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CHILD CLIENT INTAKE FORM

Today's Date: _____ Date of 1st Appt: _____ Time of 1st appt: _____ Referred by: _____

Name of Child:_____
First Middle Last

Child's Address: _____

Child's Bday:_____ Child's Age: _____ Child's Sex: _____ Child's Gender: _____

Parent/Guardian Name:		Parent/Guardian Name:	
Phone(s):		Phone(s):	
Home Address: (if different than child)		Home Address: (if different than child)	
Occupation:		Occupation:	
Employer:		Employer:	

PRIMARY INSURANCE INFORMATION: Please completely fill out if you are using insurance benefits for your child. Please also call the insurance company to find out all the following information prior to the first session. It is the parent/guardian's responsibility to make sure the child will be covered adequately at the time of service. If this information is not known at the first visit, you may be billed at the time of service.

Child's Name on Insurance Documents (if different): _____

Insurance Company: _____ Plan name: _____

Policy ID # _____ Group # _____

Primary policy holder name: _____ Relationship to child _____

Policy Holder Tel: _____ Policy holder bday: _____

Policy holder address (if different): _____

Claims Address: _____ Provider Tel: _____

Copay amount: _____ Coinsurance amount: _____ Mental health deductible? Y or N

Deductible amount? _____ $ deductible met for yr? _____ When does deductible begin annually? _____

Prior authorization necessary?: Y or N Authorization # _____ PCP Name _____

***** IF YOUR CHILD HAS SECONDARY INSURANCE, PLEASE LET THE THERAPIST KNOW AND PRINT/FILL OUT A SECOND COPY OF THE INSURANCE INFORMATION ABOVE**

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PLEASE BRING PHOTOCOPY (BOTH SIDES) OF THE INSURANCE CARD TO FIRST VISIT.

I give permission for C4VL to bill my child's insurance policy for psychological services rendered.

Parent/guardian signature: _____ **Date:** _____

Parent/guardian signature: _____ **Date:** _____

EACH PARENT/GUARDIAN(S), PLEASE INITIAL EACH BOX BELOW, which indicates that you acknowledge the following information is a summary of what is further described in the documents, Practice Guidelines and Policies and HIPAA (available on c4vl.com).

		The therapist's licensure and regulatory board information is included in the Agreement / website and I have access to this information should I need it.
		The therapist was available to answer questions on what I and my child can expect about therapy and my/my child's rights.
		The therapist's fee for therapy ranges from $120-150/session, depending on time spent or code used although it may be less if there is a contractual rate with an insurance company.
		The provider's late cancel / no-show fee for time reserved is as follows:
		*** The cancelation / no show fee is $120. I am responsible for paying this fee, regardless of the reason for missing the appointment. I will pay this fee unless I have made other arrangements with another party, in writing, signed by that person or if my child is legally exempt (Medicaid or EAP only). If my child misses multiple sessions, the therapist reserves the right to terminate therapy and refer out.**
		*** Requires 48 hours / 2 days notice for cancelation.**
		* No reimbursement from insurance for missed sessions or late cancels = parent/guardian responsibility
		* When schools / businesses close for inclement weather, imminent life-threatening illnesses, inpatient hospitalizations, death to loved ones, clients may cancel with less than 48 hours.
		No appointment reminders given; client responsibility to keep track of time, date, and location.
		Copays are due at the time of service or full payment if no insurance being used. Payments can be made via cash, credit card (can be kept on file and is PCI compliant), or check.
		Client/parent responsibility to confirm mental health benefits and know what the ongoing patient responsibility is (copays, coinsurance, deductible, etc).
		Contact – phone/ email /text policy reviewed
		Limits to Confidentiality reviewed = harm to self, harm to others, child abuse reporting
		Minor policies including confidentiality was reviewed. Minor paperwork will be provided if applicable (custody and decision making agreements, financial responsibilities, etc.).
		C4VL may provide me a referral to another therapist if the therapist is not a good fit for my child's therapeutic needs.

