clearhope
counseling & wellness

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6021 Fairmont Suite 200 Pasadena, TX 77505
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www.clearhopewellness.com
281-769-2238

Child Intake Form

Name of Child: _____ Age: _____ Birth Date: _____ Gender: _____

Parent/Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Child's School/Daycare: _____ School Phone #: _____

Grade: _____ Teacher(s): _____

Please list any medications your child is currently taking, including psychotropic medications:

_____

Please describe any medical conditions or your child I should be aware of (allergies, injuries, illnesses, etc):

_____

_____

Please describe your current household composition (names, ages, and relationship of those living with your child):

_____

_____

Please describe the role, if any, faith and religion play in your family:

_____

_____

The reason I am seeking therapy for my child is:

_____

_____

What have you already tried to correct or resolve this problem?

_____

_____

What are you most concerned about?

_____

_____

What changes would you like to see as a result of therapy?

_____

_____

Child History

Name of Child: _____ Age: ___ Gender: _____

Is your child adopted?---------- yes no

Has your child ever been or is he/she currently in foster care?---------- yes no

Explain:_____

Has your child received any previous counseling or treatment?---------- yes no

Explain:_____

Were there any problems or complications during pregnancy or birth?------- yes no

Explain:_____

Has your child experienced any form of abuse (physical, emotional, sexual)? yes no

Explain:_____

Has your child experienced any significant trauma or losses?---------- yes no

Explain:_____

Has your child experienced any divorces or separations?---------- yes no

Explain:_____

Does your child have difficulty at school or daycare?---------- yes no

Explain:_____

Does your child generally get along with other children his/her own age?---- yes no

Does your child generally get along with adults?---------- yes no

Does your child have unusual eating patterns?---------- yes no

Explain:_____

Does your child have unusual sleeping patterns?---------- yes no

Explain:_____

Child's Family History

Current custody status: _____

Visitation arrangements: _____

What are your main approaches to discipline?_____

_____

Which approaches to discipline have shown the most success? _____

_____

Which family members, including extended family, suffer from any form of mental illness?

_____

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Consent to Treat a Minor

Name of minor client: _____

Date of birth: _____

This is to certify that you give permission to _____ (therapist) for the treatment of your child, _____.
This treatment may include individual or group psychotherapy, counseling, and testing.
This treatment may also include referrals to other professional agencies.

It is very important that the parent/guardian be involved in the therapeutic process. By signing this consent form, you are also agreeing to attend occasional sessions at which your presence is requested.

In addition, you as a parent/guardian agree to the following stipulations:

- Although your child is a minor, he/she has the right to confidentiality. This confidentiality is crucial for a child to feel safe and secure in the counseling environment and a necessary ingredient for treatment success. You agree to honor this right to confidentiality. Children age 14 and older have the right to full client privilege. Parents of children younger than 14 have the right to information regarding the minor's treatment so long as it is in the best interest of the child.
- In cases of divorce or parental conflict, you agree to not request that I participate in any court proceedings, to include but not limited to, testifying, providing records, or writing letters of summary or recommendation. If my participation is required by the courts and legal entities, you agree to pay a retainer of $1000 per day and the rate of $125 per hour for my presence and participation in legal/court proceedings.

**I have a legal right to ☐ sole / ☐ shared medical decision making regarding the following children:

I understand that I may revoke this authorization by submitting my request in writing to my therapist.

_____

Signature of Parent or Legal Guardian Name (please print) Date

_____ _____

Signature of Therapist Date

SCHOOL BASED SERVICES SHARED INFORMATION CONSENT:

☐ YES, I give my consent for the therapists and school to share private health and educational information with the intent to further support my child's mental health and educational needs.
☐ NO, I do NOT give my consent for private health information to be shared between the school and the therapist at this time.

**In cases of joint custody or shared allocation of parental responsibility for medical decisions, a copy of the divorce decree and custody order along with signatures indicating consent from both parents are required in order to treat a minor, except in emergencies.

Financial Agreement Form and Privacy Disclosure

Please review the Financial Agreement and Privacy Disclosure:

1. To pay $145 for the initial assessment and $135 per 53-minute session thereafter.
2. Average treatment plans are 10-12 sessions in length and vary based on individual need.
3. To pay an hourly rate of $135 for time spent preparing and writing any formal or legal documentation including but not limited to court letters, disability determinations, assessments, and treatment summaries.
4. Payment is expected at the beginning or end of each session unless prior arrangements have been made.
5. Appointments not canceled or rescheduled 24 hours in advance may be charged a $75 no-show fee, which must be paid before the next session, and will be charged to the credit card on file.
6. Clients arriving more than 7 minutes late to their regularly scheduled appointment will need to be rescheduled, and will be subject to the aforementioned $75 no-show fee.
7. A $25 service charge will be added to all returned checks and must be paid at the next session.
8. In the event a therapist is required to attend court proceedings, a retainer of $1000 per day is required before participation in legal proceedings. Charges will be incurred at the rate of $125 per hour + the allowable IRS mileage reimbursement rate.
9. Payments of fees are the full responsibility of the client. Insurance is billed as a courtesy and does not guarantee that any/all fees will be covered by insurance.
10. Benefit Check Disclaimer: While we try to be as accurate as possible when verifying benefits, your fees may change depending on your eligibility and benefits during the date of your sessions. This is an estimate as of today, and we won't know your exact fee until we bill your insurance and get your explanation of benefits back from your insurance company. You are also encouraged to call the number on the back of your insurance card and ask your member representative about your 'mental health, outpatient, office visit' benefits. Please let us know if you have any questions about your benefits.
11. In accordance with the No Surprises Act, a “Good Faith Estimate for Health Care Items and Services,” will be discussed and agreed upon with my therapist during the initial assessment.

