PARSONS COUNSELING & PLAY THERAPY CENTER

CHILD INTAKE PACKET

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT

Welcome *to Parsons Counseling, LLC (PC, LLC.).*

This document contains important information about our services and business policies.

Client Name: _____ **Date:** _____

Social Security #: _____ **Birthdate:** _____

CONSENT TO TREATMENT AND CONFIDENTIALITY STATEMENT:

I hereby authorize staff of Parsons Counseling, LLC. to render treatment and/or service to the client listed above. I understand that information or opinions will be given to others only with my written consent.

Relationship: ☐ self, ☐ child, ☐ other (specify).

_____

Signature of Client 16 and older or Parent/Guardian **Print Name** **Date**

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required By Law including, specifically:

1. You consent in writing by signing a release of information, or
2. The disclosure is allowed by a court order and/or issued by a judge, or
3. The disclosure is made to medical personnel in a medical emergency, or
4. If you pose a threat of harm to yourself or an identified person, or
5. If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect.

State Law and Regulation do not protect any information about suspected child abuse or neglect, including spousal abuse which must be reported in situations involving a vulnerable adult. Kentucky law requires that child abuse and neglect be reported. In Kentucky, no one under the age of 16 can legally consent to sexual contact.

Initial here: _____

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by *PC, LLC.* In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. *PC, LLC.* counselors will use their clinical judgment when revealing such information. *PC, LLC.* will not release records to any outside party unless authorized by a signed release by a legal guardian.

Initial here: _____

THE PROCESS OF THERAPY/EVALUATION: By signing this agreement you are authorizing and requesting that PC, LLC. carry out counseling treatment and diagnosis of a mental health or behavior issue. Participation in therapy can result in a number of benefits through working together openly and honestly with your counselor and working on interventions to make a change. However, during sessions topics, your past history may become uncomfortable and result in negative side effects, such as strong negative emotions, heightened anxiety, insomnia, and depression to name a few. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended.

- ❖ I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.
- ❖ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT continued

- I understand that there are some occasions when confidentiality can/must be breached. These are:
  a) I sign a *Release of Information Form* or I verbally direct my counselor to tell someone else,
  b) My counselor determines that his/her client poses a threat to self or others,
  c) My counselor is ordered by a court to disclose information,
  d) My counselor knows or has reasonable cause to be believe that a child is dependent, neglected or abused and will report such information to Child Protective Services or law enforcement as required by Kentucky law, or
  e) Forensic consultation or treatment ordered by the courts.
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that PC, LLC. counselors' are not psychiatrists, they are Master's level therapists, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

Initial here: _____

Rights and Risks:

- Please feel free to ask questions about any aspect of the counseling process. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the PC, LLC counselor's expertise in employing them, or about the treatment plan, please ask and you with be answered fully.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- You may remember unpleasant events, arouse intense emotions, and/or alter close relationships.
- You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that PC, LLC does not provide, the therapist has an ethical obligation to assist you in obtaining those treatments.

Initial here: _____

TELEPHONE & EMERGENCY PROCEDURES:

- The ***best phone number*** for calling the center is **(859) 985-7862,** our Main Berea Center location. You may also use **(859) 428-7862 to text or call in Berea OR (859) 428-8696 to text or call Richmond**. If you receive the voicemail, please leave a message for our administrators. Your counselor may be on the phone, in therapy with someone else, or out of the office. Our administrators will be sure to contact you and/or relay any necessary information to your counselor in a timely manner.
- ***In a crisis,*** if your therapist cannot be reached and ***you are in imminent danger, call the police (911), or go immediately to Baptist Health Richmond Emergency Room or to your local emergency hospital.*** If you are suicidal, extremely depressed, have thoughts of hurting yourself or others, or have another mental health crisis please go directly to the closest emergency hospital. ***Parsons Counseling, LLC. DOES NOT TAKE after-hour CRISIS CALLS*** due to limited staff and availability to return your crisis phone call. Parsons Counseling does not take after-hour calls.
- If you need to contact PC, LLC. between sessions, for an emergency, please indicate it clearly in your message. Telephone calls are monitored during the day as time allows and therefore, we cannot guarantee immediate returned calls. PC, LLC. counselors are not responsible for your behaviors or decisions occurring outside the consultation room, whether before or after a telephone call, consultation, or session.

