



Kate Casey, LPC, JD
 270 Miron Drive, Suite 112
 Southlake, Texas 79092

CHILD & ADOLESCENT INTAKE ASSESSMENT

Client's Name: _____ **Date of Birth:** _____ **Age:** _____
(mm / dd / yyyy)

Gender: M ___ F ___ **Ethnicity:** _____ **Referred by:**

Child's Address _____

Current School _____ **Current Grade Level:** _____

Parent Contact Information:

Name: _____ **Relationship to child:** _____

Place of Employment: _____

I consent to being contacted at the following address:

Street/Apt: _____

City/State: _____ **Zip:** _____

I consent to being contacted at the following phone numbers, including texting/leaving voicemails:

Home Phone: (____) _____ **Cell Phone:** (____) _____

Work Phone: (____) _____ **Ext** _____

I consent to being contacted at the following email address (optional): _____

Note that cell phones and email cannot be guaranteed to be a confidential form of communication.

Parent's Marital Status: Married ___ Single (never married) ___ Divorced ___ Separated ___

Widowed _____

Who is custodial parent or legal guardian? (check all that apply)

___ Mother ___ Father ___ Legal Guardian: _____

If the child is not living with both natural parents, both adoptive parents, or only living parent, Kate Casey, LPC, JD requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page. These pages must be provided before counseling can begin.

Emergency Contact Information:

In the event of an emergency (e.g. a case where the therapist determines the client may be a danger to self or someone else), I give you permission to contact the following in addition to emergency services:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Approximate combined annual household income (check one):

up to \$40,000 _____ \$40,001-\$60,000 _____ \$60,001-\$80,000 _____ \$80,001-\$100,000 _____ above \$100,000 _____

PRESENTING CONCERN:

What are the problems that cause you to seek help here for your child?

How long has your child had these problems?

How have you attempted before now to cope and/or deal with this issue(s)?

YOUR CHILD'S SYMPTOMS

Please mark all characteristics or areas of concern that apply to your child. This is to help understand the symptoms you are seeing, not to label your child.

- | | | |
|--|--|--|
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Angry | <input type="checkbox"/> Argues |
| <input type="checkbox"/> Assaults others | <input type="checkbox"/> Bossy to others | <input type="checkbox"/> Breaks the law |
| <input type="checkbox"/> Bullied by others | <input type="checkbox"/> Bullies others | <input type="checkbox"/> Cheats |
| <input type="checkbox"/> Complains of feeling sick | <input type="checkbox"/> Conflicts at school | <input type="checkbox"/> Conflicts at home |
| <input type="checkbox"/> Conflicts with friends | <input type="checkbox"/> Cries easily | <input type="checkbox"/> Cruel to animals |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Dependent | <input type="checkbox"/> Destructive |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Difficulties with parent(s) | <input type="checkbox"/> Disobedient |
| <input type="checkbox"/> Disrupts family activities | <input type="checkbox"/> Distractible | <input type="checkbox"/> Dropping out of school |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Failure in school |
| <input type="checkbox"/> Fantasy life | <input type="checkbox"/> Fearful | <input type="checkbox"/> Feelings are easily hurt |
| <input type="checkbox"/> Fidgety | <input type="checkbox"/> Fire setting | <input type="checkbox"/> Hair chewing |
| <input type="checkbox"/> Hostile | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Imaginary playmates |
| <input type="checkbox"/> Immature | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Independent |
| <input type="checkbox"/> Inflicts pain on others | <input type="checkbox"/> Insults others | <input type="checkbox"/> Intimidated by others |
| <input type="checkbox"/> Intimidates others | <input type="checkbox"/> Intolerant | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Isolates | <input type="checkbox"/> Lacks respect for authority | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Lethargic | <input type="checkbox"/> Likes to be alone | <input type="checkbox"/> Loss of friends |
| <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Lying | <input type="checkbox"/> Manipulates |
| <input type="checkbox"/> Moody | <input type="checkbox"/> Mute, refuses to speak | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Name calling | <input type="checkbox"/> Negative attitude | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> New school | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Oppositional |
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Overactive | <input type="checkbox"/> Pouts |
| <input type="checkbox"/> Provokes others | <input type="checkbox"/> Rages | <input type="checkbox"/> Relationships with siblings |
| <input type="checkbox"/> Relationships with teachers | <input type="checkbox"/> Runs away | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Self-harming behaviors (explain: _____) | | <input type="checkbox"/> Sexual behavior |

- | | | |
|--|--|---|
| <input type="checkbox"/> Sexually active | <input type="checkbox"/> Shy | <input type="checkbox"/> Slow-responding |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Social | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Suicide talk or attempt |
| <input type="checkbox"/> Swearing | <input type="checkbox"/> Talks back | <input type="checkbox"/> Teased |
| <input type="checkbox"/> Teases others | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Tics-movements or noises |
| <input type="checkbox"/> Truancy | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Under-active |
| <input type="checkbox"/> Unhappy | <input type="checkbox"/> Violent | <input type="checkbox"/> Wets/soils bed/clothes |
| <input type="checkbox"/> Other _____ | | |

MEDICAL AND DEVELOPMENTAL HISTORY

This is a very important section of our study of your child. The information you furnish is held in confidence. Please answer in the blanks provided.

