Child (Under 18) Information

Date: _____

Child Name: _____Parent/Guardian _____

Address: _____ City: _____ St: ___ Zip: _____

Client's Social Security # _____ Client's Date of Birth: _____ Grade: _____

As a parent/guardian, do you have: Shared Custody ____ Joint Custody: _____

Do you have court documents naming conservatorship? Yes ____ No ____

Home Phone: _____ Okay to call: Yes __ No __

Cell Phone: _____ Okay to call: Yes __ No __ Okay to text: Yes __ No __

Work Phone: _____ Okay to call: Yes __ No __

Email Address: _____ Okay to send reminders: Yes __ No __

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Address: _____ City: _____ State: ____

Zip:_____ Insured's Social Security #: _____

Other Household Members	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List additional household members on the back of this form.

How did you hear about this counseling service? _____

Emergency Contact: Name _____ Relationship _____

Phone number: Daytime _____ Evening _____

Child

Turning Leaf Counseling and Education Center

Stacy Schmermund-Romo, M.A., LPC, LSOTP
403 E. Hillje St., El Campo, TX 77437
Phone: (979) 253-3849
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Statement of Understanding and Consent for Treatment

BENEFITS AND RISKS OF THERAPY:

Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist.

CONFIDENTIALITY:

Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information. Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases: 1) when there is imminent danger to the client or another person, 2) when child abuse or neglect is suspected, 3) when disclosure must be made to medical personal in a medical emergency, and 4) when the therapist is compelled by law to disclose client records or information.

CLIENTS WITH DISABILITIES:

It is the policy of **Turning Leaf Counseling** to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodations should inform the therapist prior to receiving services.

NONDISCRIMINATION POLICY:

In accordance with Title VI of the Civil Rights Act of 1964 **Turning Leaf Counseling** does not discriminate against participants or clients on the basis of race, color, or national origin. Services are offered to all eligible persons.

CONSENT FOR TREATMENT/RESPONSIBILITIES OF CLIENTS:

I do hereby authorize and give my consent to **Turning Leaf Counseling** to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional discipline governing **Turning Leaf Counseling**. **Turning Leaf Counseling** does not overbook appointments. Each appointment is a reservation of resources specifically for you. **Applicable charges are made for appointments not canceled within 24 hours prior to the appointment. Initial Acknowledgment: _____**

I have read, understand and agree to the conditions of treatment described in this document.

_____ _____

Client Signature / Parent or Guardian **Date**

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interested in friends	15	_____	_____	_____
16. Fights with other children	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits the doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

Turning Leaf Counseling and Education Center

Client Information - Child

Name: _____

PROBLEM INFORMATION:

For whom are you requesting counseling(son/daughter/other)? _____

If other than you what is your relationship to them? _____

Briefly describe the nature of the problem: _____

_____

_____

Have you (or the person who will be receiving counseling) ever received outpatient counseling? Yes __ No __

If yes, from whom? _____ When? _____

Have you (or the person who will be receiving counseling) ever received inpatient treatment? If yes from whom? _____ When? _____

Are you currently being treated by a mental health professional? Yes __ No __ If yes from whom? _____When _____

Medication prescribed for mental health issues:

_____

_____

_____

Turning Leaf Counseling and Education Center

Medical Information

Name: _____ Date: _____

MEDICAL INFORMATION:
Which of the following illnesses or complaints have you (the client) experienced?
___ Diabetes ___ Head Injury ___ Ulcer ___ Irregular menses

___ High Blood Pressure ___ Thyroid problems ___ Glaucoma ___ Difficulty Sleeping

___ Epilepsy ___ Seizures ___ Dizzy Spells ___ Loss of Appetite

___ Liver problems ___ Hepatitis ___ PMS ___ Herpes

___ Kidney problems ___ Asthma ___ Back Pain ___ Sexually Transmitted Disease(s)

___ Headaches/Migraines ___ Respiratory problems ___ Frequent constipation disease(s)

___ Heart attack ___ Stroke ___ Loss of consciousness ___ Other _____

What prescription medications are you currently taking and why?

Medication	Reason for taking it
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Please identify any allergies that you have:

1. _____ 2. _____ 3. _____

What over the counter medications do you regularly take? _____

_____

Name and Phone number of your **Primary care Physician**: _____

_____

When was the last time you saw your doctor? _____ Why? _____

_____

The last time you had a physical? _____

Forms Completed By: _____ Date: _____

Relation to Client: _____

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Patient Consent for Use and Disclosure of Protected Health Information (HIPPA Acknowledgement)

I hereby give my consent for Turning Leaf Counseling and Education Center to use and disclose **protected health information (PHI)** about me to carry out **treatment, payment and health care operations (TPO)**. (The Notice of Privacy Practices provided by Turning Leaf Counseling and Education Center describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Turning Leaf Counseling and Education Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Turning Leaf Counseling and Education Center.

With this consent, Turning Leaf Counseling and Education Center may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, Turning Leaf Counseling and Education Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Turning Leaf Counseling and Education Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Turning Leaf Counseling and Education Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Turning Leaf Counseling and Education Center to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Turning Leaf Counseling and Education Center may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

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Electronic Communication

Patient Communication Policy

It is important to note that standard email and text communication is not always secure. Email and text messages can be intercepted and for this reason, our practice does not communicate personal health information through this method. Our Practice will never ask for account information, credit card numbers, or personal information via email or text message. If you think you may have received a suspicious email or text from our practice, please contact our office immediately.

Email and Text Appointment Confirmations

By enrolling in email and text appointment confirmations, you are authorizing our office to send email and text message appointment reminders to you on your provided email address and/or cell phone number. You understand that you may reply with various commands to receive account information such as balances, future appointments, office location and other alerts. You also agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply. Your enrollment indicates that you represent and warrant that you are the person legally responsible for all use of the accounts, are at least 18 years of age, and agree to all terms and conditions of use for the text messaging services. Select ONE of the following:

- ☐ I consent and accept the risk in receiving appointment confirmations via email. I understand I can withdraw my consent at any time. My email address is: _____
- ☐ I consent and accept the risk in receiving appointment confirmations via text to a mobile number. I understand I can withdraw my consent at any time. My mobile number is: _____
- ☐ I do not consent to receiving any information via email or text. I understand that I can change my mind and provide consent later.

Client Name (Printed) Date

Parent/Guardian Name (if client is under 18 years of age)

Signature (Parent/Guardian if client is under 18 years of age)