



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center Office Policies and Consent for Treatment

WELCOME

Thank you for choosing FairView Counseling and The Play Therapy Center. As a non-profit counseling agency, our mission is to foster the health and welfare of children by providing quality, mental health treatment. This document is designed to ensure that you understand our professional relationship.

ATTENDANCE & CANCELLATION

Our office is open Monday through Thursday 8:30am – 7:30pm. Appointment times vary by clinician and last approximately 50 minutes. Evening appointments are always in high demand. We understand that there are times when you must miss an appointment due to emergencies or unforeseen obligations. If it is necessary to cancel an appointment, please call or leave a message at least 24 hours before your appointment. *Inconsistent attendance may result in the termination of service. This is determined by the clinical team in accordance with FVC policy.

You may leave a voicemail 24 hours a day, 7 days a week.
There is a fee for NO SHOWS or LATE CANCELLATIONS.

Illness - If your child arrives for therapy and is visibly ill or potentially contagious, we reserve the right to reschedule the appointment in order to protect the wellness of other children and our staff.

FVC requires our clients to follow the immunization guidelines recommended by the American Academy of Pediatrics. *Parents who choose to not vaccinate are advised to seek treatment for their children elsewhere.*

Weather - Our office is generally open and DOES NOT follow school district closings for inclement weather. You may refer to the WFMZ-TV STORMCENTER online at www.WFMZ.com or Channel 69 news for weather closing.

Emergencies - As a client in outpatient treatment, you are expected to manage your day-to-day functioning. In the case of emergency in which you feel unsafe, call 610-379-2007 for Holcomb Crisis Intervention of Berks County, dial 988 for Suicide and Crisis Lifeline, or go to your local emergency room.

CONFIDENTIALITY & RECORD KEEPING

Confidentiality pertains to the treatment of information that an individual has disclosed in a relationship with the expectation that it will not be divulged to others without permission. FairView Counseling protects the confidentiality of client information in accordance with legal and ethical requirements of Pennsylvania Code and Federal Law. Any communication about your treatment outside of FairView Counseling and The Play Therapy Center requires your written consent. Exceptions to confidentiality include child abuse, adult and domestic abuse, and serious threat to health/ safety and are reviewed in detail in our Notice of Privacy Practices (HIPAA).

FairView Counseling maintains client records as required by law. Clients may request to review their records. Inactive client charts are closed after 60 days.

Clients participating in art therapy may leave their artwork with their art therapist for duration of treatment. In order to uphold professional record-keeping practices, your art therapist may photograph your work to include it in your chart. At the end of therapy, all artwork will be sent home with you. In the event that treatment is ended prematurely, or you are unable to take some pieces home with you, any remaining artwork will be photographed for your chart and then confidentially disposed of when the chart is closed.

COMMUNICATION POLICY

If you need to communicate with your therapist or change an appointment, always do so by calling the front office. Emails and faxes are not private, and this type of communication can be intercepted. It is your informed decision to email or fax documents to this office.



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COURT POLICY

FVC therapists do not provide mediation, reunification, or custody evaluation services. Parents in high conflict separations/divorces often want a child therapist to make recommendations in court proceedings, such as custody determinations. FVC therapists do not provide testimony or clinical input to be used in court. American Psychological Association (APA) guidelines make a clear distinction between forensic evaluations and the services that therapists provide to children, families, and parents during psychotherapy. For children to feel that their concerns can be safely discussed, they must know that the content of their therapy sessions will remain confidential and that their therapist will remain neutral and uninvolved in any parental disputes, custody determinations, or legal decision-making.

If a therapist is asked by a parent or subpoenaed by an attorney to provide clinical input intended for court, doing so would be a conflict of interest, beyond our bounds of competence, and would violate several provisions of Professional Ethical Principles and Code of Conduct. *Such actions may result in termination of the therapeutic contract.*

PSYCHOTHERAPY SERVICES

Our intake session allows your therapist to get to know you and assess your needs for treatment. After the intake session(s), your therapist will be able to offer you a clinical impression, what therapy will include, and a general treatment plan. If you have questions about your therapist's procedures, you should discuss them when they arise.