Current Medical Problems? _____

Present Medications (Names and Dosage): _____

DISCIPLINE

Child is most often disciplined by: _____
 Discipline most effective with the child: _____
 Discipline least effective with the child: _____
 Explain briefly the child's most common reactions to discipline: _____

SOCIAL DEVELOPMENT

Does the child have problems relating with:
 Other Children?____ Teachers?____ Brothers/Sisters?____ Parents?____ Other Adults?____
 Does the child have problems separating from... Mother? **Yes**____ **No**____ Father? **Yes**____ **No**____
 Does the child like to play with children: ____Own Age ____Younger ____Older
 Does the child have: ____Many friends ____Few Friends ____No Friends
 Is the child a: ____Leader ____Follower ____Loner
 Hobbies or activities: _____

EDUCATIONAL HISTORY

Has the child ever participated in Special Education? **Yes**____ **No**____
 If yes, what grades did the child participate in Special Education? _____

Has the child ever repeated a grade? **Yes**___ **No**___ How many schools your child has attended? _____
 Is your child currently experiencing difficulty in school? **Yes**___ **No**___ If yes, describe

Behavioral problems in school? **Yes**___ **No**___ If yes, describe _____

Barriers to learning? **Yes**___ **No**___ If yes, describe _____

School suspensions or expulsions? **Yes**___ **No**___ If yes, describe _____

JUVENILE HISTORY

Has the child ever had problems involving the police or juvenile authorities? **Yes**___ **No**___

If yes, when and why? _____

Is the child on probation? **Yes**___ **No**___

If yes, Where? _____ Child's Probation officer? _____

FAMILY COMPOSITION

Please list family and/or significant others to the child and indicate if they live in the child's home.

<u>Member</u>	<u>Relationship</u>	<u>Age</u>	<u>Occupation & Education</u>	<u>In Home?</u>	
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N

FAMILY HISTORY

Has the child or child's parents experienced any of the following in their life?

Deaths	Yes ___ No ___	Medical Problems	Yes ___ No ___
Violence in Family	Yes ___ No ___	Legal Problems	Yes ___ No ___
Moves	Yes ___ No ___	Financial Stressors	Yes ___ No ___
Physical or Sexual abuse	Yes ___ No ___	Addiction in Family	Yes ___ No ___
Suicide	Yes ___ No ___		

Explain any items marked Yes above: _____

Significant family circumstances/stressors (current): _____

Cash, checks, MasterCard, and Visa are accepted. Any unpaid balance may be turned over to a collection agency if you refuse to remain responsible for your account. You will be expected to pay for late, cancelled, or forgotten appointments at the full rate unless you have contacted Kate Casey, by phone, voicemail, or email to cancel 24 hours before your scheduled appointment.

I agree to the above statements. I consent to be contacted at any of the addresses, phone numbers, and emails provided above (5 pages) through mail, email, calling, texting, or voicemails. I will immediately notify the therapist of any change. I understand that cell phones and email cannot be considered to be secure and confidential forms of communication. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

Signature

Relationship to Child

Date

Credit Card on File Authorization (required)

Payment is due at time of service. Our office requires that a credit card be kept on file in the event of any unpaid balances, late cancellations, or missed appointments. Cash, checks, and other credit cards may still be utilized at time services are rendered for payment.

Information to be completed by the card holder:

Cardholder Name: _____

Billing Address (required): _____

Email (optional, where statements may be sent): _____

I consent to the use of my credit card for appointments broken without 24-hour notice and for any unpaid fees or services: I understand that my card will be immediately charged the full fee for appointments cancelled or missed without 24-hours notice given. I agree to receive billing statements at the email address above that include dates and types of service. I understand that email cannot be guaranteed to be a confidential form of communication. I understand that I may choose not to provide an email address for billing, and any billing statements will instead be sent to the mailing address I have provided above. I attest that I agree to this document, and all the information provided is accurate to the best of my knowledge. I further attest that I am allowed to all the rights and privileges that are associated with this card.

Cardholder Signature

Date

Card Number: _____

Card Type: Visa MasterCard

Expiration Date: _____

CV Code: _____

****MC Visa and Discover are accepted.***

Print your name: _____

**Kate Casey, LPC JD
270 Miron Drive, Suite 112
Southlake, Texas 76092**

Limits of Confidentiality

Your disclosures here will remain confidential. My utmost concern is to guard your privacy. Nothing discussed here will be disclosed outside the therapy room, except in rare cases as required by law.

