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

Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes ☐ No If Yes, enter 1 _____

5. Did you often feel that:

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   Or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   ☐ Yes ☐ No If Yes, enter 1 _____

6. Were your parents ever separated or divorced?

   ☐ Yes ☐ No If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

   Often pushed, grabbed, slapped, or had something thrown at them?

   Or

   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

   Or

   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ☐ Yes ☐ No If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   ☐ Yes ☐ No If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   ☐ Yes ☐ No If Yes, enter 1 _____

10. Did a household member go to prison?

    ☐ Yes ☐ No If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): _____

Child Social History

_____ _____/_____/_____
(Child's Name) (Date)

1) **What would you consider to be your child's major stressors?**___Break-Up with Girl/Boy Friend __Eating Disorder __Conflict Between Parents or With Parents___Housing___Physical Abuse__ Legal ___Conflict With Siblings__Violence in Home __Neglect__Death/Loss/Serious Illness of___Loved One ___Financial Concern___Sexual Abuse___Parent's Separation/Divorce__School __ Work Health/Physical ____Religious/SpiritualL____ No Current Stressors
2) **Which of the following problems do you feel the child needs help with?**___Feeling Sad or Down ___Issues Related to Past Abuse ___Very Nervous or Tense Relationship Problems ___Problems with Sleep___Very Fast Thoughts ___Unexplained, Frequent Mood Changes___Intense Anger/Aggressive ___Problems with Appetite___Discipline___Sexual Problems___Thoughts of Harming Self or Others ____Abusing Others___Difficulty with Memory, Concentration, or Decision Making___Problems at School ___Work Conflicts ___Reoccurring thoughts of Death___ Loss, Death, Divorce, Separation___ Eating Disorder/Body Image___Drug/Alcohol__Compulsive Behaviors___Religious /Spiritual__Hearing Voices or Seeing Strange Visions __Other_____
3) **Who has custody of the child?**__Both Parents __Mother__Father__Relative___DSS Other_____
4) Are natural parents married?___Yes ___No
5) Have there been previous marriages? __Yes ___No **If "yes,"** how many? Mother____ Father_____
6) If the child does not live with both natural parents does child see the parent that he/she does not live with? ___Yes ___No ___ Little Contact ____N/A
7) If parents are divorced or separated, what are the visitation arrangements?___Regularly Scheduled Visits ___Visit with Other Parent When Child/Parent Desires__ Inconsistent Visitation__No Visits or contact
8) Who lives in the child's household?___Both Parents___Father___Mother___Stepfather___Stepmother ____Foster Parents___Foster Children___Brothers/Sisters___Stepbrothers/Sisters___Half Brothers/Sisters ____Friend (s)___Relative (s)___Another Family___Pets Other_____
9) How many brothers or sisters does the child have, including step/half siblings?_____
10) How important are religious/spiritual practices to you?_Important _Very important__Unimportant __Neutral
11) What is father's education?_____ What is mother's education?_____
12) Has either parent had serious medical problems in the past six months?___Yes ___No
13) Has either parent had a history of mental health treatment?___Yes ___No
14) Has either parent been hospitalized for mental health problems?___Yes ___No
15) Is either parent taking medication for mental health reasons?___Yes ___No
16) Does either parent have current legal charges pending?___Yes ___No
17) Were there problems with pregnancy?___Yes ___No ___Do Not Know
18) Was the child delivered full term?___Yes ___No ___Do Not Know
19) Were there any immediate difficulties with the infant?___Yes ___No
20) Were there feeding problems?___Yes ___No
21) Was he/she more or less active compared to other children?_____
22) Was he/she well coordinated? ___Yes ___No
23) Were there any problems with speech development?___Yes ___No
24) Does the child wear glasses?___Yes ___No
25) Has the child received all of his/her current shots? ___Yes ___No
26) Is the Child receiving special education services? ___Yes ___No
27) Has the child been physically or sexually abused?___Yes ___No

