



# Helping Hands Counseling Center, INC.

## Child Intake Treatment Form

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Last First Middle Initial

Child's Social Security Number: \_\_\_\_\_ Child's Date of birth: \_\_\_\_\_

Referred by: \_\_\_\_\_

Email: \_\_\_\_\_

### Demographic Information:

Parent or Guardians Name: \_\_\_\_\_

Relationship with Child: \_\_\_\_\_ Number of people living in home: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

### Academic Information:

School Child attends: \_\_\_\_\_ Grade: \_\_\_\_\_

Special Classes: [ ]Yes [ ]No

Has there been a change in level of academic success?: [ ]Yes [ ]No

### Medical Information:

Date of last Physical: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Physician's Office Address: \_\_\_\_\_

-Has child ever had a serious illness, accidents or head injury: [ ]Yes [ ]No

If yes please explain & when was said date: \_\_\_\_\_

-Does the child have frequent illnesses? [ ]Yes [ ]No

If yes please explain: \_\_\_\_\_

-Does Child have Allergies?: [ ]Yes [ ]No

Please describe: \_\_\_\_\_

-Current Medications: (Please List Below)

Medication: \_\_\_\_\_ Dose/Mg: \_\_\_\_\_ Times: \_\_\_\_\_

Has the child ever received counseling?: [ ]Yes [ ]No

Name of the Agency the child last received counseling from: \_\_\_\_\_

**Please circle any of the following that may pertain to the child**

Nervousness	Shyness	Separation	Reliable	Anger
Sleep Problems	Relaxation	Legal Matters	Energy	Loneliness
Insomnia	Stress	Health Problems	Withdrawn	Tiredness
Unhappiness	Bed Wetting	Headaches	Nightmares	Ambition Level
Depression	Memory	Appetite	Decisions	School Issues
Fighting	Drug Use	Alcohol Use	Fears	Vindictive
Peer Pressure	Suicidal Ideation	Low Concentration	Impulsive	Self-Confident
Hardworking	Impatient	Short Attention	Moody	Excitable
Serious	Calm	Easy-Going	Sexual Issues	Physical Abuse/Neglect

Reason for requesting services (behavior problems, school referral, or court ordered):

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Please give any other useful information which may help us in servicing your Child:

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**I have read and agree to abide by the above policies of Helping Hands Counseling Center- as signified by signature on last page.**

**Responsible Party**

Guardian's Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Alternate Telephone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Telephone Number: \_\_\_\_\_

**Insurance Information:**

Insurance Company Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured's ID Number: \_\_\_\_\_

Plan Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Holder's Name: \_\_\_\_\_

Insurance Holder's Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

**Authorization for payment and statement of understanding**

**I authorize payment of medical services and counseling to be paid directly to the named physician of licensed therapist supplier as indicated on the claim. I authorize release of medical information to my insurance company for the sole purpose of billing and reimbursement. I also understand my signature designates my understanding and agreement with all information contained within this Intake Treatment Form.**

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature (If applicable): \_\_\_\_\_ Date: \_\_\_\_\_

**Information for Client concerning Office Policies and procedures**

**Appointments:** Your appointment time is reserved exclusively for you. Unless you give a twenty-four hour notice to cancel your appointment, your case will be closed after two no shows with a letter of intent from this agency. Your case will also be considered for closure after three cancellations, two no shows or a combination of each within a six-month period. **A \$50.00 charge will be applied for all no show appointments.** Please be on time; we stay as close to the appointed time as possible. No alcohol or drugs are allowed before or during sessions; no beverages of food intake, no smoking or chewing gum is allowed in the agency or on agency grounds with the exception of water during session time. Please dress comfortably for your sessions.

The most commonly billed fees are listed below. Other fees are assessed as services are provided.

<u>Type of Service</u>	<u>Fee</u>
Initial Appointment-Therapist	\$200.00 per 45-50min. session
Individual Counseling	\$180.00 per 45-50min. session \$95.00 per 30min. session
Family Counseling	\$175.00 per 45-50min. session
Couples Counseling	\$175.00 per 45-50min. session
Home/Hospital Visit	\$175.00 per 45min. + travel time
Interpreter services at client's expense	
Court/Legal Appearances	\$250.00 per hour to include prep time and travel time portal-to-portal (770 W. Liberty Street, round trip) plus \$0.50 per mile
Letters	Brief Letter - \$35.00; Detailed Letter- \$50.00+ (Determined by the therapist)

**Legal Appearances:** no court appearance will be conducted by a representative of HHCC (Helping Hands Counseling Center) without a legal subpoena. A deposit may be required and will be determined by HHCC representative.

**Insurance:** we participate with most major insurance plans and accept their contracted rate as payment. **We do require payment of co-pays, coinsurance and deductible amounts as indicated at the time of service.** Please review your policy booklet prior to your first session. If we do not participate with your insurance plan, our billed rate is our charge. You are responsible for any part of that amount your insurance does not pay.

**Payment:** In order to keep fees as low as possible, payment is due at the time of the appointment. We accept personal checks or cash. There will be a \$55.00 charge for all returned checks. There will also be a \$50.00 charge for all missed appointments without a 24 hour notice.

**Telephone Calls and Emergencies:** My assistant or voice mail accepts telephone messages when the therapist is in session or otherwise occupied or unavailable. In general, telephone counseling is ineffective. Telephone calls for counseling are to be kept at a minimum. If you need more than 5 minutes to resolve an issue, you need to come in for an appointment. A charge of \$1.00 per minute will be assessed for each call lasting more than 5 minutes. This charge is not reimbursable by insurance.

**Helping Hands Counseling Center is an outpatient counseling agency.** Please leave routine messages on the voice mail if office staff is not available, someone will return your call as soon as possible. Standard office hours are Monday through Thursday 9:00am – 7:00pm. In case of an emergency please dial 911 or go to the nearest emergency room.

**Tax Information:** Transportation costs and payments may be deductible as medical expenses. You need not specify the type or length of treatment. You only need to list counseling, the agency name and the amount. Your check or our written receipt will suffice for tax purposes.

### **What to expect from our Relationship**

As professionals, we will use our best knowledge and skills to help you. This includes following the rules of Social Work and Professional Licensing Boards. Limits are put on the relationship between the therapist and a client and will abide by these limits.

**First-** We are licensed and trained to practice clinical social work or counseling- not law, medicine or any other profession. We are not able to give you good advice from other professional viewpoints.

**Second-** State laws and rules of Social Work and Professional Licensing Boards require me to keep what you tell me confidential. You can trust me not to tell anyone else what you tell me, except in certain limited situations. We try not to reveal who our clients are. This is part of our effort to maintain your privacy. If we meet in the street or socially, I may not say “hello” or talk with you. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

**Third-** In your best interest and following the rules of Social Work and Licensing Boards, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients. I cannot be a therapist to someone who is a close friend. I can never have a sexual or romantic relationship with my client during or after the course of therapy. I cannot have a business relationship with any of my clients, other than the therapeutic relationship.

**“Good-Bye Session”-** Once growth occurs, it is natural to move on; it is also natural to say “good-bye”. When you are ready to stop therapy, please let me know one week before your last appointment, so that we may review the course of our sessions together, discuss the goals you have accomplished and set goals for the future. It is also important to remember that you may wish to take a brief “vacation” from therapy for a while to return later on. Please inform the office if this is your intent.