# Child/Adolescent Registration Form

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Gender: _____ Age: _____

Primary Phone: _____ H W C Other Secondary Phone: _____ H W C Other

Is it okay to leave a message? _____ YES _____ NO If yes, which one? _____

Address: _____City: _____ State: _____ Zip: _____

Name and relationship of person bringing in client:_____

Parent/guardians names: _____

Parents Marital Status (circle): SINGLE – MARRIED – SEPARATED – DIVORCED – LIVING TOGETHER – WIDOWED – OTHER

Parents Occupations: _____

Emergency Contact #1: _____ Relationship: _____

Primary Phone: _____ H W C Other Secondary Phone: _____ H W C Other

Emergency Contact #2: _____ Relationship: _____

Primary Phone: _____ H W C Other Secondary Phone: _____ H W C Other

**Please list all current household members:**

| Name | Age | Gender | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please list significant people or family members not currently in the household:**

| Name | Age | Gender | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Reason for seeking counseling: _____

_____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

**Please check each item that is a concern to you or your child regarding him/her:**

| | | | |
|---|---|---|---|
| ____ Appetite/Weight | ____ Stomach Aches | ____ Health Problems | ____ Abuse, physical |
| ____ Bowel Problems | ____ Headaches | ____ Sleep – too little/much | ____ Abuse, sexual |
| ____ Depression | ____ Loneliness | ____ Suicidal Thoughts | ____ Abuse, mental/verbal |
| ____ Low Energy | ____ Unhappiness | ____ Tiredness | ____ Neglect |
| ____ Feeling Inferior | ____ Shyness | ____ Making Decisions | ____ Visitation/Custody |
| ____ Work | ____ Career | ____ Ambitions – too little/much | ____ Separation |
| ____ Concentration | ____ Education | ____ Difficulty Relaxing | ____ Marriage |
| ____ Anger | ____ Temper | ____ Self Control | ____ Sexual Problems |
| ____ Self-Harm | ____ Discipline | ____ Being a Parent | ____ Alcohol Use |
| ____ Nervousness | ____ Stress | ____ Fears | ____ Thoughts |
| ____ Legal Matters | ____ Finances | ____ Friends | ____ Drug Use |
| ____ Nightmares | ____ Dreams | ____ Memories | ____ Other |

Other: _____

**Please mark symptoms your child has with the number of times per week:**

| | | | |
|---|---|---|---|
| _____ Anxiety | _____ Anger | _____ Overeating | _____ Acts out sexually |
| _____ Bedwetting | _____ Defiance | _____ Undereating | _____ Masturbates excessively |
| _____ Day wetting | _____ Controlling | _____ Sleeplessness | _____ Unusual sexual knowledge |
| _____ Day pooping | _____ Lack of empathy | _____ Nightmares | _____ Plays out sexual themes |
| _____ Obsesses | _____ Lying | _____ Hyper vigilance | _____ Plays out violent themes |
| _____ Depression | _____ Low impulse control | _____ Startles easily | _____ Homicidal themes/actions |
| _____ Low energy | _____ Stealing | _____ Self-Harm | _____ Suicidal thoughts/actions |
| _____ Shy | _____ Drug/alcohol use | _____ Running away | _____ Stomachaches/Headaches |
| _____ Tantrums | _____ Impaired Conscience | _____ Peer Problems | _____ Spacing Out |
| _____ Violent | _____ Excessive crying | _____ Low concentration | _____ Feeling inferior |
| _____ Grief | _____ Putting self down | _____ Memories | _____ Academic Problems |

Other: _____

If Self-Harm is evident, please describe: _____

_____

Please list any allergies: _____

Please list any specific fears: _____

_____

Is there anything else that concerns you or your child? _____

_____

Patient Name: _____ Date of Birth: _____

**Health History**

Overall health condition of child (circle one): VERY GOOD – GOOD – AVERAGE – FAIR – POOR

Recent weight gain or loss? ___YES ___NO If yes, how much? _____

Last Physical Exam: _____ Report: _____

Please list any significant medical conditions or childhood diseases: _____

_____

Please list any medications currently using and dosage/frequency: _____

_____

_____

Please list any unusual situations surrounding pregnancy, birth, and delivery: _____

_____

_____

**School History**

School Attending: _____ Average Grades: _____

Please list any teacher's concerns regarding behavior/learning if there are any: _____

