COVENANT
FAMILY SOLUTIONS

Counseling Services Intake (Child)

Patient Information

First Name	Middle Initial	Last Name	Today's Date

Street Address	City	Zip

Birth Date:	Gender:	Phone Number:	Primary Insurance Carrier:

Email Address:	School:	Grade:

List present or previous health problems:	List any medications currently taking:

Parent/Guardian Information

First Name	Middle Initial	Last Name	Primary insurance carrier: □Yes □No

Street Address (if different):	Phone Number (if different):

Birth Date:	Employer Name:	Occupation:	Social Security #:

Email Address:	Is email contact OK: □Yes □No

Additional information/preferred method of contact:

Parent/Guardian Information

First Name	Middle Initial	Last Name	Primary insurance carrier: □Yes □No

Street Address (if different):	Phone Number (if different):

Birth Date:	Employer Name:	Occupation:	Social Security #:

Email Address:	Is email contact OK: □Yes □No

Additional information/preferred method of contact:

Family Information (Please list other family members living in home)

Name:	Age:	Relationship:	Name:	Age:	Relationship:

Other Information

What do you hope to change or accomplish by seeking help at this time? (Use the back of the form if more room is needed.)

List any agencies or other professionals who have provided counseling services in the past. (Use the back of the form if more room is needed.)

Signature	**Signature**

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Informed Consent for Treatment

We welcome you to our office, and hope that the work you do here will improve your life. The following information is important for your consideration. Your goals are more likely to be met when you understand the nature and limitations of counseling. **Your signatures below indicate that you voluntarily consent to entering therapy through an informed decision.** You may withdraw consent at any time without risk of punitive action. If you have questions about this form or the therapy process you are welcome to ask any questions and we will strive to answer them in a satisfactory manner.

Benefits and Risks

Generally, counseling is most useful for helping individuals help themselves to improve their relationships by changing feelings, thoughts, and/or behaviors. The client determines the nature and amount of change they wish to make. Most people experience improvement or resolution of the concerns that brought them to counseling, but of course, there are no guarantees; and there are some risks. For example, counseling can open new levels of awareness that may cause discomfort. If after the intake session you decide to enter treatment, your provider will review the treatment plan with you and describe the determined course of treatment, specific procedures to be followed (including the reason for use), the risks associated with participating or not participating in treatment, and alternative treatments if available.

Length of Therapy

The length of therapy will vary depending on the problem; however, as a rule we work to resolve concerns in the fewest sessions possible. If treatment extends beyond one year, we will ask you to renew your consent for treatment. When you do decide to terminate therapy, you should discuss this decision in a regular session with your therapist. Due to the nature of this clinic, if a file goes 60 days with no activity, it will be closed. If you wish to attend therapy again in the future, the file may be reopened by calling 319-261-2292. Please feel free to consult with your therapist about the length of therapy at any time.

Methods of Contact

On occasion, there may be a need to have contact outside of the normal 45-minute session. For your convenience you can contact us through email or phone. To protect confidentiality, we request email only be used to schedule or confirm appointments since it is not a secure way to communicate. If we are not available to take your call or if it is after hours, please leave a message and we will try to get back to you within 24 hours. If phone calls last over 15 minutes you will be charged a fee of $35 for each 15-minute block. If you have an emergency after hours, call 911 or the crisis hotline number.

Confidentiality

We understand that the information you share in counseling can be very personal and that by signing this ***Informed Consent for Treatment,*** **you acknowledge receipt of the** ***Notice of Privacy Practices.*** That document describes your rights and our obligations regarding the use and disclosure of that information.

Therapists at Covenant Family Solutions are required to hold information about sessions and clients in confidence and are not allowed to disclose such information without the expressed written consent of all those involved in treatment, except in the following circumstances:

1. There is clear and imminent danger to you or others in which case the therapist may be required to inform the responsible authorities and warn the identified victim. If this occurs, the therapist may inform you of their responsibilities and actions.
2. In situations of suspected physical, emotional, or sexual abuse of a child, or dependent adult abuse, therapists are required to submit a report to the Department of Human Services and may be required to contact authorities. Again, in this situation you may be informed of the therapist's responsibilities and actions.
3. Covenant Family Solutions maintains records of treatment, diagnosis, assessment, and treatment planning in accordance with state law, and to better guide your treatment and assess the effectiveness of treatment provided. You may request restrictions as to how your case information may be used or shared among staff of the group practice, but Covenant Family Solutions is not required to agree to those restrictions.
4. If the release of information is mandated by law. Some litigation may require the release of records even without the client's authorization. Therapists will not typically testify in court as this creates an irreconcilable role conflict that harms the therapeutic relationship.

