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:	Birthdate:	Live with you?	Name:	Birthdate:	Live w/you?

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 practice and hope that the work you do here will improve your or your child's 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 enter therapy through an informed decision on behalf of yourself or your child.** 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 the decision is made to enter treatment, the provider will collaboratively review the treatment plan 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 the provider. Due to the nature of this practice, if a file goes 60 days with no activity, it will be closed. If you or your child wants to attend therapy again in the future, the file may be reopened by calling 319-261-2292. Please feel free to consult with the provider 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 shared 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. Providers 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 provider may be required to inform the responsible authorities and warn the identified victim. If this occurs, the provider 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, providers 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 provider'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. Providers will not typically testify in court as this creates an irreconcilable role conflict that harms the therapeutic relationship.

Clients of providers who are interns or 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. Your signature indicates you understand in these cases session may be recorded for training purposes. Recordings are deleted after the provider's work is reviewed. Interns may have additional consent forms to complete as part of the educational requirements.

BILLING AND FEES

The fee for a standard 45-minute session is $110, 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, whether at the front desk or via the patient portal. If there is a returned check, the charge will be $25. Please be aware that if your outstanding balance exceeds $220, 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 $150 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.

When requested by patients we can complete the Family and Medical Leave Act (FMLA) paperwork with the charge being $50 for completion of the initial paperwork and $30 for any subsequent paperwork. Payment will be accepted in form of check or credit card only.

SCHOOL-BASED SERVICES

With school-based services, parents and school personnel provide input used to determine desired outcomes, in addition to information gathered from the child. Services are available over the summer if desired by parents and/or clients. When the decision is made to terminate therapy, it should be discussed collaboratively with the provider and other stakeholders in the child's well-being.

TELETHERAPY

Teletherapy is the use of electronic transmissions to treat the needs of a client. It includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communication. Teletherapy has unique risks and benefits. The risks include potential release of private information due to viruses, trojan horses, and other involuntary intrusions, which can grab and release information you may desire to keep private. There is the risk of being overhead by anyone near you if you do not place yourself in a private area. An advantage is that you may be treated from any location, which increases convenience. The first session, however, will usually take place face-to-face. This is to assess whether Teletherapy services would be appropriate. If it is determined that teletherapy is not appropriate you will be referred to a provider that can serve you in- person.

Teletherapy is conducted through a secure software service that is aligned with HIPAA's privacy guidelines. These software solutions are secure because it is reported by their manufacturer to be encrypted and therefore confidential. Despite manufacturer representations, Covenant Family Solutions does not independently certify this product meets encryption criteria for HIPAA compliance, and by signing, you release CFS and practitioners from any liability in the event of a manufacturer's misrepresentation. You are responsible for providing any necessary telecommunications equipment and internet access, securing your computer or device, and arranging a location with sufficient lighting, free from distractions and intrusions, and enough privacy to protect your personal health information.

Teletherapy is not intended for emergency services. If an emergent situation were to arise you will be required to seek fact-to-face consultation and evaluation. Furthermore, if there is a significant, imminent safety risk, you authorize your provider to contact the following people regarding safety concerns to ensure necessary medical and/or psychological care is received. You may forgo providing these names if you are not seeking teletherapy services at this time.

Safety Contact #1

Name _____ Phone Number _____

Email _____

Safety Contact #2

Name _____ Phone Number _____

Email _____

CLINICAL ASSESSMENT PLATFORM

We utilize a HIPAA-compliant mobile platform that helps you and your provider measure progress throughout treatment and adjust treatment as needed. This platform respects the privacy of all users and will never sell any personally identifiable data. You always own your data and can always request your data and account to be deleted by notifying your mental health practitioner through email with the subject of "Account Deletion." For a copy of this privacy policy in detail you can also inquire with your mental health provider. This may be a billable service by your provider towards your insurance plan and as a result may result in additional co-payments, amounts applied to deductibles, and other amounts that may be deemed the responsibility of the patient as required by contract with the insurance plan and state regulations. While strongly recommended, this service is optional and may be opted out of by making a request to your provider.