I, _____, acknowledge that I am the parent/guardian taking primary financial responsibility for the child unless another party accepts responsibility in writing, providing their signature. If a court ordered parenting agreement is in place in which another parent/guardian has financial responsibility, this must be submitted to the therapist and that parent must acknowledge their responsibility in writing before treatment begins. The therapist assumes both parents have medical decision-making rights unless a court document is submitted stating otherwise.

Parent/guardian signature: _____ **Date:** _____

☐ **For minor clients under 15:**

I acknowledge that my child is a minor (under 15). According to Colorado mental health law, I retain the right to consent to treatment for my child. I can also decide not to continue with treatment for my child at any time. My child does not retain that right until he/she reaches 15. However, I acknowledge that I am open to what is deemed best for my child's emotional well-being. Until my child turns 18, I have the right to review my child's records or ask questions about treatment with my child's mental health provider. However, I acknowledge that if I attempt to review written records or verbally consult with the mental health provider, any unnecessary involvement in treatment may jeopardize my child's willingness to be open and honest in session. Therefore, while I know I can review records and ask how treatment is going, I will do my best to rely on the professional opinion of the mental health provider to keep me informed as necessary. I also have had the ability to review the Practice Guidelines and Policies and HIPAA document on my child's behalf.

_____ _____

Parent/Guardian Signature **Parent/Guardian Signature**

☐ **For clients between ages 15 - 18:**

I acknowledge that my child has different rights to treatment than someone under 15, according to Colorado mental health law but is still considered a minor re: abuse. My child has the right to consent to treatment and he/she can also decide not to continue with treatment at any time, even if I would like it to continue. Until my child turns 18, I still have the right to review my child's records or ask questions about treatment with my child's mental health provider. However, I acknowledge that if I attempt to review written records or verbally consult with the mental health provider, any unnecessary involvement in treatment may jeopardize my child's willingness to be open and honest in session. Therefore, while I know I can review records and ask how treatment is going, I will do my best to rely on the professional opinion of the mental health provider to keep me informed as necessary. I also have had the ability to review the Practice Guidelines and Policies and HIPAA document as has my child and we are all signing below acknowledging this information.

_____ _____

Parent/Guardian Signature **Parent/Guardian Signature**

_____

Child Client Signature

For minors of divorced parents or guardians:

_____ I legally have full custody and make all mental health decisions for my child. Treatment does not need to be approved by anyone but me.

_____ I share custody but am in charge of all mental health decisions for my child. Treatment does not need to be approved by anyone but me.

_____ I have partial or joint custody and share mental health decisions for my child. In that case, my child's other parent/guardian MUST sign this document as well for my child to receive services.

_____ *I will provide any related court documentation (re: custody, medical decision-making, etc.) to confirm the above is true.*

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What are the reasons you are seeking therapy for your child at this time? (Treatment focus / goals)

☐ depression	☐ anger management	☐ relationship probs: (w/ whom?)
☐ anxiety	☐ panic attacks	☐ disordered eating
☐ mood swings	☐ low self esteem	☐ gender identity
☐ family problems	☐ trust issues	☐ stress management
☐ adoption issues	☐ trauma history	☐ sexuality
☐ academic / learning problems	☐ attachment issues	☐ psychosis (hallucinations / delusions)
☐ behavioral problems at home	☐ grief / loss	☐ addiction issues
☐ behavioral problems at school	☐ Autistic spectrum	☐ Excessive fears / Nightmares
☐ social problems w peers	☐ self-harm behaviors	☐ ODD / Conduct Disorder
☐ ADHD / attention issues	☐ adjustment issues	☐ improve verbalization of thoughts / feelings
☐ improve coping skills	☐ improve communication	☐ Other: please explain below

More info:

_____

_____

_____

_____

Racial Identity (Circle all that apply): African-American/Black Hispanic/Latino(a) Native American
Asian Caucasian/White Pacific Islander Other*: _____

First language: _____ Other languages: _____

Child's Parents:
☐ Married currently (how long? _____) ☐ Never married ☐ Divorced (child's age_____)
☐ Either parent deceased? _____ (When? How? _____

