LifeTouch MINISTRIES & COUNSELING CENTER
Helping People Return to Joy

Child Intake Form

Please provide the following information about your child:
Full Name: _____
Nick Name: _____
Birth Date: _____ Today's Date: _____

Parent Information
Full Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr.
_____
Name you prefer: _____
Social Security Number: _____ Age: _____
Date of Birth: _____
Race: □ White □ Black □ Latino □ Asian □ Other: _____
Sex: □ Male □ Female
Referred by:_____

Contact Information
Street Address: _____Suite or Apt. #: _____
City: _____ State:_____ Zip Code:_____
May we send mail here: □ Yes □ No
Mailing Address or Post Office Box:_____
City: _____State:____ Zip Code:_____ May we send mail here: □ Yes □ No
Home Phone: (_____)_____ May we leave a message here: □ Yes □ No Mobile Phone: (_____)_____ May we leave a message here: □ Yes □ No Work Phone: (_____)_____ May we leave a message here: □ Yes □ No Email Address:_____ May we send a message here: □ Yes □ No

Emergency Contact Information
Name:_____Relationship:_____
Home Phone: (_____)_____Mobile Phone: (_____)_____

Household Annual Salary: □ $0 to $10,000 □ $10,001 to $20,000 □ $20,001 to $40,000 □ $40,001 to $50,000 □ $50,001 to $60,000 □ $60,001 to $80,000 □ $80,001 to $100,000 □ More than $100,000

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

_____
_____
_____

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

_____
_____
_____

Behavioral Assets:
What does your child do that you like? What does he/she do that other people like?

_____
_____
_____

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned?

_____
_____
_____

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

_____
_____
_____

Family History:
The name of the child's biological parents:
Mother: _____ Father: _____
Who has legal guardianship of your child? _____
Who are other household members with your child?

Names	**Ages**	**Relationship to child**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who are other significant people in your child's life that live outside the home?

Names	**Ages**	**Relationship to child**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe any past counseling that either your child or any family member has had.

_____
_____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol?
_____ if yes, please describe: _____
_____
_____

Education History:

What school does your child attend? _____
Address: _____
_____
Phone: _____ Teacher's Name: _____
Current Grade: _____

What does your child's teacher say about him/her?

_____
_____
_____

Other schools attended (including pre-school):

_____
_____
_____

Has your child ever repeated a grade? If so which one(s)?

_____
_____
_____

Has your child ever received special education services?

_____
_____
_____

Has your child experienced any of the following problems at School?

____Fighting	___Lack of friends	___Drug/Alcohol	___Detention
___Suspension	___Learning Disabilities	___Poor attendance	___Poor grades
___Gang influence	___Incomplete homework	___Behavior problems	

Medical History:

What is the name of your child's primary care physician? _____
Address: _____ Phone: _____
Date of your child's last medical examination: _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

_____
_____
_____

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

_____
_____
_____

Has your child experienced any of the following medical problems?

___A serious accident	___Hospitalization	___Surgery	___Asthma
___A head injury	___High fever	___Convulsions/seizures	
___Eye/ear problems	___Meningitis	___Hearing problems	
___Allergies	___Loss of consciousness	___Other	

Please list any current medical problems or physical handicaps:

_____
_____
_____

Please list any medications your child takes on a regular basis:

_____
_____
_____

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

_____

_____

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

_____

_____

Has he/she ever purposely hurt himself or another? _____
If yes to either question, please describe the situation:

_____

_____

_____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

_____

_____

Finally, what are some of the things that are currently stressful to your child and his/her family?

_____

_____

_____

LEVEL OF DISTRESS
Indicate How Distressed Your Child Is by Placing an "X" on the Scale Below *(1= Very Little Distress; 10=Extreme Distress)*

_____
1 2 3 4 5 6 7 8 9 10
Is Your Child Currently Experiencing Any Suicidal Thoughts? □ Yes □ No
Has Your Child Experienced Them in the Past? □ Yes □ No
Has Your Child Ever Attempted Suicide? □ Yes □ No If Yes, When & How:

_____
When Was The Last Suicidal Ideation? _____Plan? _____Intent? _____
Means? _____
Have Any of Your Child's Friends or Family Ever Committed or Attempted Suicide: □ Yes □ No
If Yes, When and Who: _____
Are There Any Preventative Factors?_____
Plan To Address: In Supervision with Support System? □ Yes □ No
Inpatient Admission? □ Yes □ No
Crisis Planning? □ Yes □ No

RELIGIOUS BACKGROUND

What Words Would Your Child Use to Describe Him/Herself?

_____

Ask Your Child: How Would God Describe You?

_____

Briefly Describe the Religious Environment of Your Home:

_____

_____

_____

Have Your Child Complete the Following Thought: God is_____

Do You (Parent) Regularly Attend a Place of Worship? □ Yes □ No If Yes, Where:

_____

What is the Name of your Pastor, Priest, Rabbi or Other Spiritual Leader? _____

Do You Have a Personal Support System: □ Yes □ No If Yes, Who: _____

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TERMS OF SERVICE

I understand that payment for professional services is due when rendered. I accept full responsibility for payment of any balance incurred for services.

I understand and agree to abide by my financial responsibilities; thus I agree to pay $_____ per session.