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 (or joining a teletherapy session) 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: YES_____ NO _____ AMOUNT: $_____ (To be reviewed with provider.)

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

Your Name _____ Today's Date _____

BIOPSYCHOSOCIAL HISTORY

Current Symptom Checklist (Rate intensity of symptoms currently present)

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

SYMPTOM	IMPACT				SYMPTOM	IMPACT			
	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Aggressive Behaviors	☐	☐	☐	☐	Intrusive Thoughts	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Irritability	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	Laxative/Diuretic Abuse	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	Mood Swings	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐	Muscle Tension	☐	☐	☐	☐
Behavioral Addiction	☐	☐	☐	☐	Nightmares	☐	☐	☐	☐
Bingeing/Purging	☐	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐	☐
Mania/Manic Episode	☐	☐	☐	☐	Oppositional Behavior	☐	☐	☐	☐
Medical Condition: _____	☐	☐	☐	☐	Panic Attacks	☐	☐	☐	☐
Conduct Problems	☐	☐	☐	☐	Paranoid Ideation	☐	☐	☐	☐
Decreased Enjoyment/Interest	☐	☐	☐	☐	Phobias	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Physical Trauma Perpetrator	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Physical Trauma Victim	☐	☐	☐	☐
Destruction of Property	☐	☐	☐	☐	Poor Grooming	☐	☐	☐	☐
Difficulty Concentrating	☐	☐	☐	☐	Psychomotor Retardation	☐	☐	☐	☐
Dissociative States	☐	☐	☐	☐	Racing Thoughts	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐	Restlessness	☐	☐	☐	☐
Elimination Disturbance	☐	☐	☐	☐	Self-Injury	☐	☐	☐	☐
Emotional Trauma Perpetrator	☐	☐	☐	☐	Sexual Dysfunction	☐	☐	☐	☐
Emotional Trauma Victim	☐	☐	☐	☐	Sexual Trauma Perpetrator	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Sexual Trauma Victim	☐	☐	☐	☐
Excessiveness (spending/sex/food)	☐	☐	☐	☐	Significant Weight Gain/Loss	☐	☐	☐	☐
Fatigue/Low Energy	☐	☐	☐	☐	Sleep Disturbance	☐	☐	☐	☐
Flashbacks	☐	☐	☐	☐	Social Isolation	☐	☐	☐	☐
Grief	☐	☐	☐	☐	Somatic Complaints	☐	☐	☐	☐
Guilt	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Trauma Event(s)	☐	☐	☐	☐
Helplessness	☐	☐	☐	☐	Worry	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Worthlessness	☐	☐	☐	☐
Insomnia/Hypersomnia	☐	☐	☐	☐	Other	☐	☐	☐	☐

Describe any other symptoms not listed above.

_____

_____

Your Name _____ Today's Date _____

	Yes	No
Have you ever wanted to hurt or kill yourself in the past year?	☐	☐
Are you currently feeling suicidal?	☐	☐
Have you made, or currently have, a suicide plan in the past year?	☐	☐
Have you had any suicidal behavior or suicide attempts in the past year?	☐	☐

Progress since Starting Treatment

Has therapy been beneficial? ☐ Yes ☐ No

_____

_____

Medication

Are you currently using psychiatric medication? ☐ Yes *(If yes, please list below.)* ☐ No

Medication	Dosage	Frequency	Start Date	End Date	Physician

Living Situation/ Legal/ Socioeconomic Status

Describe any changes to your family or living situation, employment, legal, financial, or socioeconomic status in the past year (got married, divorced, had a new child, new job, promotion, arrests etc.).

_____

_____

Medical History (check all that apply for patient)

Describe current physical health ☐ Good ☐ Fair ☐ Poor

Describe any changes in health in the last year.

_____

_____

Substance Use

Describe any changes in substance use in the past year (increase/decrease/frequency).

_____

_____

Sources of Data Provided Above

☐ Patient self-report for all ☐ A variety of sources