_____

Please check if your child has any difficulties at school with any of the following:

| | | |
|---|---|---|
| _____ Writing | _____ Reading | _____ Arithmetic |
| _____ Poor Coordination | _____ Retaining information | _____ Making friends |
| _____ Bullying | _____ Being Bullied | _____ Keeping friends |
| _____ Concentration | _____ Responsibility | _____ Other |

Other: _____

Please list your child's strengths in school: _____

_____

**Legal History**

Please list any custody disputes or arrangements in place for the child: _____

_____

Is child/adolescent currently on probation or parole: ___YES ___NO If Yes, explain: _____

_____

Are any family members currently on probation/parole or currently incarcerated: ___YES ___NO If Yes, explain: _____

_____

Patient Name: _____ Date of Birth: _____

**Family History**

Describe for each parent the quality of home life (ie: happy, tense, communication, relations with children, stability, security, abuse, ect): _____

_____

Please describe the type of discipline used in the family/with the child: _____

_____

Describe the relationship between the child and parents: _____

_____

Describe how the child gets along with others within the family: _____

_____

Please list how many moves the family has made and the age of the child at each move: _____

_____

Did either parent have similar characteristics or problems as a child? ___YES ___NO If yes, please describe: _____

_____

Please list any history of mental illness within the family and their relation to the child: _____

_____

**Personality of Child**

Please check all that apply:

| | | | |
|---|---|---|---|
| _____ Tense | _____ Relaxed | _____ Restless | _____ Calm |
| _____ Daydreamer | _____ Self Starter | _____ Active | _____ Sluggish |
| _____ Stubborn | _____ Eager to please | _____ Easy to manage | _____ Disobedient |
| _____ Happy | _____ Sad | _____ Angry | _____ Loving |
| _____ Aloof | _____ Friendly | _____ Secure | _____ Easily frightened |
| _____ Bod | _____ Cautious | _____ Whiny | _____ Generous |
| _____ Jealous | _____ Cruel | _____ Aggressive | _____ Affectionalte |

_____ Relates easily to adults _____ Relates poorly to adults _____ Attached to certain toys/objects

Child's life in general (circle one): VERY HAPPY – HAPPY – AVERAGE – UNHAPPY – VERY UNHAPPY

Child's life in past 6 months: (circle one): VERY HAPPY – HAPPY – AVERAGE – UNHAPPY – VERY UNHAPPY

Please describe your child's greatest fear: _____

_____

Please describe your child's greatest hope: _____

_____

Please note anything else you would like us to know: _____

_____

Patient Name: _____ Date of Birth: _____

**Insurance Information**

**Primary Insurance**: _____ Policy Holder: _____
Policy or ID#: _____ Group #: _____
Employer: _____ Policy Holder DOB: _____
Policy Holder's Address (if different from patient): _____
Effective date of Policy: _____ Copay/Deductible: _____
**Secondary Insurance**: _____ Policy Holder: _____
Policy or ID#: _____ Group #: _____
Employer: _____ Policy Holder DOB: _____
Policy Holder's Address (if different from patient): _____
Effective date of Policy: _____ Copay/Deductible: _____

I hereby authorize Behavioral Health Counseling to:

- furnish my insurance company with any/all information requested concerning my present claim(s), including records if requested.
- Bill my insurance company and accept payment from that company on my behalf for all services relating to my care.

I acknowledge that:

- All of the information in this Registration Form is complete and true to the best of my knowledge.
- I am responsible for all charges not covered by my insurance, including missed appointments.
- Any money credited as overpayment due to me will be refunded after completion of treatment.
- I will be charged for any appointment that I fail to keep or cancel at least 24 hours prior to the scheduled time.