Initial here: _____

INFORMED CONSENT FOR TELEPHONE, ELECTRONIC, PHOTOGRAPHS, AND MAIL CONTACT:

Privacy precautions have been made to ensure your privacy. PC, LLC. uses a secure program, TherapyNotes, for storing all documents, along with storing some in house documents in a locked filing cabinet. All precautions are attempted to keep your information confidential. If you choose to communicate over the internet or via phone through texting you understand you are waiving your right for confidentiality since there is no 100% guarantee of privacy through email or texts.

Initial here: _____

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT continued

Permission for PC, LLC. to initiate emails to you: Initial below if you give your permission for PC, LLC. to initiate sending emails to you and reminder appointments. Email is not to be used for emergencies or in a crisis.

Print your email clearly: _____ **Initial here: _____**

Photographs and artwork: I give permission for my therapeutic work, such as clients' miniatures, sandworlds and therapeutic artwork, to be shown for educational and training purposes without disclosing confidential identifying information.

Initial here: _____

INTERNS: PC, LLC is working with qualified students to train them for the human services profession. They will maintain client confidentiality and maintain professionalism in the workplace. Interns will schedule appointments, work with clients, assist with intakes, and other office tasks.

Initial here: _____

APPOINTMENTS: All office appointments are scheduled for 53 minute sessions. Consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. No more than 2 future appointments can be scheduled at a time in order to fairly accommodate all of our clients. Please arrive on time to all scheduled appointments. If you are unable to keep a scheduled appointment, you must notify PC, LLC. **at least 24 hours in advance** to avoid the *canceled or missed appointment fee of $30.00.* To cancel an appointment, you may choose to leave a message on voicemail, leave a text message at 859-428-7862, or email appt@parsonscounseling.com. ***Your compliance in keeping appointments and active participation in treatment is vital.*** (*only instances *not prohibited by law are subject to the missed/cancelation fee**)

I understand that I will be charged $30 for each missed appointment canceled inside a 24 hour period from my scheduled appointment. I understand that I cannot have another appointment until the missed appointment fee is paid. A doctor's note will waive fee.

Initial here: _____

TERMINATION:

- An orderly end of therapy has positive effects for clients. It is suggested that you discuss openly with your counselor your wish to end therapy at least three (3) sessions before your last session.
- If at any point during psychotherapy, a PC, LLC. counselor assesses that she/he is not effective in helping you reach the therapeutic goals, they are obligated to discuss it with you and, if appropriate, terminate treatment. In such a case, the counselor would give you a number of referrals that may be of help to you.
- Frequent missed or rescheduled appointments will result in termination of services deemed by PC, LLC. A letter will be sent to you acknowledging the termination, reasons why, and a closing bill for any unpaid balance.
- If you have not had an appointment for at least 60 days a letter will be sent to the address on file inviting you to schedule an appointment within 10 days before terminating your chart. ***If you choose to schedule an appointment and do not show your chart will be terminated.***
- **If you cancel or miss three visits within a 90 day period PC, LLC. reserves the right to terminate your chart immediately & refer you elsewhere.**

Initial here: _____

Notification of Follow-Up Consent: I give permission to be contacted during the course of treatment and/or following termination from treatment to determine my satisfaction with the services received at PC, LLC **____Yes ____No**

Initial here: _____

CONTRACT, OFFICE PROCEDURES and FINANCIAL AGREEMENT continued

Appeals and Grievances: If you have a complaint about quality of care please contact the Practice Administrator by email at info@parsonscounseling.com within 30 days of the incident.

Initial here: _____

PAYMENT & INSURANCE REIMBURSEMENT:

- Clients paying on a ***cash basis*** are expected to ***pay in full at time of service*** unless other arrangements have been made.
- ***Additional fees*** of $100 an hour will be charged for lengthy telephone communications, court attendance, and report/letter writing. Insurance does not cover this.
- If your case requires us to hire an attorney to assist or protect our office involving your case you will be responsible for ***all attorneys' fees***
- There is a ***$30.00 service fee*** **for checks returned** for Insufficient funds, and the client will be required to pay for future sessions in cash. Before any future visits occur, the client or responsible party must pay ***in cash*** the service charge ***PLUS*** the value of the check.
- I authorize my insurance to be billed for counseling services in attempt to assist in paying for my services.
- At any time during treatment ***should the client become ineligible for insurance coverage****, the client and/or responsible party agrees to notify the counselor and* ***will be responsible for 100% of the bill.***

Initial here: _____

CONSENT TO TREATMENT AND FEE:

By signing this contract, you agree that if you have not obtained any necessary authorizations from your insurance, or are not eligible at the time services are rendered, **you are responsible for payment** even if the determination is made after the services are rendered. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company.

