Individual Intake Form Today's Date: _____

Individual Completing Packet and Relationship To Child: _____

Child's Name: _____ Gender: _____

D.O.B. _____ Grade/School: _____

Complete Address: _____

Parent(s) Name(s): _____

Home Telephone #: _____ Work Telephone #: _____

Email: _____ Cell Telephone #: _____

Parent Relationship Status (Circle One): Married, Separated, Divorced, Never Married, Widowed

If parents are separated or divorced, who has legal custody? _____

Additional parent info: _____

Complete Address: _____

Home Telephone #: _____ Work Telephone #: _____

Email: _____ Cell Telephone #: _____

Emergency Contact: _____ Relation to Patient: _____

Complete Address: _____

Home Telephone #: _____ Work Telephone: #: _____

Email: _____ Cell Telephone #: _____

Siblings? Please list name(s) and age(s) below:

Child's current school, grade and teacher:

Is your Child receiving Special Education Services? If so, for what diagnoses?

On the next several pages there are a variety of questions. Please answer each item as completely and honestly as possible. These responses lay a foundation through which I can begin to understand the environment in which your child operates and the context that surrounds them each day.

Family Life and History

Who does your child live with?: _____

Where was your child born?: _____

What is the ethnic makeup of the family members?

Mother:_____ Father:_____

Stepparents: _____

Siblings:_____

Languages spoken in the home (please circle the primary language if there is more than one):

_____

Does your child practice a religion? Which?: _____

If so, how important is this practice to the family?: _____

_____

To the child?: _____

_____

Are there family/cultural traditions that are practiced? Please describe: _____

_____

_____

_____

What are your child's hobbies or interests?: _____

_____

_____

Favorite foods?: _____

_____

Major family events? For example, births, deaths, moves, changing schools, etc. Please provide date and details:

_____

_____

_____

How does your child get along with their sibling(s)?: _____

_____

_____

Please describe the quality of the parental relationship(s) -both with each other and with your child:_____

_____

_____

_____

_____

Parent(s) occupation(s) and hobbies: _____

_____

_____

_____

Has the child been in out-of-home care? If so, at what ages and for how long: _____

_____

_____

Academics

For each grade level, please list where the child attended:

Preschool: _____

K: _____

1st: _____

2nd: _____

3rd: _____

4th: _____

5th: _____

6th: _____

7th: _____

8th: _____

9th: _____

10th: _____

11th: _____

12th: _____

Please list any awards (e.g., honor roll, Principal's list, citizenship, etc.) and year(s) received:

_____

_____

Does your child like school? Please explain: _____

_____

_____

_____

We may request copies of report cards and IEP documents if pertinent.

Developmental History

Pregnancy and Delivery -

How was Mom's health during pregnancy?: _____

_____

Alcohol or substance use during pregnancy?: _____

_____

Was delivery complicated? Full-term? C-section? Please describe details of the birth: _____

_____

_____

Developmental Milestones -

At what age did your child -

Sit on their own:_____ Crawl:_____Walk: _____

Speak first words:_____ Speak in 2 - 3 word sentences: _____

Toilet train, daytime:_____ Nighttime: _____

Comments or other notes about developmental milestones:_____

_____

_____

Sleep Habits -

What is your child's bedtime routine or ritual?: _____

_____

Nightmares? Night terrors? Sleep walking or talking?: _____

_____

_____

Medical History

Please describe your child's health, in general: _____

_____

_____

_____

When was your child's last physical?: _____

Any hearing, vision, or dental problems? If so, please describe: _____

_____

_____

Any chronic health problems not described above (e.g., asthma, diabetes)?: _____

_____

_____

Any head trauma, concussion, loss of consciousness? If so, when and what were the circumstances?:

_____

_____

_____

Please list any medications your child is taking, ***both prescription and over-the-counter***, dosage and reason for taking:

Medication	**Dosage and frequency**	**Reason**

Mental Health Background

Please list dates and the reason for admission of any inpatient psychiatric treatment your child has received: _____