Psychotherapy can have benefits and risks. Since therapy often involves discussing difficult parts of life, psychotherapy may elicit uncomfortable thoughts and feelings. Psychotherapy also leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

There are many treatment methods that your therapist may use to deal with the concerns that you hope to address. Psychotherapy calls for an active effort and requires work during our sessions and at home.

When clinically appropriate, touch may be used in combination with other therapeutic interventions during therapy. Physical contact often occurs naturally during a child's session but may also be used for modeling relaxation and coping skills and/or to help maintain your child's safety. You are encouraged to discuss this with your child's therapist if you have concerns.

CONSENT FOR TREATMENT

For children 13 and younger, FVC requires a signed 'Consent for Treatment' from BOTH PARENTS REGARDLESS of marital status. You must bring two signed consent forms with you on the day of intake, or you will not be seen for your scheduled appointment.

Signing below indicates that you have reviewed and understand the information described above and agree to abide by the contents and terms of this agreement.

PRINT Client name _____

**For clients age 14+*

Client signature _____ **Date** _____

Parent/Guardian signature _____ **PRINT** _____ **Date** _____

Copy Given to Client _____ Date: ____/____/____



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center
Acknowledgement of Privacy Practices

A copy of the Privacy Practices is provided in the waiting room and at reception and is located on our website.

I acknowledge Notice of Privacy Practices, (HIPAA) effective April 14, 2003.

PRINT Client name _____

**For clients age 14+*

Client signature _____ **Date** _____

Parent/Guardian signature _____ **PRINT** _____ **Date** _____



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center
Authorization to Exchange Information with PCP/ School

FairView Counseling emphasizes communication among treating professionals. We would like to send a brief summary after the intake session so that your Primary Care Physician is aware of your diagnosis and treatment plan and can better address your needs.

_____ **Yes, I authorize FVC to communicate with my PCP**

_____ **No, I do not authorize.**

Physician Name _____

Practice Name _____

Fax _____

(if client is an adult- skip this section)

We would like to send a Teacher Feedback form to your child's teacher and/or guidance counselor so that we may better understand how he/she functions at school. Your therapist will discuss the feedback with you.

_____ **Yes, I authorize FVC to communicate with my child's school.**

_____ **No, I do not authorize.**

Name of School _____

Name of teacher/guidance _____

Address _____

PRINT Client name _____

**For clients age 14+*

Client signature _____ **Date** _____

Parent/Guardian signature _____ **PRINT** _____ **Date** _____



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center
Financial Policy & Contract for Clients Utilizing Insurance

We accept cash, check, and most credit cards.
If you are using an insurance plan, your co-pay is due at the beginning of each session.
Fees incurred for returned checks are the client's responsibility.

Client Name _____ Effective Date of Policy Coverage ____/____/____

Insurance Company Name _____ Ins. Phone # _____

Policy/ID # _____ Group # _____ Subscriber's Employer _____

Insurance Subscriber's Name _____ Relationship to Client _____

Subscriber's SS # _____ Subscriber's Phone _____ Subscriber's DOB ____/____/____

Subscriber's Address _____

- You are responsible to know the coverage for services and levels of payment by your insurance company. You are responsible for any amounts not covered by your plan.
- If Fairview Counseling is an in-network provider with your insurance plan, we will bill your insurance company for reimbursement. If our charges apply to your deductible or are not covered by your plan, you will be responsible for the unpaid amounts.
- If Fairview Counseling is not an in-network provider with your insurance plan, you will be charged the full fee for our services, and a receipt will be provided for you to submit to your insurance company for reimbursement.
- **Supplementary Correspondence** such as completing forms, writing letters, copying therapy records, etc. requires therapist time away from patient care. We may require payment at a rate of \$25.00 per 15-minute unit of time depending on the length and complexity of your request. *These fees are your direct responsibility and will not be billed to your insurance company.
*FVC reserves the right to change fees without notice.

