1130 SE 18TH PLACE
OCALA, FL 34471
PHONE: (352) 390-6656
FAX: (352) 390-8756

CONSENT FOR A MINOR CHILD TO BE COUNSELED

I_____,(Mother) and_____,(Father)

hereby give my / our permission for my / our minor child,_____,

to be seen for counseling and / or evaluation by_____.

_____ _____
Parent / Guardian Signature Date Signed

_____ _____
Parent / Guardian Signature Date Signed

_____ _____
Witness Signature Date Signed

URBAN COUNSELING
CLIENT INFORMATION SHEET
(Parent Information if Client is a Minor)

Name_____DOB_____

Address_____

Phone Number_____Work_____Sex M_____F_____

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Have you had counseling before? Yes___ No___ When?_____ Therapist_____

Number of people in household_____
Total Income Before Taxes From All Sources (include all income of all persons in the home)

___Less than $5,000
___$5,000 – 9,999
___$10,000 – 14,999
___$15,000 – 19,999
___$20,000 – 24,000
___$25,000 – 29,000
___More

___Black
___Hispanic
___White
___Other

Source of Income:
____Employment
____Social Security
____SSI
___Pension
___Disability
___Spouse
___Other

Are you handicapped? Yes___ No___ If so, please explain:_____

Emergency Contact:_____
Phone:_____**Relationship**:_____

Place of Employment:_____
Address:_____ Phone Number_____
Method of payment: Cash____ Check____ Credit Card____ Insurance____
Name of Insurance Company_____

Policy Number_____Group Number_____

Please read, sign and date: I understand that this is not an application. I authorize use of this information or any subsequence information derived from this form with the understanding that data will be used for general reporting purposes only. I consent for therapy.

_____ _____
Client Signature Date of Signing

_____ _____
Therapist Signature Date of Signing

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CHILD / ADOLESCENT PSYCHOSOCIAL

IDENTIFYING INFORMATION

Date of assessment:_____

Name of Child _____ Sex ___M ___F

Birth date: _____ Place of birth _____

Address:_____City:_____State____Zip_____

Home Phone:_____Religious organization_____

Education (grade)_____

Referral source_____

I give permission for Therapist to contact (physician/teacher/etc) regarding treatment issues, symptoms, behaviors or other information necessary for the treatment of _____

Parent's signature_____

CHIEF COMPLAINT:

Presenting problems (check all that apply)

__ Very Unhappy
__ Irritate
__ Temper Outburst
__ Withdrawn
__ Daydreaming
__ Fearful
__ Clumsy
__ Overactive
__ Slow
__ Short attention span
__ Distractible
__ Lacks initiative
__ Undependable
__ Peer conflict
__ Phobic
__ Impulsive
__ Stubborn
__ Disobedient
__ Infantile
__ Mean to others
__ Destructive
__ Trouble with the law
__ Running away
__ Self-mutilating
__ Head banging
__ Rocking
__ Shy
__ Strange behavior
__ Strange thoughts
__ Fire Setting
__ Stealing
__ Lying
__ Sexual Trouble
__ School performance
__ Truancy
__ Bed wetting
__ Soiled pants
__ Eating problems
__ Sleeping problems
__ Sickly
__ Drug use
__ Alcohol use
__ Suicide talk

Explain:

How long has this problem occurred? Number of weeks, months or years?_____

_____

What happened that makes you seek help at this time?_____

_____

Problems perceived to be: ___very serious ___Serious ___not serious

What are your expectations of your child?_____

_____

What changes would you like to see in your child?_____

_____

What changes would you like to see in yourself?_____

_____

What changes would you like to see in your family?_____

_____

PSYCHOSOCIAL HISTORY:

CURRENT FAMILY SITUATION

Mother ---Relationship with child ___natural parent ___ relative
___ step –parent ___ adoptive parent

Occupation _____

Education _____ Religion _____

Birthplace _____Birth date _____

Age _____

Marital History of parents

Natural parents ___ Married When _____ Age _____
___ Separated When _____
___ Divorced When _____
___ Deceased M / F _____
Step-parents ___ Married When _____

If child is adopted:

Adoption Source:

Reason and circumstances:

Age when child first in home:

Date of legal adoption:

What has the child been told?