28) Have parents or other family members been investigated for allegations of physical or sexual abuse? ___Yes ___No
29) Has Child Protective Services been involved with the child's family?___Yes ___No
30) Has the child ever been accused of abusing another child?___Yes ___No
31) Has the child ever been placed outside the home?___Yes ___No
32) Has the child seen hitting or hear threats to hit within the home?___Yes ___No
33) Have there been separations of parents?___Yes ___No
34) Has the child seen much conflict/fighting between parents and/or other household members?__Yes __No
35) Has the child had other traumatic experiences?___Yes ___No
36) Has the child been held back from any previous grades?___Yes ___No
37) What kind of grades does the child make? _____
38) Was there any difficulty getting the child to go to school when he/she first started?___Yes ___No
39) Is there now a problem getting the child to go to school or stay at school? ___Yes ___No
40) Where does the child go after school? __Home__Babysitter__Daycare__Relatives__Work_ Not Supervised
41) Is he/she involved in any after school activities?___Yes ___No
42) Does the child participate in team sports?___Yes ___No
43) Does the child have interests outside of school? ___Yes ___No
44) Does the child like his/her teacher?___Yes ___No
45) Has there been a history of conduct or behavior problems at school?___Yes ___No
46) Has the child ever been suspended?__Many times __Few Times __Once __Never
47) Does the child have a best friend?___Yes ___No
48) Is the child a leader with other children?___Yes ___No__At Times
49) Is the child a follower with other children?___Yes ___No__At Times
50) Who does the child prefer to spend time or play with?__Children of the Same Age __Younger Children ___Older Children___Adults___Parents/Guardians ___Prefers to Be Alone
51) Have there been any changes in the child's relationships with friends?___Yes ___No
52) Does the child have a lot of difficulty with one or more brothers and sisters? ___Yes ___No
53) Have brothers or sisters been treated for similar emotional or behavior problems? ___Yes ___No
54) Are there indications of similar problems with any brother or sister?___Yes ___No
55) Are there any children living outside of the family?___Yes ___No
56) ***The Following Questions Are to Be Answered About the Child's Mother***

Number of brothers and sisters… _____

Did mother grow up with both parents present?___Yes ___No

How were mother's economic conditions growing up?__ Below Average__Above Average__average

What was mother's religious affiliation growing up?__Protestant__Jewish__Catholic___Other

Please check any of the problems that the mother experienced:__Alcohol/Drug Abuse___Physical Abuse ___Mental or Emotional Illnesses__Sexual Abuse__Financial Problems__Marital Problems/Divorce __Physical Illnesses__Legal Problems Other_____

Does mother currently use alcohol or other drugs? ___Yes ___No

Has mother had any legal consequences as a result of alcohol or drug use?___Yes ___No

57) **The Following Questions Are to Be Answered About the Child's Father**

Number of brothers and sisters:_____

Did father grow up with both parents present?___Yes ___No

How were father's economic conditions growing up_ Below Average_Above Average__average

What was father's religious affiliation growing up?__Protestant__Jewish__Catholic___Other

Please check any of the problems that the father experienced:__Alcohol/Drug Abuse__Physical

Abuse ___Mental or Emotional Illnesses__Sexual Abuse__Financial Problems__Marital Problems/Divorce __Physical Illnesses__Legal Problems Other_____

58) Does father currently use alcohol or other drugs?___Yes ___No
59) Has father had any legal consequences as a result of alcohol or drug use?___Yes ___No
60) How long did parents know each other before they began living together?_____
61) Were there any specific problems in the relationship?__Financial__Religious __Sexual__Drugs/Alcohol __Personality__Violence/Abuse
62) **As things are now in the relationship, parents generally agree on:**__Raising Children__Family Finances ___Partner's Employment__Recreational Activities__Seeking Help for Children__Nothing
63) Are both parents involved in the child rearing?___Yes ___No
64) Which of the following are problems in the household?__Conflicts With Parents__Conflicts with Stepparent ___Conflicts with Grandparents___Conflicts with Parent Dating
65) Has the child used alcohol or drugs?___Yes ___No
66) Has the child been placed on probation as the result of alcohol or other drug use?___Yes ___No
67) Is the child on probation now? ___Yes ___No
68) Has the child been suspended, expelled, or absent from school because of alcohol or other drug use? ___Yes ___No
69) Has the child had school grades drop because of alcohol or drug use? ___Yes ___No
70) Have there been any health problems as a result of alcohol or drug use? ___Yes ___No
71) Does child have friends who are "users of alcohol or drugs"? Yes No
72) Has the child recently had problems with bed wetting or soiling pants**?** _____
73) Has there been a change in the child's daily activities?___Yes ___No
74) Does the child have a set time for:___Bed Time___Meals___Bath__Homework
75) Where does the child sleep?___Alone___With Other Children___With Parents
76) The child can:___Bathe Self ___Dress Self ___Comb/Brush Hair