Client Signature _____

POLICIES FOR CLIENTS

- Clients will be invoiced for the agreed amount of payment per appointment.
- If you need to cancel an appointment, **24-hour notice** is required. If the 24-hour time frame for advance notice has already lapsed, we nevertheless request that you call as soon as possible.
- **No Call/No Show Clients:** We realize that there are extenuating circumstances that prevent you from giving 24-hour notice (i.e., illness, inclement weather etc.). We will evaluate those on a case-by-case basis. A fee of $20.00 **may** be assessed to your account if you fail to keep your appointment. After 3 no call/no show appointments, our Director of Administration and the counselor will determine if the client will be moved to an "inactive" status.
- **Unless otherwise agreed upon, clients who cancel more than twice in a row will be contacted by an office staff member and reasons for cancelling will be assessed.**
- The baseline rate is $80.00 per 1 hour session beginning **October 1, 2021**.
    - Existing clients will continue with the same rate previously agreed upon.
    - New clients will follow the new rate unless an alternative agreement is made with the Director of Administration.
- **When you do not show for an appointment, three people are affected:**
    1. YOU- because you are not getting the consistent care you need as directed by your counselor.
    2. YOUR COUNSELOR- who has a vacancy in their schedule that was once reserved for you. Our counselors are not paid for missed appointments.
    3. ANOTHER CLIENT- who could have been scheduled for an appointment had proper notice been given.

Client Signature: _____Date: _____

Counselor Signature: _____Date: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

·*Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

·*Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

·*Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

·The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

·The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

·The right to request an amendment to your PROTECTED HEALTH INFORMATION.

·The right to receive an accounting of disclosures or PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

·The right to obtain a paper copy of this notice for us upon request.
We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775 (toll-free)

LifeTouch MINISTRIES & COUNSELING CENTER
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www.lifetouchmin.org
574-269-7990
info@lifetouchmin.org

Acknowledgment of Receipt of Privacy Practice Notice

I, _____
(Full Name)
have received a copy LifeTouch Ministries & Counseling Center, A Non-profit Corporation Notice of Privacy Practices.

Name:
_____

Street Address: _____ Suite / Apt. #: _____

City: _____State: _____ ZIP Code: _____

Client
Signed: _____Date: _____

Parent/Guardian
Signed: _____Date: _____

Witnessed
Signed: _____Date: _____

www.lifetouchmin.org
574-269-7990
info@lifetouchmin.org
Counselor:
_____

Informed Consent & Release of Liability

LifeTouch Ministries & Counseling Center is operated to provide counseling with a distinctively Christian framework to the community of believers, and non-believers, at various churches and to the local community, as a whole. Counseling services are provided by practitioners who have earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who have been licensed by the state of Indiana as Mental Health Counselors, lay counselors under the supervision of a licensed mental health counselor, or are Student Interns under the supervision of a licensed mental health counselor (hereafter referred to as Counselors).
The completion of an intake questionnaire and an informed consent and release of liability are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent.
In order to initiate counseling, please read the following agreement. Your signature attests that you both understand and agree to the terms and conditions contained herein.

1. I _____ understand that my counselor is a lay counselor, a mental health counselor, or a student intern, working under the laws and rules specified by the state of Indiana and/or the Federal Government where applicable.

2. I understand that my counseling records (files) are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession (e.g. child, elder, disabled abuse/neglect reporting requirements, serious threat of harm to self or others, etc.) The clinical records are the property of LifeTouch Ministries & Counseling Center and as such, are deemed records of confidential sessions between counselors and clients. Other than as required by law these records will only be released subject to the following paragraph and with the advanced written consent of the client and LifeTouch Ministries & Counseling Center.

3. In consideration of the benefits to be derived from the counseling, the receipt of which is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable the ministry of LifeTouch Ministries & Counseling Center, the counselors, and the supervisors, if applicable, from any and all claims, demands, damages, actions, or causes of action whatsoever related to the counseling process.

4. I waive any right I may have otherwise had to seek to use my counseling records with LifeTouch Ministries & Counseling Center, except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any counselor or supervisor associated herewith. If testimony is required, I agree to pay twice the normal hourly rate for any, and all, of these individuals for their testimony, and preparation therefore.

I have read and understood the preceding information and agree to the terms and conditions of LifeTouch Ministries & Counseling Center as stated herein. I understand that these comments are prerequisite to my receiving and continuing counseling services through this ministry.

Date:_____ Signed: _____
Signed: _____
Witness: _____

www.lifetouchmin.org
574-269-7990
info@lifetouchmin.org
Counselor:
_____

Release of Confidential Information to Primary Care Physician

I, _____hereby authorize LifeTouch Ministries & Counseling Center to disclose to my Primary Care Physician, _____
(Primary Care Physician Name) (Address)
all clinical information about me as may be necessary to permit my Primary Care Physician to monitor the continuity of my care and to inform my Primary Care Physician of health status.

This authorization may be revoked by me in writing at any time, with the exception of any actions already taken to coordinate my care. I understand this authorization does not extend to the release of any AIDS/HIV information unless I also place my initials here. _____

I further understand that the information authorized by this release will be released to the authorized representative only, for purposes noted above. I understand I am entitled to a copy of this authorization form for my records.

NOTE TO RECEIPIENT: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and /or state law. In accordance with federal and state law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.