I hereby authorize treatment. I authorize Charis Institute to furnish insurance carriers with any medical information necessary to process this claim. I hereby assign to Charis Institute all payments for services rendered to my dependents or myself. *I understand that I am responsible for payment of any amount not covered by insurance and that billing the insurance company is a courtesy to me and not an obligation of Charis Institute.* I acknowledge that insurance claims pending beyond 60 days are my responsibility and I agree that I will not delay payment and that I will pay the balance if a claim is pending more than 60 days. I understand that if I make a payment and payment is received later by Charis from my insurance company, I will be reimbursed. I understand that if my account is referred to a collection agency or an attorney for collection I agree to pay all costs of collection, including but not limited to, 35 percent, whether or not suit is filed. If a check is returned to Charis Institute, I understand that I will be responsible of paying the fee that bank charges them.

I have read and understand the Privacy Policy that is posted in the office

_____ _____/_____/_____

Signature/Guarantor Date

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often:

   Swear at you, insult you, put you down, or humiliate you?

   Or

   Act in a way that made you afraid that you might be physically hurt?

   ☐ Yes ☐ No If Yes, enter 1 _____

2. Did a parent or other adult in the household often:

   Push, grab, slap, or throw something at you?

   Or

   Ever hit you so hard that you had marks or were injured?

   ☐ Yes ☐ No If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you ever:

   Touch or fondle you or have you touch their body in a sexual way?

   Or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   ☐ Yes ☐ No If Yes, enter 1 _____

4. Did you often feel that:

   No one in your family loved you or thought you were important or special?

   Or