I hereby agree to full responsibility for all expenses incurred by or because of this client and hereby assign Parsons Counseling, LLC. and all insurance benefits due to me to the full extent of my financial obligation to Parsons Counseling, LLC. I understand my insurance coverage is a relationship between my insurance company and me and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with Kentucky State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. If conjoint (couple or family), all adults need to sign this contract because of confidentiality and your rights... even though one person is the identified client (and paying).

Initial here: _____

. . . . . .

HIPPA Notice of Privacy Practices

Please mark one of the following: _____ I have received a copy of the HIPAA Notice of Privacy Practice (available at the Center or on www.parsonscounseling.com)

_____ I decline to receive a copy of the HIPAA Notice of Privacy Practice

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them; I have been given an opportunity to discuss these policies with a Parsons Counseling, LLC staff person and all questions I raised were answered to my satisfaction.

_____ _____ _____

Signature of Client age 16 or older/Legal Representative **Print Name** **Date**

_____ _____

Signature of Parsons Counseling, LLC. Representative **Date**

PARSONS COUNSELING & PLAY THERAPY CENTER

CHILD'S CONTACT INFORMATION & PSYCHOSOCIAL

*Child's Name: _____ *Date: _____

*Social Security #: _____ *Birthdate: _____ * Height: _____ *Weight: _____

*Gender at Birth: M or F (If applicable) Gender Identity: _____ Sexual Orientation: _____

*Address:_____

*City, State,Zip:_____

***FOR THE FOLLOWING LINES, please list information for the Parent(s) or Guardian(s) who have *LEGAL CUSTODY* of the client:**

*Parent/Guardian 1 Contact Name: _____ *Relationship: _____

*Phone _____ Circle: Home Cell Work *May we leave a message or text this phone? Yes No

*E-mail _____ May we e-mail you or put you on our mailing list? Yes No

*Parent/Guardian 2 Contact Name: _____ *Relationship: _____

*Phone _____ Circle: Home Cell Work May we leave a message or text this phone? Yes No

*E-mail _____ May we e-mail you or put you on our mailing list? Yes No

PARENT and GUARDIAN INFORMATION (all areas must be COMPLETELY filled out).

Note: ***If parents are separated or divorced, or the child lives with another guardian, a copy of custodial papers MUST be on file at Parsons Counseling, LLC. Counseling services will only be rendered to a child with a parent or guardian with legal documentation from a judge.***

*Biological Mother's Name: _____Does the child live with?: Yes or No **If no**, Visitation?: Yes or No

*Biological Father's Name: _____ Does the child live with?: Yes or No **If no**, Visitation?: Yes or No

*Biological Parents are: ___Married ___Divorced ___Separated ___Never married

*Do the biological parents have legal custody of the child? Yes or No

- If not, has the child been legally adopted? Yes or No OR ● If not, is the child currently in foster care? Yes+ or No

+If **yes**, list the social worker's name and cell phone number: _____

INSURANCE INFORMATION

****If you have Medicaid & other insurance in addition to Medicaid please list the OTHER insurance as the Primary Health Insurance. Medicaid will NOT pay if we do not bill the other insurance first. Ms. Lisa Parsons, Ms. Brittany Wills & Ms Jeanne Nakazawa are currently the only participating therapists with other private insurances outside of Medicaid. If you have other insurance & see another therapist you will be responsible for the full intake fee of $80.00. ****** For Medicaid, the client is the subscriber; all other insurances an adult parent is the subscriber.

