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

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 $40 for NO SHOWS or LATE CANCELLATIONS.

Illness - If your child arrives for therapy and is visibly ill or potentially contagious (including but not limited to lice, bed bugs, etc), we reserve the right to reschedule the appointment in order to protect the wellness of other children and our staff. We encourage our clients to be fever and symptom (vomiting, diarrhea, pink eye, lice, etc) free for 24 hours before attending a session. 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.

To maintain the privacy of all individuals at FairView Counseling, there will be no visual or audio recording in the building unless discussed with your provider beforehand.

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.

Date: _____ Client number: _____

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. Any communication between sessions will be discussed in your next session unless other action is deemed necessary by your provider.

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.*

FINANCIAL OBLIGATION

FVC and/or it's providers are in-network with many insurance companies. It is the client's responsibility to be familiar with what their specific plan benefits are prior to services being rendered. If you choose to use your insurance coverage, your co-pay is due at the time of service. You are responsible for any amounts that apply to your deductible or that are not covered by your plan. Our office will bill your insurance company directly. For this to occur, FVC may have to provide necessary client health information, including HIPAA protected information to the insurance company for payment purposes. By signing this consent, you are assigning medical benefits to be paid to FVC.

FVC also offers a sliding fee scale for clients without insurance or who are covered by insurances we don't accept. Household income is used to determine your portion of our fee for services. By signing this consent, you are agreeing to pay your portion at the time of services

Any changes in insurance coverage or household income must be reported to our office as soon as possible so that your information can be updated appropriately.

Fees for other services such as completing forms, writing letters, etc. are typically not covered by insurance companies and therefore due at the time of request. Cash, checks, and major credit cards are accepted.

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

Date: _____ Client number: _____

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: ____ /____/____

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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

Financial Information

For Clients Utilizing Insurance – please complete this section

Client Name _____

Insurance Subscriber's Name _____ Relationship to Client _____

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

Insurance Company Name _____ Effective Date of Policy Coverage ____/_____/_____

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

For Clients Utilizing Sliding Fee Scale – please complete this section

Client Name _____

Household Member Name	**Gross Income Amount** (before deductions) **Pay Frequency**	**Yearly Income**
	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
Child Support and/or Alimony	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
Unemployment Compensation	Weekly Amount $ _____ x 52	$_____
Other Income:_____ (Worker's compensation, social security, etc.)	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
	Total Yearly Household Income:	**$_____**

Verification of income is required at the initial session or full fee will be charged.

To be completed by office staff only
Sliding scale rate effective ____/____/____
$ _____ for the initial intake evaluation/s (For clients 13 yrs & under the initial intake evaluation consists of 2 sessions)
$ _____ for regular therapy sessions.
This rate will be reviewed every **6 months** and could change, depending upon financial determination.

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

Child / Teen Questionnaire

Client name_____ Age_____ Gender_____ DOB_____

Name of 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

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

DEVELOPMENTAL/ MEDICAL/ SOCIAL HISTORY

Age of mother at pregnancy _____ Length of pregnancy _____ Birth weight _____ Type □ Vaginal □ C-section

Was 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?	□ N	□ Y (explain)
Did mother use alcohol/drugs during pregnancy?	□ N	□ Y (explain)
Any complications of delivery or birth defects?	□ N	□ Y (explain)
Was mother depressed or sad after delivery?	□ N	□ Y (explain)
Any problems with sleep or feeding?	□ N	□ Y (explain)

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

Notes:

Date: _____ Client Number:_____

Check the following developmental milestones

Respond to parent	□ WNL	□ Late	Stood alone	□ WNL	□ Late
Spoke single words	□ WNL	□ Late	Walked	□ WNL	□ Late
Put two words together	□ WNL	□ Late	Toilet trained bladder	□ WNL	□ Late
Sat up	□ WNL	□ Late	Toilet trained bowel	□ WNL	□ Late
Crawled	□ WNL	□ 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 of Child Child's reaction/behavior

_____

_____

If your child has been treated for/suspected of having any the following, please check

□ Suicide attempt/thoughts	□ Allergies	□ Self Injury	□ Visual problems
□ Eating problems/disorder	□ Head injury/headaches	□ Broken bones	□ Hearing problems
□ Drug/ Alcohol	□ Dizziness/fainting	□ Seizures	□ Memory problems
□ Autism (describe)		□ Personality Disorder	□ Skin conditions
□ Thought disorder (delusions, hallucinations, paranoia)		□ Past trauma	□ ADHD
□ Hospitalizations/Surgeries (describe)			
□ 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/ Diagnosis Given

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) _____

_____

Date: _____ Client Number:_____

Does your child/has your child

Receive added services in school? (speech, resource room, separate classes)	□ N □ **Y** (describe)
Been suspended from school?	□ N □ **Y** (describe)
Been held back a grade?	□ N □ **Y** (describe)
Have an IEP/ 504 Plan?	□ N □ **Y** (describe)
Have any difficulties with: □ Reading □ Math □ Spelling □ Writing □ Science □ Organization □ Social Skills Notes:	