Signature: _____ Date: _____

**Communications Consent**

| | |
|---|---|
| Phone #1: _____ H W C Other<br>☐ Okay to leave a message with information<br>☐ Leave message with call back number only | Phone #2: _____ H W C Other<br>☐ Okay to leave a message with information<br>☐ Leave message with call back number only |
| Appointment Reminders: Our office may use an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference of contact:<br>☐ Home Phone<br>☐ Cell Phone<br>☐ Text Message to Cell Phone | |

**Communications with other Healthcare Providers**

Please list the name, address, and phone number of any healthcare provider that you would like us to be able to communicate with and/or share medical records, diagnosis, etc. (i.e. your primary care physician).

| | |
|---|---|
| Name: _____<br>Address: _____<br>_____<br>Phone: _____<br>Fax: _____<br>Type of Provider: _____ | Name: _____<br>Address: _____<br>_____<br>Phone: _____<br>Fax: _____<br>Type of Provider: _____ |

I hereby authorize Behavioral Health Counseling to contact me in the manner I have selected above. I also authorize Behavioral Health Counseling to contact and/or share information regarding patient care such as medical records, mental health records, office reports, treatment plans, and diagnosis with the above listed providers in the interest of continuity of care.

Signature: _____ Date: _____

# BEHAVIORAL HEALTH COUNSELING
## HIPAA Privacy Notice
## Notice of Privacy Practices
**Effective Date: March 16, 2017**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### What is this Notice and Why is it Important?

As of April 2003. a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how the practitioners at Behavioral Health Counseling, LLC are required to be HIPAA compliant will protect your medical information, howl may use or disclose this information, and describes your rights. If you have any questions about this notice, please contact us directly at

### Understanding Your Health Information.

During each appointment, we record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors. your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed
- A tool with which we can assess and work to improve the care we provide

### Your Health Information Rights.

You have the following rights related to your medical record:

- Obtain a copy of this notice. – You can read this notice in the waiting room, and you can also obtain your own copy if you would like. It will take up to 10 days to produce records.
- Authorization to use your health information. – Before we use or disclose your health information, other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- Access to your health information. – You may request a copy of your medical record from us at any time.
- Change your health information. – If believe the information in your record is inaccurate or incomplete, you may request that we correct or add information.
- Request confidential communications. – You may request that when we communicate with you about your health information, we do so in a specific way (e.g. at a certain mail address or phone number). we will make every reasonable effort to agree to your request.
- Accounting of disclosures. – You may request a list of disclosures of your health information that we have made for reasons other than treatment, payment or healthcare operations.

### Our Responsibilities

We are required by law to protect the privacy of your health information, to provide this notice about our privacy practices, and to abide by the terms of this notice. we reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice. Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.

## When Can We Legally Disclose Your Health Information Without Your Specific Consent?

• To facilitate your medical treatment. – For example: Your primary care physician might call us to discuss your treatment, and in that situation, we would disclose information about your diagnosis, your medications, and so on.
• To collect payment for health care services that we provide. – For example: To get paid for our services, we have our billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, we fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis.

## Will we Disclose Your Health Information to Family and Friends?

While the new law allows such disclosures without your specific consent (if it contributes to your treatment), our office policy is that we will never share your clinical information with your family without a signed authorization from you. The BIG EXCEPTION to this is if we believe you pose an immediate danger to yourself or someone else—in that case, we will do whatever is necessary, even if that means breaching confidentiality.

## Less Common Situations in Which We Might Disclose Your Health Information

• Workers compensation: we may disclose your health information to comply with laws relating to worker's compensation or other similar programs.
• Law enforcement: we may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order. This includes any information requested by the Department of Social Services (DSS) related to cases of neglect or abuse of children.
• Food and Drug Administration (FDA): we may disclose to the FDA your health information relating to adverse events due to medications.
• Business associates: we hire a billing company to send out bills to insurance companies. Some of the employees of this company have access to a small portion of your health information to allow them to do their job.

## For More Information or to Report a Problem.

If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us any time at 304-232-7232. If you feel your privacy rights have been violated in any way, please let us know and we will take appropriate action. You may also send a written complaint to:

Department of Health & Human Services, Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Avenue
S.W. Room 509 HHH Building
Washington, D.C. 20201

**We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and disclose your health information. Please sign this form to acknowledge receipt of this notice.**

**Patient Name: _____**

**Signature: _____ Date: _____**

**Witness Signature: _____ Date: _____**

Behavioral Health Counseling
1025 Main St. Suite 310
Wheeling, WV 26003
Ph. 304-232-7232 Fax. 304-232-1852
Jamie J. Davis, MA, LPC – owner/therapist

# CONSENT TO TREATMENT FORM

**IMPORTANT INFORMATION AND CLIENT CONSENT:** Please read and sign at the end stating you have fully read and understand the information below.