*Primary Health Insurance: _____ *ID #: _____ Group #: _____

*Subscriber Name: _____*Child's Relationship to Subscriber:_____ *Subscriber DOB:_____

*Subscriber Address: _____

Secondary Health Insurance: _____ ID #: _____ Group #: _____

Subscriber Name: _____Child's Relationship to Subscriber:_____ Subscriber DOB:_____

Subscriber Address: _____

CHILD'S CONTACT INFORMATION & PSYCHOSOCIAL continued

Problem Analysis - History of Present Problem

PROBLEM DESCRIPTION: Briefly describe the problem you most wish help with right now for the child: _____

_____

_____

PROBLEM INTENSITY: How would you rate the intensity of the problem or concern the child is experiencing? (Circle the appropriate number):

1	2	3	4	5	6
Not intense			Moderately Intense		Extremely Intense

PROBLEM DURATION: Approximately how long has the child had the current problem? _____

COPING ATTEMPTS: In what ways has the child or family attempted to cope with this problem? _____

_____

EXPECTATIONS: What do parent/guardian hope to accomplish by coming here? _____

_____

ADHD and concentration issues: On a scale from 1-10 with ten being extremely hyperactive or inattentive, how is the child? ____

DEPRESSION: On a scale from 1-10 with ten being extremely depressed/suicidal, how depressed is the child? _____

ANXIOUS: On a scale from 1-10 with ten being extremely anxious, how anxious is the child? _____

HOSPITALIZED: Has the child ever been hospitalized for psychological/emotional difficulties? ___Yes ___No

If yes, explain difficulty, dates hospitalized _____

_____

SUICIDAL: Has the child had suicidal thoughts recently? ___frequently ___sometimes ___rarely ___never

Has the child had suicidal thoughts in the past? ___frequently ___sometimes ___rarely ___never

Has the child attempted suicide? ___Yes ___No ___Unsure

CUTTING/OTHER: Has the child ever intentionally inflicted any harm upon self? ___Yes ___No ___Unsure

Trauma History

1. Please describe any past or current **traumas** your child has experienced (including abuse, physical sexual or verbal):

   _____

   _____

2. Has the child experienced any serious **emotional losses** (such as a death of or physical separation from a parent or other caretaker)? YES NO
3. **Abuse:** Has the child been physically abused? YES NO Sexually abused? YES NO Neglected? YES NO
4. Has the child witnessed domestic violence or seen physical abuse? YES NO

CHILD'S CONTACT INFORMATION & PSYCHOSOCIAL continued

About Child's Family

1. List **major changes**, including marriages, divorces, moves, and deaths etc., which have occurred in your family in the last 5 years. (If there are other events that happened earlier that still affect the family, please add those.)

_____

_____

2. **Support system that your child can depend on (**mark all that apply:)

__ Boyfriend/girlfriend __ Mom __ Dad __ Brother __ Sister __ Aunt __ Uncle
__ Grandparents __ Friend (s) __ Neighbor __ Friends __ Pastor __ Church member

3. What **stresses** does your family struggle with?_____

_____

_____

Please **list family members**.

Relatives	**Name**	**Age**	**Does Child Get Along Well with this Person?**	**Grade/ Occupation**	**Substance Use** alcohol, cigarettes, pills, drugs
Father					
Mother					
Brother(s)					
Sister(s)					
Other people who live in the home					

4. Has anyone in your child's **family been diagnosed** with a psychiatric illness (anxiety, depression, suicide, schizophrenia)?

YES NO If yes, please explain: _____

_____

_____

CHILD'S CONTACT INFORMATION & PSYCHOSOCIAL continued

Your Child's Social Information

1. Interacts: **Adults**: Shy Fair Good Great Very Social

   Children/Peers: Shy Fair Good Great Very Social

2. Do **you like** your child's peers? ___None ___Some ___Most ___All

3. Have any of your child's friends been **in trouble** with the law? ___None ___Some ___Most ___All

4. How would you describe your child's **personality and/or temperament**? (mark all that apply)

   ___ happy ___ content ___ fussy ___ quiet ___ angry ___ hostile ___ irritable

About Your Child's Education

1. What **school** does your child currently attend? _____

   Teacher's Name (s): _____

   _____

2. Current **Grade**: _____ Has your child ever **repeated a grade**? YES NO If so, which one(s)? _____

3. How many classes did your child A) fail last year?_____ B) failing now? _____

4. Child's **Favorite** Class/Subject_____ **Least favorite** Class/Subject_____

5. Has your child experienced any of the following **problems at school**? (mark all that apply):

   ___fighting ___drug/alcohol ____detention ___suspension

   ___learning disabilities ___poor attendance ____poor grades ___ gang influence

   ___incomplete homework ___behavior problems ____emotional problems ___lack of friends

_____ _____

Signature of Parsons Counseling, LLC. Representative **Date**

Check all that apply:

Accident prone
Affectionate
Aggressive
Argues, "talks back," smart-alecky, defiant
Assaults
Bathroom language
Bigoted
Bossy to others
Breaks rules
Breaks the law
Bullied by others
Bullies/ intimidates, teases, inflicts pain on others
Cheats
Clowns around
Competition
Complains
Complains of feeling sick
Compliant
Concern for others
Conflicts at school
Conflicts at home with parents over rule breaking, money, chores, choices
Conflicts with friends
Conflicts with police
Cries easily, feelings are easily hurt
Cruel to animals
Dares others
Dawdles, procrastinates, wastes time
Daydreams
Defiant
Dependent, immature
Destructive
Developmental delays
Difficulties with parent's paramour/new marriage
Disobedient, uncooperative, refuses, noncompliant
Disrupts family activities
Distractible, inattentive, poor concentration, daydreams
Dropping out of school
Drug or alcohol use
Drug sales
Eating issues, poor manners, over/under eats, refuses
Exercise problems
Extracurricular activities interfere with academics
Failure in school
Fantasy life
Fearful
Feelings are easily hurt
Fidgety
Fighting, hitting, violent, aggressive, hostile, threatens
Finger sucking
Fire starting
Fire setting
Friendly, outgoing, social
Hair chewing, pulling

Head banging
Hitting
Hostile
Hyperactive
Hypochondriac, always complains of feeling sick
Imaginary playmates, fantasy
Immature, "clowns around," has only younger playmates
Inappropriate sexual behaviors
Inattentive
Independent
Inflicts pain on others
Insults others
Interrupts, talks out, yells
Intimidated by others
Intimidates others
Intolerant
Irritability
Isolates
Lacks organization, unprepared
Lacks respect for authority, insults, dares, provokes
Learning disability
Legal difficulties, truancy, loitering, vandalism, drinking
Lethargic
Likes to be alone, withdraws, isolates
Loitering
Loss of friends
Low-frustration tolerance, irritability
Lying
Manipulates
Masturbation
Mental retardation
Moody
Mute – refuses to speak
Nail biting
Name calling
Needs high supervision at home over play/chores/schedule
Negativism
Nervous
New school
Nightmares
Noisy
Noncompliant
Obedient
Obesity
Only younger playmates
Oppositional, resists, refuses, does not comply, negativism
Outgoing
Out-of- seat behaviors
Overactive, restless, hyperactive, restlessness, fidgety
Picks on others
Poor concentration
Prejudiced, bigoted, insulting, name calling, intolerant
Procrastinates

Provokes others
Rages
Recent move, new school, loss of friends
Refuses
Relationships with friends are poor
Relationships with siblings –competition, fights, teasing/provoking
Relationships with teachers poor
Resists
Responsible
Restless
Rocking motion/behavior
Repetitive movements
Runs away
Sad, unhappy
School avoiding
Self-harming behaviors—biting, hitting self, scratching
Sexual preoccupation, inappropriate sexual behaviors
Sexually active
Shy, timid
Slow moving
Slow responding
Smart-alecky
Smoking
Social
Speech difficulties
Stealing
Stubborn
Suicide talk or attempt
Swearing, blasphemes, foul language
Talks back
Teased, picked on, victimized, bullied
Teases others
Temper-tantrums, rages
Threatens
Thumb sucking, finger-sucking
Tics – involuntary rapid movements, noises or word productions
Timid
Truancy, school avoiding
Uncooperative
Uncoordinated, accident-prone
Underactive, slow-moving
Unhappy
Unprepared
Vandalism
Violent
Wastes time
Wetting/soiling of bed or clothes
Withdraws
Yells

Other:

Initials of Parsons Counseling. LLC Rep.

