Turning American Families Around **F**
Individual, Marital and Family Counseling

STUDENT INFORMATION

DATE_____________________

STUDENTS FULL NAME____ DATE OF BIRTH ___________________ AGE _______

EDUCATION WHAT GRADE IS YOUR CHILD IN? ________________ SCHOOL ____

PARENT INFORMAION

FATHER'S NAME ____ PHONE _________________

ADDRESS ____ CITY ___________________________ ST ________ ZIP __________

PHONE (GIVE PHONE NUMBERS WE CAN CALL YOU ON ONLY) HOME ______________ CELL _______________ WORK ________________

PARENTS E-MAIL (PRINT CLEARLY) ____ CAN WE EMAIL YOU? _____ CAN WE TEXT YOU? _____

MOTHER'S NAME ____ PHONE _________________

ADDRESS ____ CITY ___________________________ ST ________ ZIP __________

PHONE (GIVE PHONE NUMBERS WE CAN CALL YOU ON ONLY) HOME ______________ CELL _______________ WORK ________________

PARENTS E-MAIL (PRINT CLEARLY) ____ CAN WE EMAIL YOU? _____ CAN WE TEXT YOU? _______

REASON FOR SEEKING COUNSELING

____
____
____
____
____

FATHERS PREVIOUS MARRIAGES OR RELATIONSHIP WITH A SIGNIFIGANT OTHER – 1ST (YRS _______) 2ND (YRS______) 3RD (YRS ______)

MOTHERS PREVIOUS MARRIAGES OR RELATIONSHIPS WITH A SIGNIFICANT OTHER - 1ST (YRS _______) 2ND (YRS______) 3RD (YRS ______)

OTHER CHILDRENS NAMES, AGES, (INCLUDING PREVIOUS RELATIONSHIPS IF APPLICABLE)

____ ________ CUSTODY SPLIT _______________________________________
____ ________ CUSTODY SPLIT _______________________________________
____ ________ CUSTODY SPLIT _______________________________________
____ ________ CUSTODY SPLIT _______________________________________
____ ________ CUSTODY SPLIT _______________________________________
____ ________ CUSTODY SPLIT _______________________________________

CHURCH AFFILIATION ☐ YES ☐ NO – IF YES WHAT CHURCH ____

DO YOU WANT TO INCORPORATE A CHRISTIAN MODEL OF COUNSELING ☐ YES ☐ NO _________________________________

STUDENTS GENERAL PHYSICAL HEALTH (CIRCLE ONE) - VERY GOOD GOOD AVERAGE POOR IMPROVING DECLINING

____
____

Counseling Goal Sheet
E. Michael Priddy, MA, LCPC

Childs Name ______________________________________ DOB ________________ Parent Name ______________________________________

Please identify the main problem that has brought you and your child to counseling and rate its severity:

____
____
____

On a continuum "None" to "Extreme", how much distress are you experiencing from this problem
_____ None _____ Some _____ A large amount _____ Extreme _____ Current thoughts of hurting yourself

Please identify three (3) main goals that you would like to address in counseling for you and your child:

____
____
____

What about your child's present behavior do you want to change?

____
____
____

What benefits do you expect to derive from therapy? ____
____

How would you describe the ideal therapist interaction for you/for your child? ____
____

What do you think therapy will do for you and your child?

____
____

How long do you think therapy should last?

____

Parent/Guardian Signature ____ Date __________________

Parent/Guardian Signature ____ Date __________________

Insurance/Payer Information Form

Client Name: ____ DOB ____________________________

WHO IS FINANCIALLY RESPONSIBLE

INSURED NAME ____ DOB _______________

RELATIONSHIP TO CLIENT _________________________ PHONE ____________________

BILLING ADDRESS ____

CITY _________________________ST. ___________ ZIP ___________

E-MAIL WE MAY CONTACT YOU AT ____

PRIMARY INSURANCE COMPANY____

MENTAL HEALTH PHONE # ______________________ COPAY _________ DEDUCTIBLE ____________ AUTHORIZATION # ____________________

(YOU MAY CONTACT INSURANCE COMPANY TO GET THIS INFORMATION AND AUTHORIZATION #)

SECONDARY INSURANCE COMPANY____

MENTAL HEALTH PHONE # ______________________

COPAY _________ DEDUCTIBLE ____________

AUTHORIZATION # ____________________

(YOU MAY CONTACT INSURANCE COMPANY TO GET THIS INFORMATION AND AUTHORIZATION #)

EMPLOYEE ASSISTANCE PROGRAM (EAP) EAP COMPANY NAME ____ PHONE # _____________________ AUTHORIZATION # ____

NUMBER OF UNITS AUTHORIZED ____________________

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED REGARDLESS OF REIMBURSEMENT FOR THESE SERVICES BY MY INSURANCE COMPANY AND THAT ANY INACCURACY IN INFORMATION ON THIS FORM MAY RESULT IN NONPAYENT BY MY INSURANCE COMPANY.