_____

_____

Please list, chronologically, all therapy or counseling your child has received:

Dates of treatment	Professional	Reason for treatment

Has your child ever harmed him or herself? Suicide attempt(s)? Cutting or self-injurious behavior? Deliberate or non-deliberate harm? Please describe: _____

_____

_____

_____

Substance use or experimentation - including cigarettes, marijuana, and nitrous: _____

_____

_____

_____

Family Mental Health Background

Please list any relatives (parents, siblings, grandparents, aunts, uncles, etc.) with mental health diagnoses (depression, anxiety, eating disorder, bipolar, etc.):

Relative	Diagnosis

Please take a moment and share any information that you feel was not included on these pages that is important for your child's assessment or the reason for seeking services:

_____

_____

_____

How long have you had these concerns?: _____

_____

Previous Outpatient Therapy: _____

_____

Previous Inpatient Treatment: _____

_____

Referred By: _____

Primary Care: _____ Phone Number: _____

Psychiatrist: _____

Signature on File

(Please initial each applicable line and sign at bottom of page)

_____ I understand that I am responsible for my bill.

_____ I authorize Amy Fortney Parks (and Wise Mind Solutions, LLC) to charge my card on file pursuant to the credit card authorization policy.

_____ _____

Patient/Guardian Name Date

_____ _____

Signature Date

*Relationship if not patient _____

* The signature of a parent or legal guardian is required if the patient is under 18 years of age or legally incompetent.

Statement of Confidentiality

The law protects the privacy of all communications between a patient and a clinician. In most situations, we only release information about your treatment to others if you sign a written authorization form. There are other situations that require that you provide written, advance consent. Your signature on this contract provides consent for those activities, as follows:

- We occasionally consult with other health and mental health professionals about a case. The other professionals are legally bound to keep the information confidential.
- If we believe that a patient presents an imminent danger to his/her health or safety, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information **without** your consent:

- If you are involved in a court proceeding and a request is made for information concerning the services that we provided you, such information is protected by the therapist-patient privilege law. We cannot provide any information without your written authorization, *or* a court order.
- If a government agency requests information for health oversight activities, we may be required to provide it for them.
- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

There are some situations in which we are legally obligated to divulge information about your case, when we believe it is necessary to protect others from harm. In these cases, we may have to reveal some information about a client's treatment.

- If we have cause to suspect that a child under 18 is abused or neglected, the law requires that we file a report with the State Central Register of Child Abuse and Maltreatment and the local department of social services (LDSS). If we have reasonable cause to believe that a disabled adult is need of protective services, we are required to file a report with the LDSS Adult Protective Services (APS).
- If we believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim (if identifiable), and/or calling the police.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit disclosure to what is necessary.

I understand the above policies. I consent to the provision of services.

_____ _____

Signature of Patient Date Office Staff or Doctor's Signature Date

_____

Signature of Parent/Guardian Date

Policies & Procedures

Please feel free to direct any questions to our office. Your understanding of this contract is important to me and I am happy to discuss any or all of these conditions with you at any time. I look forward to serving you and your family.

This contract contains information about our services and the Health Insurance Portability and Accountability Act (HIPAA). HIPPA is a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. A Notice of Privacy Practices (NPP) is attached to this contract and explains HIPAA in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information. Signing this agreement also represents an agreement between us. You may revoke this contract in writing at any time, which will be binding on us unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

APPOINTMENTS

Your appointment represents time reserved for you. As schedule permits, we will work out the most convenient time for you for these appointments. We reserve the right to charge a $50 fee for broken appointments and cancellations made less than 24 hours in advance of your appointment time. Please help us serve you better by keeping scheduled appointments. We have 24-hour voicemail service for your convenience. Simply call 1-844-947-3326 and leave a voice message or email our office at info@thewisefamily.com. We also reserve the right to reschedule your appointment if you arrive late, dependent upon the schedule that day.

PAYMENT OF FEES

Payment is to be made in full at the time of the session or within 5 days of receiving your session invoice, with the exception of pre- payments, when applicable. We accept cash, check, or credit card. Unpaid balances older than 5 days may be subject to a $25.00 late penalty and a $50.00 late penalty per month after 30 days until paid in full.