_____

MEDICATION RECONCILIATION RECORD for ALL MEDICATIONS

Client Name: _____ **Birthdate:** _____

Date: _____

❑ **No Known Allergies OR List Allergies:**

Current Medications: *Prescribed medications, herbal supplements, vitamins, over-the-counter drugs, everything that you are taking on a regular basis for any reason.*

Medication Name	Dose and Frequency	Date Started	Date Discontinued	Reason for Taking It	Prescriber (first and last name with specialty)

Initials of Parsons Counseling, LLC. Representative: _____

AUTHORIZATION FOR RELEASE AND EXCHANGE OF MENTAL HEALTH RECORD OR INFORMATION for Child

Client Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize Parsons Counseling, LLC. to use or disclose protected health information from the mental health records of the client listed above, which may include psychiatric diagnosis, treatment plans, and progress (written, verbally or electronically) to the following and initial for my consent:

Primary Care Physician:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Inform physician of therapeutic services and any medical or mental concerns.

***Psychiatrist or Prescribing Doctor of Psychotropic Drugs (if applicable):**

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Collaborate and obtain medical information from the physician to assist in meeting any medical, medication, or mental concerns.

School/ Daycare:

School County District: _____

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: To work with teacher, family resource/youth service center, counselor, or principal regarding behavioral or mental health concerns to assist in school performance.

***Emergency Contact:**

Name: _____ Phone: _____

Relationship to client: _____ Address: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: In case of a medical emergency and scheduling appointments.

***DCBS or Agency who has custody of child (if applicable):**

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Collaborate with DCBS/agency to report progresS & therapeutic goals regarding behavioral or mental health concern to assist in reaching DCBS or agency goals & obtain a copy of most recent Family Prevention Plans/case plans.

AUTHORIZATION FOR RELEASE AND EXCHANGE OF MENTAL HEALTH RECORD OR INFORMATION for Child

***Other Parent/Step-Parent/ Guardian:**

Name: _____ Phone: _____

Relationship to client: _____ Address: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: Appointments, progress of treatment goals, concerns, and areas where adult can make improvement to assist client.

Legal, CDW or other:

Name: _____ Phone: _____

Address: _____ FAX: _____

City: _____ State: _____ Zip: _____

Purpose of Disclosure: _____

By signing below, I acknowledge that I have read and understand this Authorization.

1. I understand that, unless withdrawn, this authorization will expire in one year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Parsons Counseling, LLC. at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that Parsons Counseling, LLC will NOT give copies of client notes without another release signed indicating such. .
5. I understand that I may inspect or request a copy of my mental health records, with the exception of my psychotherapy notes. Parsons Counseling, LLC is not required to release psychotherapy notes.
6. I understand that I may refuse to sign this authorization and that Parsons Counseling, LLC. will not allow my refusal to interfere with receipt of payment for mental health and counseling services.
7. I understand that I am entitled to receive a copy of this authorization

_____ _____ _____

Signature of Client age 16 or older/ Legal Guardian **Relationship to Client** **Date**

_____ _____

Signature of Parsons Counseling, LLC. Representative **Date**

RELEASE OF INFORMATION TO PROVIDE IN-SCHOOL & IN-DAYCARE COUNSELING & TARGETED CASE MANAGEMENT

I hereby authorize Parsons Counseling, LLC to provide in-school, in-daycare counseling, and/or targeted case management services to the following client listed below. I understand that the client will be taken out of class for 30-60 minutes at the counselor/ case manager's discretion and may be seen with Parsons Counseling staff in public areas of the school or daycare. The client will be seen in an office or space provided by the school or daycare to conduct counseling in lieu of counseling offered at Parsons Counseling & Play Therapy Center.

Client's Name: _____

DOB: _____ **SS#**: _____

Address: _____
(street) (city) (state) (zip)

Daycare/School Information

County District:_____ (Madison County Schools have their own form to fill out too.)

Daycare/School Name: _____

Address: _____
(street) (city) (state) (zip)

Parent or Guardian's Name consenting for services: _____ _____

Parent or Guardian's Number: _____

Additional agreement: I agree to have the following information disclosed and to exchange information to the school or daycare staff and counselor and/or TCM Coordinator:
[ ] Attendance Records [ ] Behavior Issues [ ] Academic information
[ ] Summary of treatment progress verbal or written [ ] Progress in counseling and/or TCM services
[ ] Other (specify) _____

For DayCare clients:
[ ] I understand and agree that the daycare setting may be used as a therapeutic playroom with the child, resulting in some treatment in public settings.
[ ] I do not agree to therapeutic playroom activities in public settings at the daycare.

This consent is effective for one year from the date signed below or _____.

I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

Parent/Legal Guardian Signature: _____ **Date**: _____