Signature to contact your insurance company ____ Date ________

Signature to contact your insurance company ____ Date ________

ALL COPAYS AND BALANCES ARE DUE IN FULL AT THE BEGINNING OF YOUR APPOINTMENT

Credit Card on File Authorization

Please complete this form if you would like Turning American Families Around to keep your credit card information on file for future charges. <u>The use of this form is optional and for your convenience</u>. By utilizing this service it does not take up valuable session time to complete credit/debit card transactions. You may elect to provide payment information with each charge if you do not wish to keep your credit card on file.

Information to be completed by card holder:

Card Holder Name: ____

Card Number____

Card Type: (circle one) Visa MasterCard Discover American Express

Expiration Date: ___________________________

Security Code: _____________________________ (3 digit code on the front or back of your card)

Billing Address and Zip Code: ____

Phone: _____________________________________

Email: ____

Would you like for us to send you a receipt by text or by email? __________________________________

I, ____, authorize Turning American Families Around to charge the above credit card account for psychotherapy services. I agree to update any information regarding this account. The above information is complete and correct

____ ___________________

Cardholder Signature Date

IMPORTANT SIGNATURES: **Please read and initial those statements you agree to:**

_____ I understand that counseling children becomes a family matter and that as a parent I am willing to participate in counseling.

_____ I understand that since my child is a minor that I or other responsible adult must be present at each session.

_____ I agree to keep my counselor aware of my needs, resolving any difficulties which may arise and that I am free to terminate counseling at any time.

_____ I understand I am consenting only to those mental health services that my counselor is qualified to provide within the scope of the professional (or his/her supervisor's) license, certification, and training he/ she has obtained.

_____ I understand my treatment will be kept in confidence. Release of information will only occur by my informed, signed, and witnessed consent. The only exceptions to this are those required/allowed by law, including but not limited to perpetration of child abuse, elder abuse, sexual abuse, danger to self or others, and treatment of minors.

_____ I authorize my counselor to release necessary medical information to appropriate third parties for reimbursement purposes and/or to persons authorized to conduct service utilization reviews.

_____ I am responsible for payment for services rendered regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company.

_____ I agree to notify my counselor immediately whenever I have lost insurance coverage or I have changes in my employment health insurance.

_____ I understand and agree: I am personally and fully responsible to pay for all services rendered; if I have insurance with a carrier which has a contract with Elton M. Priddy, MA, LCPC his office will file claims on my behalf.

_____ I have received a copy of HIPPA -Policies and Practices to Protect the Privacy of Your Health Information.
(see form)

_____ I understand that all fee's or co-pay are due at the beginning of each session.

_____ I understand the Cancellation Missed Appointment Policy. (see attached document).

_____ Litigation Limitation – It is agree that should there legal proceedings (such as, but not limited to divorce and custody disputes, injury, lawsuits, etc.) neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or any other proceeding, nor will a disclosure of psychotherapy records be requested.

_____ I understand that the parent(s) who have medical decision making need to consent to my child's counseling except where a court order instructs otherwise due to custody issues.

_____ All information in this assessment and paperwork is correct to the best of my knowledge.

AUTHORIZED PARENT SIGNATURE ____ Date: _________

AUTHORIZED PARENT SIGNATURE ____ Date: _________

Consent to Leave Information

Turning American Families Around has adopted a policy that requires our staff to obtain authorization from the client to leave detail messages for the client if they are not available. This policy is to protect the privacy of the client and also to protect Turning American Families Around and its staff from violating the client's confidentially. If there is not a signed consent on file, our staff will only leave their name and phone number on an answering machine, voice mail, or with the person answering the phone asking the patient to return the call.
By completing the consent form below, you are allowing the staff of Turning American Families Around to leave a detailed message on an answering machine, voice mail or text message with a specific individual. You can specify what information can be left and with whom.
I give my consent to the staff of Turning American Families Around to leave a message regarding appointment times, billing and other information necessary.

___ On answering machine or voice mail at home. Phone number ___________________________________

___ On an answering machine or voice mail at work. Phone number _________________________________

___ On cell phone via voice mail or text messages Phone number ___________________________ Phone number ________________________

___ With ________________________Relationship __________________

___ With ________________________Relationship __________________

___ I do not want messages left at home, work, or my cell phone or with any other person.

___ Correspondence may be sent via e-mail at ____________________________________

___ Correspondence may be sent via US Postal Service to my home address.

___ By law is there anyone we should not talk to about this child's information? ____
____
____
____

Client Signature ____ Date ____________

Client Signature ____ Date ____________

Witness ____ Date ____________