List your child's social/extracurricular activities _____

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

Amount of screen time per _____ day _____ week

FAMILY HISTORY

Mother/ Legal Parent 1/ Guardian Name _____ Age_____

Occupation _____ Employer _____

Father/ Legal Parent 2/ Guardian Name _____ Age_____

Occupation _____ Employer _____

List family members and all others in the home

Name Age Relationship

_____

_____

_____

_____

List any other siblings not in the home

Name Age

_____

_____

_____

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

_____

Potential Traumas Experienced:

Circle Yes (Y) or No (N) **If yes, describe** **□ No known trauma history**

Death/ illness of someone close	**Y**	**N**	
Family legal trouble	**Y**	**N**	
Family abuse (phys/emo/sexual)	**Y**	**N**	
Domestic violence	**Y**	**N**	
Family moves	**Y**	**N**	
Victim of a violent crime	**Y**	**N**	
Motor vehicle accident	**Y**	**N**	
Family drug/alcohol problems	**Y**	**N**	
Family history of mental illness	**Y**	**N**	
CYS involvement(current/previous)	**Y**	**N**	

Date: _____ Client Number:_____

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

_____
_____
_____
_____

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

Describe your separation/divorce	□ Amicable	□ Neutral	□ High Conflict
Describe your co-parenting	□ Amicable	□ Neutral	□ High Conflict
Is there an official (legal) custody agreement?		□ N	□ Y (Describe)
Are you involved in any legal action through which this treatment may become relevant?		□ N	□ Y (Describe)
Describe your child's custody schedule below *Example: sun -wed – mom's house, thurs- sat – dad's house*			

Does Mother/Legal Parent 1/ Guardian 1 have a partner in their life? □ YES □ NO

What is the status of this relationship? □ Dating □ Cohabitating □ Married

What is the partner's name: _____ Age: _____

Where does the partner reside if not living together: _____

What is the quality of the partner's relationship with the child: _____

Does Father/Legal Parent 2/ Guardian 2 have a partner in their life? □ YES □ NO

What is the status of this relationship? □ Dating □ Cohabitating □ Married

What is the partner's name: _____ Age: _____

Where does the partner reside if not living together: _____

What is the quality of the partner's relationship with the child: _____

Date: _____ Client Number:_____

FairView Counseling and The Play Therapy Center

Authorization to Exchange Information with PCP

□ Client name differs from insurance name

Client name _____ DOB _____

To encourage communication among treating professionals, we would like to send a brief summary after the intake session so that your or your child's Primary Care Physician is aware of your diagnosis and treatment plan. This allows for more prompt discussions to address your needs moving forward.

I hereby authorize FairView Counseling and The Play Therapy Center to:

□ Exchange information with □ Release information to □ Request information from
□ I do not authorize

Physician/ Practice Name: _____

Address _____

Phone _____Fax_____

I assume sole responsibility for specifying what I would like released/requested below.

□ Documentation of treatment/ progress
□ Treatment Plan
□ Termination summary
□ Other (specify) _____

This information is regarding: □ Myself □ My child

And will be used for the purpose of:
□ Coordinating treatment
□ Evaluation/assessment
□ Other (specify) _____

I understand that my clinical record contains confidential and privileged information. By consenting to release my information, I am waiving that privilege, and I hereby relieve and hold harmless FairView Counseling and The Play Therapy Center from any liability related to this release. I also understand that I have the right to revoke this authorization at any time.

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 School

□ Client name differs from insurance name

Client name _____ DOB _____

We would like to send a Teacher Feedback Form to your child's school so that we may better understand how they function in that environment. It is sometimes helpful or necessary to communicate further with your child's school. Please indicate your preferences below.

I hereby authorize FairView Counseling and The Play Therapy Center to:

□ Exchange information with □ Release information to □ Request information from
□ I do not authorize

Teacher/Guidance Counselor/Other _____

Address _____

Phone _____Fax_____

I assume sole responsibility for specifying what I would like released/requested below.

□ Teacher Feedback Form
□ Documentation of treatment including diagnosis
□ Documentation of treatment including diagnosis and progress
□ Verbal Communication
□ Other (specify) _____

This information is regarding: □ Myself □ My child

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Client signature _____ Date_____

Parent/Guardian signature _____PRINT _____ Date_____

Date: _____ Client Number:_____

FairView Counseling and The Play Therapy Center

Authorization for Additional Parties in Treatment

□ Client name differs from insurance name

Client name _____ DOB _____

The individual(s) who signed the 'Consent for Treatment' is/are the only individual(s) who may participate in treatment. Consent is required for any Additional Parties other than the client and legal parents/guardians to participate in treatment, sign for records, make/cancel appointments, and request billing statements.

Are there additional individuals (step-parent, grandparent) who will be involved with your/your child's care to whom you need to provide consent? [Include name, relationship to client, and phone number]

___ No additional parties

Name/Relationship/Phone Number: _____

Name/Relationship/Phone Number: _____

Name/Relationship/Phone Number: _____

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