Adolescent Intake Form

13yrs old -17yrs old

Identification

Date: _____

Name: _____ Nickname: _____

Mailing Address: _____ City:_____ State:____ Zip:_____

Birth Date: _____ Age: _____ Gender:_____ Parent SSN:_____

Which parent/guardian should we call for scheduling and/or billing details? (please list full name and primary phone number): _____

Family Information

Parent's Status ☐ Married ☐ Separated/divorced ☐Remarried

Primary Household (include anyone living in the home and siblings that have moved out)

Name	Relationship to client	Age	Cell phone (only necessary for guardians)	History of mental health issues or substance abuse

Secondary Household (if applicable)

Name	Relationship to client	Age	Cell phone (only necessary for guardians)	History of mental health issues or substance abuse

If parents are separated/divorced, who do you primarily live with?_____

How often do you see each parent? Mom_____% Dad_____%

According to the parenting plan, who has medical decision making? _____

Health Information

Rate your physical health: ☐ Very good ☐ Good ☐Average ☐Declining ☐Poor

Current or relevant past health concerns?_____

Physician's Name:_____ Phone #:_____

Are you presently taking any medication? ☐Yes ☐No Drug Allergies? ☐Yes ☐No

Specify:_____

Medical Illnesses:_____Surgeries:_____

Please provide information about any previous counseling or mental health treatment (when, how long, reason for, etc.)

_____

_____

Spiritual Information

Do you believe in God?_____Religious Affiliation:_____

Describe your spiritual life:_____

Describe your family's beliefs:_____

Educational Background

What school are you enrolled in?_____What grade are you in? _____

What kind of grades do you usually get in school?_____

What kinds of problems do you have in school?_____

Additional Questions

Describe your personality:_____

_____

What are your reasons for seeking therapy at this time and what do you hope to work on?

_____

_____

Please check any concerns for the following;

☐ ADHD	☐ Academic struggles	☐ Social concerns	☐ Suicidal thoughts
☐ Depression	☐ Anger	☐ History of trauma	☐ Family conflict
☐ Anxiety	☐ Substance issues	☐ Self harm	☐ History/concern of abuse

SOCIAL MEDIA POLICY

This policy is designed to explain the specific types of communication you can expect in our therapeutic relationship. My primary concern is protecting and maintaining your privacy. Not only is this an ethical concern for me, but it is also a professional mandate. I have outlined the areas that I believe could compromise confidentiality:

Friending

I do not accept or respond to friend/contact requests from current or former clients on social media networking sites (such as Facebook, LinkedIn, etc.). Including clients on these sites poses a significant privacy risk for the client and clinician. Also, having this kind of social connection can make the boundaries of our work together confusing and less professional in nature.

Communicating outside of session

I ask that you please do not contact me via phone text messaging or on social networking sites (such as Facebook or LinkedIn). These sites are not secure for your privacy and I do not usually read texts in a timely manner.

I prefer not to use email as this is not a completely confidential means of communication. If you do choose to send me a message, please be aware that emails are managed by internet service providers and may be accessed by such providers. You should also be aware that any emails I do receive/exchange with you become part of your record.

The best way to reach me in between our visits is to call me on my office phone line. You are welcome to leave me messages at this number and to contact me on my cell phone in extreme emergencies.

Our professional relationship is highly important to me and I have adopted these policies in what I believe is for your best interest. Please do not hesitate to ask any questions or clarify any concerns you may have regarding these aforementioned communication standards.

AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

Cascade Counseling

360.866.7406 * info@cascadecounseling.net

2100 Caton Way SW * Olympia, WA, 98502

I,_____ **DOB:**_____

hereby give my permission to **CASCADE COUNSELING**, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released upon request to the following:

To:

_____

First and last name, phone and/or fax number

The type of information to be disclosed/requested is as follows:

To Be Released * *from* ***Cascade Counseling***

____Treatment Plans

____Process Notes

____Health/Medical Records (if applicable)

____Letter(s) of Progress

____Bio Psychosocial Evaluation/Assessment (if applicable)

____Scheduling and Billing

____Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **CASCADE COUNSELING.**

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **CASCADE COUNSELING** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **CASCADE COUNSELING**. **CASCADE COUNSELING** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **CASCADE COUNSELING** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire one year after signing. This agreement is subject to revocation in writing at any time.

Release:

_____

Signature Client/Next of Kin/Guardian **Date**

_____

Clinician Signature/Credentials **Date**

CLIENT INFORMATION AND OFFICE POLICY

Office Copy

(Both the parent and the teenager's signatures are required)

Cascade Counseling

Cascade Counseling was established in 1994 and houses many skilled and qualified psychologists and counselors who specialize in treating individuals, couples, families, adolescents and children. Cascade Counseling also houses a highly trained and skilled psychiatric nurse practitioner, who provides medication management for our clients. The focus of Cascade Counseling is healing the distressed and troubled life through the healthy integration of clinically proven techniques with Christian-based principles. Our goal is to help our clients uncover their true potential and lead lives worth celebrating.