_____ _____/_____/_____

Psychologist Signature Date

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Client Information

We would like to take the opportunity to let you know about some very important aspects of the services we will be providing for you at Charis. We would also like you to signify your acceptance of these arrangements by signing this form during the first visit you have with your therapist.

Confidentiality

Your identity and any information shared by you will be held in the strictest confidence. The right to release information about you belongs to you. No information, including the fact that our office is seeing you, will be released to anyone without your written or verbal permission. We will ask you to sign a release if we agree that this is necessary. Exceptions to this confidentiality policy are made as a result of legal requirement to report any of the following:

- The abuse or neglect of a child or dependent adult.
- Imminent danger of hurting yourself or someone else.
- In the case of court involvement, if the court would order it.
- Information regarding your involvement in treatment (i.e. Dates of treatment and billing records) if legal collection action becomes necessary by our office.
- Information regarding your treatment, dates of service, diagnosis, and treatment plans if you submit claims for these services to your insurance company and your insurance company requires such information.
- For the purpose of ensuring quality services, our staff is involved in on-going training and supervision. For this reason, confidential information will be shared among staff to enhance therapeutic effectiveness. Sessions may be audio taped or videotaped (with additional consent from you) with the goal of enhancing therapeutic effectiveness, and these tapes will be treated with the same level of confidentiality as other clinical records.
- For the purpose of scheduling appointments and receiving notice of cancellations when necessary, you give permission for us to leave a message at your home or work with numbers to call.
- Unethical or illegal practices of a psychologist.

Appointments and Fees

- You will see your therapist on an appointment basis. If you request this, where possible, we will try to establish a regular time for your appointments to make it more convenient for you. You should check with the office before your session or before you leave to confirm your next appointment.
- **Please notify us at least 24 hours prior to your appointment if you cannot keep your scheduled time. If we do not receive a 24 hour notice for a cancellation or if you do not show up for your appointment, you will be charged a $35 fee and we will remove any future appointments you have scheduled.** After two cancellations with insufficient notice or two "no shows," you will be given a referral elsewhere. If you are a new client and do not show up for your first appointment, you will not be rescheduled. Insurance will not pay for "no show" fees, and you are responsible for payment.
- **There is a charge of $200.00 for your first session** (which involves various intake procedures.) **Subsequent sessions are $130.00 for 40-45 minute sessions** (other session fees available upon request). **You agree to pay in full for services not covered by your insurance and for your portion of covered services**. We will file insurance claims for you if you wish. If you file your own claim, and pay in full at the time of service we will give you a 25% discount. We will also give the same discount for those who do not have insurance and wish to pay cash at the time of the

visit.

- Telephone consultations are necessary at times and we want to make that available to all of our clients; however, anything over ten minutes will be on a prorated basis. *Insurance companies do not pay for telephone consultations.* If I need professional help between sessions, I agree to call the Charis office at 540.568.1876 and either someone in the office or the answering service will contact the therapist. I understand that the therapists do not carry beepers, and if I should need assistance and be unable to reach the therapist, I agree to go for help to the Rockingham Memorial Hospital Emergency Room, or to a Hospital Emergency Room near me. If I am unable to do so, I agree to call 911 for assistance.
- You may request copies of your notes, reports, or any other information that we have concerning your records. At times it is necessary for the clinicians to write reports concerning your treatment. Please know that there will be a small fee for processing any of the above.
- **We will provide you with a regular statement on your account. You agree to pay 1.5% interest (18% per year) on a balance that is 120 days or more past due. We understand that due to conditions of employment, health, or other factors, a payment plan or other necessary arrangement will need to be made. If this should occur please bring this to the attention of the Accounts Manager to avoid collection action. If collection is necessary you will be charged the collection fees in addition to your account balance.**
- If I should be dissatisfied with the services I receive, I agree to discuss this with my therapist and express the extent of my dissatisfaction. I understand that I may terminate treatment at any point, and may request a referral to another qualified therapist. In the event that I should make an ethical or legal complaint to any source regarding treatment rendered, and it is determined that the therapist is not found in error, I understand that I am liable for reimbursement of any costs incurred and income lost by the therapist in pursuing the matter.