☐ Raised by bio-mother AND bio-father
☐ Raised by single parent (which one?)_____
☐ Raised by bio-parent (which one?) _____and step-parent _____
☐ Raised by someone other than bio parent(s) _____
☐ Adopted. When? _____
☐ Foster care (Ages: _____)

Siblings: DO NOT PUT THEIR NAMES PLEASE
(# sisters_____, # brothers_____)

Age	Gender	Live w/ child?	Any relevant details (how is their relationship, where they are, other important details etc.)
	☐ M ☐ F	Y or N	
	☐ M ☐ F	Y or N	
	☐ M ☐ F	Y or N	
	☐ M ☐ F	Y or N	

Others living in child's household besides siblings above

Relationship to child	Gender	Age	Any relevant details (how is their relationship, other important details etc.)
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

Please briefly describe your child's relationships with his family, friends, peers, teachers, etc. Include anything relevant to their functioning.

_____

_____

_____

_____

_____

_____

Trauma hx? (Physical or Sexual Abuse? Abuse reported?)

_____

_____

_____

Has your child had previous mental health treatment? □ Yes □ No
Provider name(s)_____ Dates_____
_____ _____

Prev. mental health Diagnos(es)? _____

Has your child ever taken any medications on a regular basis? If yes, please list medications and doses.

_____

_____

Please describe if child's immediate blood relatives have had any mental health problems? (depression, anxiety, bipolar, addictions, etc.) _____

Suicide and self-harm

Current thoughts of hurting him/herself? _____ Current plan/ method? _____

Previous thoughts or attempt(s)? _____

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Homicide and Harm to Others

Does your child have current thoughts of hurting someone else? _____

Current plan / method? _____History of violence? _____

EDUCATIONAL / DEVELOPMENTAL HISTORY

Birth or Delivery Complications? **Y or N** Complications during mother's pregnancy? **Y or N**

In utero exposure to drugs? **Y or N** Domestic Violence exposure? **Y or N**

Any delays with: Crawling? **Y or N** Walking? **Y or N** Talking? **Y or N** Reading? **Y or N** Writing? **Y or N**

School: _____ What grade is your child in? _____ Grades repeated? _____

Spec. Ed. classes? **Y or N** For what? _____ Self-contained class? **Y or N**

Integrated/mainstreamed? **Y or N** IEP? **Y or N** 504 plan? **Y or N**

Other school info: _____

Any other relevant information you want your child's therapist to know:

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

FOR OLDER CHILDREN:

Does your child have work history? **Y or N** Describe: _____

Does your child have a romantic relationship history? **Y or N** Describe: _____

_____

To your knowledge, is your child sexually active? **Y or N** On birth control? **Y or N**

Any Substance use problems? **Y or N** Describe. _____

_____

Criminal History: **Y or N** For what? _____

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CREDIT CARD AGREEMENT

PLEASE READ: Please fill this out if you would like Center for Valued Living, PLLC ("C4VL") to use a credit card to remit any necessary payments in lieu of using a check or cash. By signing this agreement, you acknowledge and accept the credit card terms and conditions listed on the C4VL.com website. We will use this credit card to pay any balance in full for the client. This includes any balance for copay, coinsurance, deductible, or charges for late cancels or missed sessions. **If we know the copay, cards will be charged soon after the appointment. If not, cards will be charged once claims have been processed; it can take 30-45 days from the date of service but can sometimes take longer depending on the insurance.** Please use black ink and write legibly. This form can be faxed directly to Julie Burke @ Flatirons Practice Mgmt, our billing company at 866-715-5418.

Client: _____

_____ _____
Signature of Cardholder only please Date

Billing Address for Cards:

_____ Special Instructions:

_____ _____

Phone Number: _____ _____

Type of Card:
☐ Visa ☐ Master Card
Card Number: _____/_____/_____/_____
Expiration Date: _____/_____ (mm/yyyy)
Security Number on back of Card: _____
Exact Name on Card: _____

Please use the following card as a "backup" for the first, in case it does not allow charges.
Type of Card:
☐ Visa ☐ Master Card
Card Number: _____/_____/_____/_____
Expiration Date: _____/_____ (mm/yyyy)
Security Number on back of Card: _____
Exact Name on Card: _____