I give FairView Counseling and The Play Therapy Center permission to release any information that is necessary to support any insurance claims on my account and secure timely payments due to the assignee or myself. I hereby assign medical benefits, including those from government sponsored programs and other health plans, to be paid to FairView Counseling. I have read, understand, and agree to abide by this financial contract.

PRINT Client name _____

**For clients age 14+*

Client signature _____ **Date** _____

Parent/Guardian signature _____ **PRINT** _____ **Date** _____

Copy Given to Client _____ Date: ____/____/____



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center

Financial Policy & Contract for Clients Utilizing Sliding Fee Scale

We accept cash, check, and most credit cards.
If you are using our Slide Fee Scale, your contracted fee is due at the beginning of each session.
Fees incurred for returned checks are the client's responsibility.

Client name _____

- **Verification of income is required at the initial session or full fee will be charged.**
- **Supplementary Correspondence** such as completing forms, writing letters, copying therapy records, etc. requires therapist time away from patient care. We may require payment at a rate of \$25.00 per 15-minute unit of time depending on the length and complexity of your request. **These fees are your direct responsibility.*

Household Member Name	Gross Income Amount (before deductions)	Pay Frequency	Yearly Income
	\$_____	<input type="checkbox"/> Weekly(x 52) <input type="checkbox"/> Bi-Weekly(x26) <input type="checkbox"/> Monthly(x12)	\$_____
	\$_____	<input type="checkbox"/> Weekly(x 52) <input type="checkbox"/> Bi-Weekly(x26) <input type="checkbox"/> Monthly(x12)	\$_____
	\$_____	<input type="checkbox"/> Weekly(x 52) <input type="checkbox"/> Bi-Weekly(x26) <input type="checkbox"/> Monthly(x12)	\$_____
Child Support and/or Alimony	Weekly Amount \$ _____ x 52 =		\$_____
Unemployment Compensation	Weekly Amount \$ _____ x 52=		\$_____
Other Income:_____ (Worker’s compensation, social security, etc)	\$_____ <input type="checkbox"/> Weekly(x 52) <input type="checkbox"/> Bi-Weekly(x26) <input type="checkbox"/> Monthly(x12)		\$_____
	Total Yearly Household Income:		\$_____

To be completed by office staff only

Effective Date ____/____/____

I agree to pay the sliding scale rates of:

\$ _____ for the initial intake evaluation/s (For clients 13 yrs & under the initial intake evaluation consists of 2 sessions)

\$ _____ for regular therapy sessions.

I understand that this rate will be reviewed every 6 months and could change, depending on my financial situation. If there is a change in your financial situation, prior to your 6 month review, please notify us so that your information can be updated appropriately. * FVC reserves the right to change fees without notice.

PRINT Client name _____**For clients age 14+***Client signature** _____ **Date** _____**Parent/Guardian signature** _____ **PRINT** _____ **Date** _____

Copy Given to Client _____ Date: ____/____/____



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center

Child / Teen Questionnaire

Client name _____ Age _____ Gender _____ DOB _____

Person completing this form (relationship to client) _____

Describe the reason for seeking treatment

Check any of the following that is currently or has been a concern for your child