Informed Consent to Treatment

I give my consent for the provision of psychotherapy and/or psychological evaluation services to **myself/my child** _____. I have read the policies and procedures on the preceding pages and I have discussed with my therapist any area(s) I do not understand. I agree to these provision. I understand that this consent will continue in effect as long as the individual noted above continues in treatment, unless I should notify my therapist in advance in writing that, as of a certain date, I am no longer consenting to further treatment, or any of the provisions listed above. I may request a copy of this form for my own records.

My therapist will discuss with me the specifics of my treatment plan in our intake session. I understand and am satisfied with my therapist's qualifications to treat the difficulties for which I am seeking help. I understand that my therapist will conduct him/herself in a manner consistent with ethical, legal, and professional standards of practice. **If I have any concerns, it is my responsibility to communicate these to my therapist.**

_____ _____/_____/_____
(Client/Guardian Signature) (Date)

_____ _____/_____/_____
(Psychologist Signature) (Date)

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Authorization to Disclose Information to Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. Until I revoke my consent, this authorization is valid.

I hereby authorize on behalf of myself/my child _____

Please Check One:

_____ To release or to exchange any applicable information with my Primary Care Physician.

_____ To release or to exchange medication information only with my Primary Care Physician.

_____ Not to release or exchange any information to my Primary Care Physician.

_____ _____
(Patient or Patient's Guardian, please sign) (Date)

_____ _____
(Please print the name signed above) (Date)

_____ _____
(Psychologist Signature) (Date)

Primary Care Physician's Name, Address & Phone

_____
(Please Print Physician's Name)

_____
(Street/Mailing Address)

_____
(City) (Zip)

_____
(Area Code) (Phone)

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Release/Exchange of Information

I, _____, authorize Charis Institute regarding myself /child

_____ to
(Name of self and child)

_____ Release information *including* medical, psychiatric, alcohol and /or drug abuse, HIV testing, and /or AIDS information to
_____ Receive information, *excluding* medical, psychiatric, alcohol and/or drug abuse, HIV testing, and/or AIDS information from
_____ *Exchange* information on an ongoing basis with:

_____ (Name of individual or agency) Phone	_____ (Name of individual or agency) Phone
_____ (Name of individual or agency) Phone	_____ (Name of individual or agency) Phone
_____ (Name of individual or agency) Phone	_____ (Name of individual or agency) Phone

This information will be released for the purpose of:

___ obtaining information
___ exchanging information with the above agencies
___ evaluating service needs
___developing and maintaining a treatment plan
___ongoing service coordination
___continuity of care
___ psychological evaluation

The specific records/reports to be disclosed shall include:

___Complete Records (including progress notes)
___Discharge Summary
___Psychological Evaluations
___Psychological Records
___Medical Records
___Psychiatric Evaluation
___School Records
___Other -Specify type:_____

I understand that the records and information released/exchanged shall be regarded as confidential communication except when public safety is threatened or when a release of such information is court ordered. I further understand that the purpose of this release is to assist the staff of Charis Institute to plan, implement, and to conduct follow up evaluations on the outcome of the counseling program. I know that I may request to receive a copy of this authorization. I agree that this authorization shall be valid for two years from the date in which I sign it and that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this release /exchange of information in writing.

Alcohol, drug, HIV, ARC, and /or AIDS information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. Copies or faxes of this authorization are acceptable. I understand I may be charged a service fee for requesting copies of any records.

_____ _____
Patient signature (if over 14 years of age) *Print name of person who released information*

_____ ___/___/___
(Patient/Guardian, or authorized signature if patient is a minor) (Date)

_____ _____/_____/_____
Psychologist Signature (Date)