Clients of therapists who are currently temporary licensed by the state of Iowa will be provided with clinical supervision. This supervision is designed to ensure that all clients are getting the highest level of services. Supervision includes: case reviews and discussions, viewing sessions that have been video recorded, sitting in on live sessions, and chart audits.

Billing and Fees

The fee for a standard 45-minute session is $145, except for the initial consultation, which is billed at a higher rate. Additional time will be charged in one-half hour increments at $50 each. Payments are to be made immediately following each session. If there is a returned check, the charge will be $25. Please be aware that if your outstanding balance exceeds $145 we will not be able to schedule further appointments until the balance is paid. Outstanding balances will be forwarded to a collection agency after 90 days of non-payment.

When requested, we can assist you in seeking payment from your insurance by providing necessary information to your insurance carrier. **In signing this form, you authorize Covenant Family Solutions to bill and seek payment from third-party payers on your behalf.** If a health insurance will be covering your psychotherapy you are required to pay your co-payment at each session. Payments will be accepted form of check or credit card only. **If insurance denies coverage or payment for any reason, you remain responsible for paying any outstanding balance.**

Fees for court appearances, whether by subpoena or client request, are $145 per hour. The fee includes travel and prep time that may be required for the appearance. Emails or phone calls with attorneys, even at the request of a client, will be charged at $75 per incident. In addition, there is a cost-based fee to process a request for records to be released to court, an attorney, or other individual. These fees are incurred on top of regular session fees. Covenant Family Solutions reserves the right to not respond to requests to appear in court or provide documents.

Cancellation of Appointment

If you need to change or cancel an appointment, as a courtesy to your counselor and the office, please notify us at least ***24 hours*** in advance. You will be personally charged $50 for not showing for an appointment and $25 for late cancellations, except in emergency situations or as otherwise prohibited. After three occurrences you also may be asked to seek services elsewhere.

By signing this form, you acknowledge that a copy of the Covenant Family Solution's Grievance Policy, as well as a copy of a Patient's Rights and Responsibilities has been made available to you.

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the counseling process at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

Payment arrangement is as follows: *INSURANCE: YES* _____ *NO* _____ *CLIENT PAY: $* _____

Parents of minors receiving services: I authorize_____to receive services provided by Covenant Family Solutions. This authorizes any necessary psychological and/or psychiatric evaluation and treatment. My signature below indicates that I agree and give consent to the above services. I also understand that parental participation in one or more of the following ways may be required: assessment, individual counseling, marital counseling, family counseling, parenting skills training or group counseling.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

Note: For new clients this form is only needed if you already know you want us to communicate with a third part (e.g., a doctor).

Release of Information

Client name: **DOB:**

I, hereby authorize Covenant Family Solutions to release verbal and/or written information to:

_____ _____ _____

Name of person or entity information is to be released/received **Phone** **Fax**

_____

Address

For the following purposes:

□ All of the following: □ Treatment and assessment □ Coordination of care □ Referral of new or additional services
□ Other_____

Specific information to be released includes:

□ All of the following: □ Assessment and diagnosis □ Treatment goals □ Session content □ Discharge
□ Other_____

I understand that by signing this General Authorization I am authorizing Covenant Family Solutions to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to Covenant Family Solutions.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Covenant Family Solutions. I understand that my revocation of this General Authorization will not affect a disclosure that Covenant Family Solutions has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Covenant Family Solutions' confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized. I understand that signing this is not a condition of receiving services. This authorization will expire on_____ or 12 months from the date it was signed.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(**Initial any category <u>NOT</u> to be released**)

_____HIV/AIDS_____ Genetic information including genetic test_____Mental Health_____Substance Abuse

_____ _____ Printed name and signature of Client and/or Client's Parent or Legal Guardian	Date
_____ _____ Printed name and signature of Client and/or Client's Parent or Legal Guardian	Date
_____ _____ Printed name and signature of Doctor, Therapist, or Witness	Date