<input type="checkbox"/> Speech/ language	<input type="checkbox"/> Anxiety/ worry	<input type="checkbox"/> Slow learner	<input type="checkbox"/> Running away	<input type="checkbox"/> Sexual acting out
<input type="checkbox"/> Trouble w/ friends	<input type="checkbox"/> Wets bed	<input type="checkbox"/> Sadness	<input type="checkbox"/> Self-injury	<input type="checkbox"/> Destroys property
<input type="checkbox"/> Prefers to be alone	<input type="checkbox"/> Nail biting	<input type="checkbox"/> Stomach trouble	<input type="checkbox"/> Anger	<input type="checkbox"/> Criminal acts
<input type="checkbox"/> Fights w/ siblings	<input type="checkbox"/> Thumb sucking	<input type="checkbox"/> Reckless behavior	<input type="checkbox"/> Injured animals	<input type="checkbox"/> Psychosis
<input type="checkbox"/> Sleep	<input type="checkbox"/> Attention	<input type="checkbox"/> Shy/timid	<input type="checkbox"/> Fights with peers	<input type="checkbox"/> Lack of empathy
<input type="checkbox"/> Tantrums	<input type="checkbox"/> Head banging	<input type="checkbox"/> Stubborn	<input type="checkbox"/> Arrests/ legal	<input type="checkbox"/> Arson
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Coordination	<input type="checkbox"/> Depressed	<input type="checkbox"/> Physical Aggression (pinch, hit, kick, bite)	
<input type="checkbox"/> Stealing	<input type="checkbox"/> Self-esteem	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Bowel and/or bladder problems	
<input type="checkbox"/> Poor eye contact	<input type="checkbox"/> Fights w/ adults	<input type="checkbox"/> Indecisive	<input type="checkbox"/> Significant lack of communication skills	
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Obsessive	<input type="checkbox"/> Overactive	<input type="checkbox"/> Highly focused interests	
<input type="checkbox"/> Repetitive behaviors (rocking, spinning)			<input type="checkbox"/> Suicidal thoughts /actions	
<input type="checkbox"/> Odd habits (describe)				

DEVELOPMENTAL/ MEDICAL/ SOCIAL HISTORY

Age of mother at pregnancy _____ Length of pregnancy _____ Birth weight _____ Type ☐ Vaginal ☐ C-sectionWas this pregnancy planned? _____ Mother's health ☐ Good ☐ Fair ☐ Poor

Child's pediatrician _____ Date of last exam _____

Are your child's immunizations up to date? ☐ Yes ☐ No ☐ Exempt

*FVC requires our clients to follow the immunization guidelines recommended by the American Academy of Pediatrics.

Check the following

Any illness /complications during pregnancy?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)
Did mother use alcohol/drugs during pregnancy?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)
Any complications of delivery or birth defects?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)
Was mother depressed or sad after delivery?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)
Any problems with sleep or feeding?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)

Describe child as an infant ☐ Pleasant ☐ Fussy ☐ Calm ☐ Colicky ☐ Irritable ☐ Hard to manage

Notes:

Check the following developmental milestones

Respond to parent	<input type="checkbox"/> WNL <input type="checkbox"/> Late	Stood alone	<input type="checkbox"/> WNL <input type="checkbox"/> Late
Spoke single words	<input type="checkbox"/> WNL <input type="checkbox"/> Late	Walked	<input type="checkbox"/> WNL <input type="checkbox"/> Late
Put two words together	<input type="checkbox"/> WNL <input type="checkbox"/> Late	Toilet trained bladder	<input type="checkbox"/> WNL <input type="checkbox"/> Late
Sat up	<input type="checkbox"/> WNL <input type="checkbox"/> Late	Toilet trained bowel	<input type="checkbox"/> WNL <input type="checkbox"/> Late
Crawled	<input type="checkbox"/> WNL <input type="checkbox"/> Late		

How old was child when parent(s) returned to work? _____

Have there been any caregivers other than parent prior to kindergarten? ☐ No ☐ Yes

Caregiver

Age

Child's reaction/behavior

If your child has been treated for any the following, please check

<input type="checkbox"/> Suicide attempt/thoughts	<input type="checkbox"/> Allergies	<input type="checkbox"/> Headaches	<input type="checkbox"/> Visual problems
<input type="checkbox"/> Eating problems/disorder	<input type="checkbox"/> Head injury/LOC	<input type="checkbox"/> Broken bones	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Drug/ Alcohol	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Autism (describe)	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Skin conditions	
<input type="checkbox"/> Thought disorder (delusions, hallucinations, paranoia)			
<input type="checkbox"/> Hospitalizations/Surgeries (describe)			
<input type="checkbox"/> Other (describe)			

Is your child on a special diet? ☐ N ☐ Y (describe) _____

CURRENTLY does your child take prescription medications/over the counter/supplements/vitamins? ☐ None