Cancellation and No Show Policy

Your appointment reserves our time. Once an appointment is scheduled, you will be expected to pay for that session unless you provide at least ***48 business hours*** advance notice of cancellation. (For example, to cancel an appointment for Monday, you would need to call the previous Thursday.) The fee for failing to cancel within our policy, or not showing up for your appointment, is $100.00. These charges cannot be billed to your insurance company. Please help us serve you best by keeping scheduled appointments or calling us at least 2 business days prior to your appointment if you must cancel.

Insurance

We are contracted with several insurance plans. If we are contracted or in-network with your insurance company, your co-pay and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If you happen to be insured by a plan we are not in network with or contracted with, payment in full is expected at the time of service. Knowing your insurance benefits is your responsibility. We do, however, work diligently to make the billing process as smooth as possible to assist you. Please contact your insurance company with any questions you may have regarding your coverage prior to your appointment. Any payment made at the time of service is an estimated charge. If the prices for services are not available at the time of service, these will be included in a statement. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If there are any changes to your insurance plan (name change, new plan, change of insurance company, the addition of a secondary coverage, etc.) please give the receptionist the updated information *prior* to your appointment, as we will need to verify your new coverage. If we do not receive updated insurance information prior to the time of service, payment in full will be required. Please also note that any co-pay or deductible due on a minor's account must be paid in full by whichever adult brings them in for their session and that payment is still due at the time of service. This is also true for minors who are not running through insurance, their cash discount rate is still due (in full) at the time of service by whoever brings them in. We do have an option to put a card on file to charge at each visit if that is more convenient.

Initial Session

Your first session is general in nature. The purpose is to clarify problems, obtain personal history, answer any questions you may have and, if needed, form a plan of therapy. If your problems are best approached by another therapist, your provider will refer you.

Confidentiality

Confidentiality is very important and all conversations are considered private for clients 13 years and older. For younger children, limits of confidentiality will be discussed with parents and a mutual agreement will be reached regarding confidentiality. Consent for treatment from both parents is required in order for treatment to occur. There are some exceptions to confidentiality: regarding the report of suspected child abuse, sexual abuse of a minor, abuse of an elderly or disabled person, presenting a clear danger to yourself or others, or if your therapist receives a court order from a judge

to disclose information. According to the laws of the State of Washington and the ethical guidelines of the profession of psychology, our providers are obligated to do whatever is needed to assure your safety and the safety of others. If you are seeing more than one practitioner in this office, signing this indicates agreement in allowing your practitioners to discuss your treatment. Practitioners will only communicate for your benefit, and in a private and ethical manner. All administrative and office staff are bound to confidentiality and cannot disclose any information. This becomes especially sensitive when relatives call the office requesting information, such as an appointment time for their spouse. Even under the simplest of situations, the office personnel cannot disclose any information. If ongoing contact is to occur with a relative, regarding billing or scheduling for example, then a release of information form can be signed, specifying the information that is permitted to be exchanged. The ROI's stay on file for one year and can be revoked at any time by the client. If you see your provider and/or staff members of our office in public, we will not approach you in order to maintain this confidentiality. You are more than welcome to approach us if you choose to do so and we will respond appropriately.

Professional Records and Patient Rights

The laws and standards of this profession requires that we keep Protected Health Information about you in your Clinical Record. HIPAA provides you with several new or expanded rights. You may receive a copy of your clinical record, if you request it in writing, in the form of an ROI (Release of Information). Since these are professional records, they can be misinterpreted and /or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your provider, in session. If necessary, we can also send records to other providers if you have signed an ROI for that specific provider. Please keep in mind that there are fees when we release records. It is customary that we charge a $26.00 service fee plus $1.17 per page fee for the first thirty pages and $.88 cents per page for all other pages. If you request records, please allow ample time for your provider to prepare these records.

Crisis or Emergency

In case of crisis or emergency you can call our office (during normal business hours), or your provider (during non-business hours). Your provider will provide you with their personal number to be used for crisis or emergency situations. Please use their personal number only for the purpose of emergencies. If you do not hear from them within 15 minutes please call 911 or the crisis line at (360) 586-2800 or report to your local hospital emergency room.

This statement is for your information and is an agreement between you and Cascade Counseling regarding procedures and fees. If you have any questions, please feel free to ask.

Client Signature _____ Date_____

Parent Signature _____ Date_____

Provider Signature _____ Date_____

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