By law, it is necessary for me to report any information I have regarding the following:

- *If you are planning to take your own life*
- *If I determine that you are a danger to someone else*
- * You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person*
- *If you have knowledge of abuse or neglect taking place in a mental health or Rehabilitative facility*
- *If you are a minor---your parents have the right to know about your progress*
- *If your records are subpoenaed in connection with a legal proceeding*
- *If a professional offering mental health services is being sexual with you*
- *If you are in therapy along with someone else (i.e., couples or family therapy), these notes are the property of both parties, and can be obtained by any of the parties involved.*
- *If required by the Secretary of the Department of Health for investigating compliance with the Privacy Rule.*

If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

I consult regularly with other professionals regarding my clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

Finances

Therapy costs are as follows:

- *50 minute individual session \$200**
- *75 minute individual session \$300**
- *50 minute couple/family session \$225**
- *Premarital Counseling Package \$1350**
(to include Assessment and 6 sessions)

Other services such as court appearances, travel time, writing reports or summaries, will be billed at the same rate of \$125.00 per hour. I do not provide counseling services via email or text messaging. Should you need immediate mental health attention, you should call 911 or go to your nearest emergency room.

Cancellations: *If you must cancel an appointment for any reason, please give at least 24-hour notice. Otherwise, you will be billed the regular session fee per the amount of time you scheduled.* Cancellations may be left on voicemail or email (817-881-1914 or Kate@AutumnRidgeLPC.com).

If you are late to a session, I will wait 10 minutes, unless you call (817-881-1914) to say you're on your way. Clients arriving late for a session will receive the remainder of the scheduled appointment slot (e.g. 2:00pm-2:50pm) and will be responsible for the full fee.

Forms of Payment: Cash, check, Visa and MasterCard are accepted as payment. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I can use legal or other means (courts, collection agencies, etc.) to obtain payment.

Insurance Reimbursements: Please note that this office does not accept insurance, but upon request, I can provide documentation of out-of-network services for you to submit to your insurance company, if you choose to do so. Cancellation fees are not likely to be covered. It is your responsibility to verify the specifics of your coverage. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk regarding confidentiality of computerized records.

My Contact Information

Email: Kate@AutumnRidgeLPC.com / Phone/Voicemail: 817-881-1914

If you need to contact me between sessions, please leave a voicemail on the phone number above and your call will be returned as soon as possible. I check my voice messages a few times during the daytime only, unless I am out of town. If an emergency situation arises, you can call 911, the Suicide Crisis Hotline 214-828-100 or 1-800-273-TALK, or the MHMR Crisis line at 817-335-3022 or 1-800-866-2465 or the Police. Please do not use the phone or email for emergencies as I cannot assure I will get your call/email in a timely manner.

The phone number listed is a cell phone number. Email and cell phones cannot be guaranteed to be a secure and confidential form of communication. It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Please notify me if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, or phone messages. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, e-mail, or voice mail for emergencies.

Emergencies

I **do not** provide 24 hour crisis counseling. Should you need immediate mental health attention, you should call 911 or go to your nearest emergency room. If there is an emergency where I become concerned about your personal safety or the possibility of you injuring someone else, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may contact the police, suicide assessment services, or other emergency personnel and/or the person whose name you have provided on the biographical sheet as the emergency contact. You may request at any time to update your emergency contact person.

Records

Unless otherwise agreed to be necessary, I retain clinical records only as long as is mandated by state law, five years from the last date of contact. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. Considering all of the above exclusions, if it is still appropriate, and upon your request, I will release information to any agency/person you specify in writing. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

Agreements

Mediation: I agree that I will seek mediation in the event of any dispute with the therapist regarding the therapist-client relationship. All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator chosen will be one to which both parties can agree. The costs of mediation shall be equally shared. Judgment upon the award entered by the mediator shall be binding upon the parties and may be entered by either party in a court of competent jurisdiction.

Court Involvement: I agree that I am seeking treatment for the purpose of therapy only and not for legal purposes. I waive the right to subpoena the treating therapist. If the therapist is subpoenaed by any party, I agree to compensate the therapist for time spent producing records and being present in court at the full rate of \$85 per hour with a minimum of two hours per court date.

Therapist's Incapacity or Death: I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

Contact: I consent to the telephoning of my home, business, or cell phone numbers I have provided on the intake assessment form, including texting or having messages left on voicemail. I consent to communication by email for any email address I have provided. I understand that communication via email or on a cell phone is not considered secure and confidential.

Emergency Contacts: In the event that Kate Casey, LPC, JD reasonably believes that I am a danger to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in a position to prevent harm to myself or another person, in addition to suicide assessment services, medical and law enforcement personnel, and the following persons:

Name	Relationship	Phone

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that I have received and reviewed. I acknowledge the potential of the redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

A photocopy or fax of this consent is as valid as the original.

I have read and understand the above information and agree to the limitations and restrictions set forth herein. I have received a copy of this document and any questions have been answered to my satisfaction. **I voluntarily agree to receive mental health care, assessment, treatment, or services and understand I can terminate such services at any time.**

Client Signature

Date

Kate Casey, LPC, JD

Date



Kate Casey, LPC, JD
270 Miron Drive, Suite 112
Southlake, Texas 76092

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have read and understand this office's Notice of Privacy Practices, available in paper format in the office and online at www.AutumnRidgeLPC.com. Any questions I had have been answered to my satisfaction. I understand that I may request a paper copy to take with me at any time and one will be provided to me.

Patient name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ **Patient refused to sign.**

_____ **Communication barriers prohibited obtaining the acknowledgement.**

_____ **An emergency situation prevented this office from obtaining it.**

_____ **Others:** _____