Payments are non-refundable. You will be liable for all costs if your account defaults and requires the use of a collection agency. In addition, you will be liable for all other costs incurred in their service including, but not limited to, corporation fees, attorney's fees, and all court related expenses. Services may be interrupted until payment is made.

PACKAGE OPTION

For your convenience, we offer a pre-payment option. Should you elect to take advantage of this option, we offer a 6-session package. This package is for individual sessions only and does not include family sessions or ancillary service fees (i.e. telephone calls, emails, preparation of records/see fees for services for more details). The 6-sessions in the package expired 12-months from the date of purchase. Payment can be made by cash, check, credit card, or recurring credit card payment. Should you elect to take advantage of our package option, missed or cancelled appointments will not be refunded or credited.

INSURANCE/THIRD PARTY/MANAGED CARE
We highly recommend that you verify your insurance benefits prior to beginning services. As a courtesy to you, we will provide you with a receipt for all services to be submitted to your insurance company. Your insurance policy is a contract between you and your insurance carrier; we are not the party to contact. It is your responsibility to obtain authorization for the initial visit if you are intending to seek reimbursement from your insurance carrier for services. Our office cannot guarantee coverage of our fees.

CONTACTING YOUR THERAPIST
In the event that our office is unavailable to take your call, you may leave a voice message or send an email message and we will make every effort to return your message on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave times when you will be available.

AUTHORIZED CONTACT METHODS
Please initial next to the methods of contact you authorize our office (Wise Mind Solutions, LLC) to leave you messages:_____Email_____Cell Phone_____Home Phone___Work Phone

PROFESSIONAL RECORDS
The laws and standards of the helping profession require that we keep PHI about you in your Medical Record. Except in circumstances that involve danger to yourself and/or others, or the record makes reference to another person and we believe that access is likely to cause harm to such other person, you may examine and/or receive a copy of your Medical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence or have them forwarded to another professional so you can discuss the contents. If we refuse your request for access to records you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS
HIPAA provides you with several rights with regard to your Medical Records and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your Medical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this contract, the attached NPP form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

READ CAREFULLY AND COMPLETE
I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

_____ _____
Signature of Patient or Responsible Party Date Office Staff or Doctor's Signature Date

AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION FOR CLINICAL SERVICES

I request that the following information be shared for treatment and/or service coordination. By signing this form, I am allowing service providers and agencies to exchange information that will be useful in planning current treatment, and/or will make it easier for them to work together effectively in planning and/or providing services.

/ /

(Please print full name of client) (Please print client's date of birth) My relationship with client is: Δ Self Δ Parent Δ Guardian

I request that the following information be released or exchanged in person, by phone, or in writing:

Δ Psychological/Psychiatric Assessment/Treatment Information, Diagnosis and Records

Δ Medical Assessment/Treatment Information, Diagnosis and Records

Δ Educational Records (including assessment and social data)

Δ Other

I request that Amy Fortney Parks and the following service providers or agencies exchange the above information (please provide names and telephone numbers, if available):

Δ Physician

_____

Δ Family Member(s)

_____

Δ Attorney

_____

Δ Educational Institution

_____

Δ Psychiatrist/Psychiatric Professional(s)

_____

Δ Other

_____

***Expiration & Terms*:** I understand that this consent is good for one year from the date of my signature below, and that it encompasses consent to release information from before the signature date, as well as additional information received after this consent is signed. In addition, I understand that information may be shared in writing, via HIPPA compliant email, via computerized form, and or in meetings or by telephone and that I have a right to inspect and review the information that will be released under the supervision of my clinician.
Revocation: I understand that I can withdraw this consent at any time. The revocation will not apply to information that has already been released. I must revoke this consent in writing to Amy Fortney Parks.

_____ _____

Client's Signature * Date

**The signature of a parent or legal guardian is required if the client is under 18 years of age or legally incompetent.*