Explanation of any alternate payment plan:

☐ FBISD VOCA
☐ LPISD Grants

INSURANCE INFORMATION

Name of Insurance Company: _____
Insurance Company Address: _____
(City)_____ (State)_____ (Zip Code)_____
Phone Number: _____ Place of Employment: _____
Subscriber Name: _____ Date of Birth: _____
Policy ID:_____ Group Number: _____

I understand the above payment procedures and I agree to this plan of payment.

Client Signature _____ Date _____

I give Clearhope Counseling & Wellness Center, PC permission to bill my insurance as indicated above.

Client Signature _____ Date _____

I have received a copy and reviewed the Clearhope Counseling & Wellness Privacy Disclosure: Your Information. Your Rights. Our Responsibilities.

Client Signature _____ Date _____

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Notice of Compliance with The Consolidated Appropriations Act of 2021 and the “No Surprises Act”

Effective January 1, 2022, a ruling went into effect called the **"No Surprises Act"** which requires practitioners to provide a **"Good Faith Estimate"** about out-of-network care.

Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers and health care facilities are required to inform individuals who are not enrolled in an insurance plan or a Federal health care program, or not seeking to file a claim with their plan, that prior to service and upon request they are entitled to receive (both orally and in writing) a "Good Faith Estimate" of expected charges.

Note: The PHSA and GFE does not currently apply to clients who are using insurance benefits, including "out of network benefits" (i.e., submitting superbills to insurance for reimbursement). However, we are furnishing this information to all clients so that you may understand your estimated charges in the event that your health insurance expires, or you choose to become a cash pay client. These charges would also apply if you received services after the expiration of your health insurance plan and did not give us prior notification of the expiration.

Disclaimer
This Good Faith Estimate shows the costs of services that are reasonably expected for your mental health care needs. The estimate is based on information known at the time the estimate was created. The good faith estimate is not a contract and services can be discontinued at any time.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could require more sessions depending on your progress. Any changes to the treatment plan will be discussed with the therapist as needed.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 800-985-3059. Keep a copy of this Good Faith Estimate in a safe place.

PRIVACY DISCLOSURE: YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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.

YOUR RIGHTS	YOUR CHOICES	OUR USES AND DISCLOSURES
Your have the right to: • Get a copy of your paper or electronic medical record • Correct your paper or electronic medical record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated	You have some choices in the way that we use and share information as we: • Tell family and friends about your condition • Provide disaster relief • Include you in a hospital directory • Provide mental health care • Market our services and sell your information • Raise funds	We may use and share your information as we: • Treat you • Run our organization • Bill for your services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests • Work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**

  We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**

  We can use and share your health information to run our Clearhope Counseling & Wellness, PC, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

- **Bill for your services**

  We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research We can use or share your information for health research.

Comply with the law We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

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Credit Card Authorization Form

Payments are due at the time of service. Clearhope Counseling & Wellness Center requires a credit, debit, or flex spending/HSA card on file in order to schedule sessions. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (in which case, the credit card on file will be charged our full fee on the day of scheduled session). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please check the box and sign below:

☐ Please charge my card for charges in full for sessions at the time of service.

Client Name:		
Cardholder Name:		
Credit Card Number:		
Expiration Date:	Billing Zip Code of Credit Card:	Security Code:
Cardholder's Signature:		Date:

I understand that by signing above, I am authorizing Clearhope Counseling & Wellness Center to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancel fees.

Consent & Statement of Understanding:

Telehealth Video Sessions

Client Information

Name _____ Date of Birth_____

Home address_____ Zip_____

Phone: (Work)_____ (Home)_____ (Cell)_____

I hereby authorize Clearhope Counseling and Wellness and its associates to use Google Meet, Zoom, Doxy.me, Vsee.com and other Hipaa compliant platforms for telecommunication as a means for psychotherapy. I further attest that since I have chosen this form of communication, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent Clearhope Counseling & Wellness has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

_____ _____

Client's signature (age 12 and older) Date

_____ _____

Parent/guardian of minor OR of legally disabled recipient Date

Video Surveillence

Cameras are used in Clearhope's common areas (waiting rooms, hallways) to provide security for clients and clinicians. Cameras are not present anywhere private, treatment rooms (therapists' offices). Sessions should not be audio or video recorded without two-party consent between the therapist and any other individuals present in the session. A THERAPIST DOES NOT HAVE A LEGAL OR ETHICAL OBLIGATION TO ALLOW A CLIENT TO RECORD SESSIONS.

Communication

Our office uses TherapyNotes to send automated text and email reminders for all appointments. Email reminds will go out approximately 48 hours prior to the appointment, and text messages will go out 24 hours prior. Please let your therapist know if you would like to opt out of automated reminders.

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH
AND OTHER PERSONAL HEALTH INFORMATION

I,_____hereby authorize _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange/release any and all records or information regarding _____
(Name of Patient)

The following items must be **checked** to be included in the use and/or disclosure of other health information:

☐ Diagnosis/Treatment Plan ☐ Mental health information ☐ Psychotherapy Notes

☐ Drug/alcohol diagnosis, treatment/referral

to_____ (receiving
Agency/person) (Address)

for the purpose of (please check all that apply):

☐ Continuing (health and mental health) treatment or care and continuity of care ☐ Therapist transition

☐ Billing, payment and financial matters and arrangements ☐ Consultation, advise and representation

☐ Housing or other arrangements and services ☐ Other _____

This consent is valid until (calendar date)_____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use theinformation only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur _____

_____ _____
(Client/Minor recipient) (Signature of adult Client or parent)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/orparent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.