**CLIENT/THERAPIST RELATIONSHIP**: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

**AVAILABLE SERVICES**: Behavioral Health Counseling, LLC and all its affiliates offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed mental health professionals. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

**RISKS AND BENEFITS**: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

**COUNSELING**: We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your therapist will determine your concerns, and if both agree that we can meet your therapeutic needs, a plan of treatment will be developed. Should you choose not to follow the plan of treatment provided to you by your therapist, services to you may be terminated.
The goal of Behavioral Health Counseling, LLC is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current therapist are not a good fit, please discuss this matter with your therapist to determine if transferring to a more suitable therapist is right for you. If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.
Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

**YOUR RIGHTS:** It is the policy of Behavioral Health Counseling, LLC that all individuals who are seeking and/or receiving services from any of our programs will be provided with effective, efficient services. These services will be directed toward health and habilitation. As an individual receiving services at our offices, you have the following rights:

To be treated with consideration and respect for human dignity;
To receive quality treatment regardless of race, religion, sex, age, ethnic background, mental and/or physically disabling condition;
To be provided confidentiality and protection from any unwarranted disclosure regarding your treatment;
To be involved in planning your treatment and to be informed about your treatment process;
To be involved in your discharge and aftercare planning;
To refuse treatment to the extent permitted by law and to be informed of the possible consequences of your actions;
To expect continuity of care from one service to another, should you need another service;
To examine and receive an explanation about the bill for your services;

**APPOINTMENTS**: Appointments are typically scheduled on a weekly basis and are approximately 50-60 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your therapist. If you must cancel or reschedule your appointment, we ask that you call our office at least 24 hours in advance, whenever possible. This will free your appointment time for another client. Any lack of notice without reasonable cause will result in a cancellation fee.

**FEE SCHEDULE:**

| | |
|---|---|
| Self-Pay Diagnostic & Evaluation Session (1st visit) | $140.00 |
| Self-Pay Regular Office Visits (50-60 minutes) | $80.00 |
| Returned check fee per check | $35.00 |
| Cancellation Fee (without proper notice) | $50.00 |

A reasonable fee will be charged for copies of any records requested by the Client.

**PAYMENT/INSURANCE FILING:** Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, we will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

**EMERGENCIES**: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to be seen immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, or If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

**CONFIDENTIALITY:** Behavioral Health Counseling, LLC follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.
Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist to discuss this matter further.
By signing this Information and Consent Form, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

**DUTY TO WARN/DUTY TO PROTECT:** If my therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact any medical or law enforcement personnel deemed appropriate.

**CONSENT TO TREATMENT:** By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Behavioral Health Counseling, LLC will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.

_____ _____

**Patient's Name** **Relationship to Patient**

_____ _____

**Signature of Patient or Authorized Representative** **Date**

# *Behavioral Health Counseling*

1025 Main St. Suite 310
Wheeling, WV 26003
Ph. 304-232-7232 Fax. 304-232-1852
Jamie J. Davis, MA, LPC – owner/therapist

## 2018 FEE SCHEDULE

**INDIVIDUAL COUNSELING**

| | |
|---|---|
| Initial Session | $140.00 |
| Session: 50-60 mins | $80.00 |
| Session: 35-45 mins | $65.00 |

**MARRIAGE/COUPLES COUNSELING**

| | |
|---|---|
| Initial Session | $180.00 |
| Session: 50-60 mins | $100.00 |
| Package* | $550.00 |

*Package includes 6 full sessions (50-60 minutes each). Requires a $250 deposit due upon signing and scheduling. The remainder is due prior to the second session. Any Late Cancellation or No Show appointments will be considered a full session. Exceptions made at our discretion.

**OTHER FEES**

| | |
|---|---|
| Treatment Summary/Letter | $50.00 |
| Court Related Fees | see court related fee schedule |
| **Late Cancellation**** | **$35.00 - $50.00** |
| **No Show *** ** | **$50.00** |

**All appointments not cancelled with at least 24-hour notice is considered a Late Cancellation and will be subject to the cancellation fee. Exceptions are made at our discretion for emergencies, illnesses and weather-related cancellations. Please give as much notice as possible with reasoning.

***If a client does not attend a scheduled appointment and has not notified the office of any cancellation, this is considered a No Show and will be subject to the No Show fee. Exceptions will be made at our discretion for EMERGENCIES ONLY.