Drug	Dosage/Frequency	Start Date	Reason	Prescribed by

In the PAST has your child taken any medication for emotional/behavioral reasons? ☐ None

Drug	Dosage/Frequency	Start Date	Reason	Prescribed by

Has your child ever received mental health treatment? (including school guidance) ☐ None

Agency /Provider	Dates	Reason

Are there any additional physicians/therapists/professionals involved in your child's care? ☐ No ☐ Yes

If yes, describe _____

EDUCATION HISTORY

School/ District child presently attends _____ Grade _____

Primary teacher _____ School refusal ☐ No ☐ Yes

Guidance counselor _____

Please note any difficulty your child has at school (academic, attendance, peer relations) _____

Does your child/has your child

Receive added services in school? (speech, resource room, separate classes)	<input type="checkbox"/> N	<input type="checkbox"/> Y (describe)
Been suspended from school?	<input type="checkbox"/> N	<input type="checkbox"/> Y (describe)
Been held back a grade?	<input type="checkbox"/> N	<input type="checkbox"/> Y (describe)
Have an IEP/ 504 Plan?	<input type="checkbox"/> N	<input type="checkbox"/> Y (describe)
Have any difficulties with Notes:	<input type="checkbox"/> Reading	<input type="checkbox"/> Math <input type="checkbox"/> Spelling <input type="checkbox"/> Writing <input type="checkbox"/> Science <input type="checkbox"/> Organization

List your child's social/extracurricular activities _____

List your child's close friends (school/neighborhood) _____

Amount of screen time per _____ day _____ week

FAMILY HISTORY**Legal Parent 1/ Mother/ Guardian Name** _____ **Age** _____

Occupation _____ Employer _____

Legal Parent 2/ Father/ Guardian Name _____ **Age** _____

Occupation _____ Employer _____

List family members and all others in the home

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any other siblings not in the home

<u>Name</u>	<u>Age</u>
_____	_____
_____	_____
_____	_____

What type of discipline do you use in your home, and is it effective? _____**Check applicable**

(Describe)

<input type="checkbox"/> Death/ illness of someone close	
<input type="checkbox"/> Family legal trouble	
<input type="checkbox"/> Family abuse (phys/emo/sexual)	
<input type="checkbox"/> Domestic violence	
<input type="checkbox"/> Family moves	
<input type="checkbox"/> Victim of a violent crime	
<input type="checkbox"/> Motor vehicle accident	
<input type="checkbox"/> Family drug/alcohol problems	
<input type="checkbox"/> Family history of mental illness	

*** Separated / Divorced Families ONLY** (skip if not applicable)

Partner of [Legal Parent 1/ Mother/ Guardian]

☐ None

Name _____

Status: ☐ Dating ☐ Cohabiting ☐ Married

Age _____ City/state of residence _____ Quality of relationship with child _____

Partner of [Legal Parent 2/ Father/ Guardian]

☐ None

Name _____

Status: ☐ Dating ☐ Cohabiting ☐ Married

Age _____ City/state of residence _____ Quality of relationship with child _____

Describe your separation/divorce	<input type="checkbox"/> Amicable	<input type="checkbox"/> Neutral	<input type="checkbox"/> High Conflict
Describe your co-parenting	<input type="checkbox"/> Amicable	<input type="checkbox"/> Neutral	<input type="checkbox"/> High Conflict
Is/Has CYS been involved with your family?	<input type="checkbox"/> N	<input type="checkbox"/> Y (Describe)	
Is there an official (legal) custody agreement?	<input type="checkbox"/> N	<input type="checkbox"/> Y (Describe)	
Are you involved in any legal action through which this treatment may become relevant?	<input type="checkbox"/> N	<input type="checkbox"/> Y (Describe)	
Describe your child's custody schedule below <i>Example: sun -wed – mom's house, thurs- sat – dad's house</i>			

List any additional individual /environmental factors that may be relevant (cultural, financial)