LIVING ARRANGEMENT

	Place	Date
Number of moves in a child's life _____		

Present Home ___ Renting ___ Buying
___ House ___ Apartment

Does the child share a room with anyone else? ___ Yes ___ No
If yes, with whom?
If no, how long has he/she has own room?
Was the child ever placed, boarded, or lived away from the family? ___Yes ___ No

Explain
What is the major family stress at the present time if any?

What are the sources of income?

BROTHERS and SISTERS (Indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (Yes/No)	Use drug or alcohol (Yes/No)	Treated for drug abuse (Yes/No)
1.							
2.							
3.							
4.							

Name	Age	Sex	School or Occupation	Present Grade	Living at home (Yes/No)	Use drug or alcohol (Yes/No)	Treated for drug abuse (Yes/No)
5.							
6.							

List all other extended family members by their relationship to the patient who have drug and/or alcohol problems (legal/illegal), history of depression, self-destructive behavior or legal problems.

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

Other living in the home (and their relationship)

1 _____

2 _____

HEALTH OF FAMILY MEMBERS: (excluding patient)

Name	Relation-ship to child	Type of Illness	When occurred	Length of Illness
1.				
2.				
3.				
4.				

Does or did any member of the child's family have any problems with:

___ reading ___ spelling ___ math ___ speech

(If yes, please explain)

Is there any history in the child's family of:

___ mental retardation ___ epilepsy ___ birth defect ___ schizophrenia

(If yes, please explain)

CHILD HEALTH INFORMATION

Note all health problems the child **has had** or **has now**

	Age		Age
___ High Fever	_____	___ Dental Problems	_____
___ Pneumonia	_____	___ Weight problems	_____
___ Flu	_____	___ Allergy	_____
___ Encephalitis	_____	___ Skin problems	_____
___ Meningitis	_____	___ Asthma	_____
___ Convulsion	_____	___ Headaches	_____
___ Head Injury	_____	___ Stomach problems	_____
___ Fainting	_____	___ Accident prone	_____
___ Dizziness	_____	___ Anemia	_____
___ Tonsils out	_____	___ High or low blood pressure	_____
___ Vision problems	_____	___ Sinus problems	_____
___ Hearing problems	_____	___ Heart problems	_____
___ Earache	_____	___ Hyperactivity	_____
		___ Other illness etc (Explain)	_____

Has child ever been hospitalized? ___ Yes ___ No

If yes, please explain

Age	**How long**	**Reason**
_____	_____	_____

Has child ever been seen by a medical specialist? ___ Yes ___ No

Age	**How Long**	**Reason**
_____	_____	_____

Has child ever taken, or is he/she presently taking any prescribed medication?

Age	**How Long**	**Reason**
		_____

_____

Name of Medication / Dosage / Frequency _____

_____

Allergies _____

_____

Nicotine, Alcohol, Substance Use _____

Name of Primary Care Physician _____

Address: _____ Phone Number _____

DEVELOPMENT HISTORY

Prenatal: Child wanted? ___ Yes ___ No Planned for? ___Yes ___ No
Normal Pregnancy? ___ Yes ___ No
If mother ill or upset during pregnancy, explain _____

_____

Length of pregnancy: _____
Parental support and acceptance: (Explain)

BIRTH

Length of active labor: _____ hours ___ Easy ___ Difficult
Full term? ___ Yes ___ No

If premature, how early? _____

If overdue, how late? _____
Birth weight ___ lbs ___ oz
Type of delivery ___Spontaneous ___Caesarean ___ with instruments
___ Head first ___ Breech
Was it necessary to give infant oxygen? ___Yes ___ No If yes, how long?_____
Did infant require blood transfusion? ___ Yes ___ No
Did infant require X ray? ___ Yes ___ No
Physical condition of infant at birth?
If yes, explain Anorexia ___ Yes ___ No
Trauma ___ Yes ___ No
Other complications ___ Yes ___ No
Did mother abuse alcohol/drugs during pregnancy? ___ Yes ___ No

NEW BORN PERIOD

			How Long
Irritability	___ Yes	___ No	_____
Vomiting	___ Yes	___ No	_____
Difficulty breathing	___ Yes	___ No	_____
Difficulty sleeping	___ Yes	___ No	_____
Convulsion/twitching	___ Yes	___ No	_____
Colic	___ Yes	___ No	_____
Normal weight gain	___ Yes	___ No	_____
Was child breastfed?	___ Yes	___ No	_____

DEVELOPMENT MILESTONES:

Age at which child:

Sat up _____
Crawled _____
Walked _____
Speak single words _____
Sentences _____
Bladder trained _____
Bowel trained _____
Weaned _____

Describe the manner in which toilet training was accomplished: _____

_____

_____

EARLY SOCIAL DEVELOPMENT

Relationship to siblings and peers

___ Individual play ___ Group play
___ Competitive ___ Cooperative
___ Leadership role ___ Follower

Describe special habits, fears, or idiosyncrasies of the child:

EDUCATIONAL HISTORY

Name of school	City/State	Dates attended From	to	Grade completed in this school
Preschool				
Address	Phone Number			
Elementary				
Address	Phone Number			
Junior High				
Address	Phone Number			
High school				
Address	Phone Number			

Type of classes ___ Regular ___ Learning Disability ___Continuation
___ emotionally handicapped ___ opportunity ___ others

Did child skip a grade? ___ Yes ___ No Repeat a grade? ___ Yes ___ No

(If yes, when and how many years appropriate grade level at present time?)

_____

Did child have any specific learning disability? ___ Yes ___ No
Has child ever had a tutor or other special help with school work? ___ Yes ___ No
Does child attend school on a regular basis? ___ Yes ___ No
Does child appear motivated for school? ___ Yes ___ No
Has child ever been suspended or expelled? ___ Yes ___ No

ACADEMIC PERFORMANCE

Highest grade on last report card?
Lowest grade on last report card?
Favorite subject?
Least favorite subject?
Does child participate in extracurricular activities? ___ Yes ___ No (Explain)

In school, how many friends does the child have? ___ A lot ___ A few ___ none

What was the child's aspiration? ___ Quit school

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Notice of Privacy Practices Acknowledgement Form

I, _____ have read and

understand the **Urban Counseling, L.L.C.,** notice of Privacy practices.

Information can be shared with:

Name_____Relationship_____ Phone #_____

Name_____Relationship_____ Phone #_____

Name_____Relationship_____ Phone #_____

_____
Signature of Patient or Legal Guardian

_____
Date

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CONFIRMATION FOR COUNSELING AND FEE AGREEMENT

This Agreement confirms my decision to participate in counseling at Urban Counseling. I realize that Urban Counseling is not a crisis center and the counselors are not available 24 hours a day. The therapeutic services provided by Urban Counseling include individuals,families, children, adolescents, relationships and martial counseling. Each session should be 45-50minutes in length. This will be discussed with the counselor at the time of my first visit.

Self-Paying Clients: Services are provided on a sliding fee schedule for clients not covered by other payers. Proof of annual income and number of people living in a household determine fee arrangements. I certify that my annual family income before taxes is $_____ And that there are _____ people living in my household. Accordingly, I agree to pay a fee of $_____ for the first session and $_____ per session thereafter. I realize that Urban Counseling is charging me a low and reasonable fee. **If this payment cannot be paid at the time of session, future sessions will be postponed until payment is made.** I realize that if my income level changes, the fee can change. I agree to notify Urban Counseling if and when my income level or the number of people in my household change.

Basic Fee: Sliding scale fees are contingent upon **proof of income.** Failure to provide proof of income at the time of service will result in our maximum fee of $125.00.

I recognized that if I fail to show up for my appointment, I will be charged for a full session. Therefore, I agree that if I DO NOT notify Urban Counseling 24 hours in advance that I am going to miss that scheduled appointment, I will pay the fee for that appointment. Consecutively missed appointments and non-payment of fees will result in termination of my counseling; and fee collection by other means.

_____ Initials
I have read the above information, have had the opportunity to have any questions about the above answered, and I understand the requirements. Urban Counseling will give me a signed copy of this Agreement upon request.

_____ _____
Client's Signature Date Signed

_____ _____
Witness's Signature Date Signed

Urban Counseling, L.L.C.

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Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a Federal Program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties covered entities that misuse personal health information.

We may use and disclose your medical records only for each of the following purposes:
Treatment, payment and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost –management analysis and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions or certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- Right to Inspect and Copy: You have the right to inspect and copy mental health information that may be used to make decisions about your care. This includes your own billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed

- Right to Amend: If you feel that the mental health information we have about you (not including psychotherapy notes), in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your record.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information by asking to speak to our Privacy Officer or for written inquires, note “Attention Privacy Officer”.