DONARSKI CENTER *for* MENTAL HEALTH COUNSELING

CHILD CLIENT INTAKE FORM

DEMOGRAPHIC INFORMATION

Child's Name: First _____ Middle _____ Last _____

Birthdate:_____ Biological sex: M F _Primary Phone: _____

Address: _____ City/State: _____ Zip Code: _____

Circle One: Parent Step Parent Guardian

Name: First _____ Last _____ Birthdate:_____

Phone: Home: _____ Cell: _____ Work: _____

Address: _____ City/State: _____ Zip Code: _____

Email: _____

Do you have full legal custody of this child? YES NO If no, what is the custody arrangement? _____

_____

If you do not have full legal custody of the child then we require both parents/guardians sign this document.

I consent to my child/stepchild/ward participating in behavioral health care.

Signature: _____ Date: _____

Circle One: Parent Step Parent Guardian

Name: First _____ Last _____ Birthdate:_____

Phone: Home: _____ Cell: _____ Work: _____

Address: _____ City/State: _____ Zip Code: _____

Email: _____

I consent to my child/stepchild/ward participating in behavioral health care.

Signature: _____ Date: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

DCMHC

FINANCIAL INFORMATION

Person responsible for bill:

Name: First _____ Middle _____ Last _____

Birthdate:_____ Social Security Number: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: Home: _____ Cell: _____ Work: _____

Email Address: _____

I understand that I am responsible for this child's fees. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I will honor contractual agreements made with managed health care companies which stipulate specific reimbursement restrictions.

I hereby consent to treatment by a specified provider. Although the chances for obtaining the goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance prior to a decision to end therapy.

I hereby authorize the release of necessary medical information for insurance reimbursement purposes. Furthermore, I authorize the payment of medical benefits to the Donarski Center for Mental Health Counseling, LLC/Edwin R. Vergara MA, LPC (provider services).

Responsible Parent/Guardian Signature: _____Date: _____

LEGAL INFORMATION

Is this a court mandated appointment? Yes No
If yes, please include a court order with the judge's signature.

If parents/step parents/guardians are utilizing legal services, please complete the following:

Attorney's name: _____ Law Office: _____

Phone: _____ Email Address: _____

Providing Representation For: _____

Attorney's name: _____ Law Office: _____

Phone: _____ Email Address: _____

Providing Representation For: _____

DCMHC

PAYMENTS & INSURANCE

Are you using an Employee Assistance Plan (EAP)? Yes No If Yes, complete the following:

Name of employee who is eligible for the EAP _____

Employer: _____

Name of EAP provider: _____

EAP authorization number:_____ Number of authorized visits: _____

PRIMARY INSURANCE

Insurance Provider: _____ ID# _____

Group/Plan: _____

Insured's Name: _____ _____ _____
first middle last

Address: _____ City: _____ Zip Code: _____

Birthdate: ____/____/_____ Social Sec: _____-_____-_____ Relationship to client: _____

SECONDARY INSURANCE

Insurance Provider: _____ ID# _____

Group/Plan: _____

Insured's Name: _____ _____ _____
first middle last

Address: _____ City: _____ Zip Code: _____

Birthdate: ____/____/_____ Social Sec: _____-_____-_____ Relationship to client: _____

DCMHC

CLIENT HISTORY

PRESENTING PROBLEM

What are your reasons for seeking treatment for this child? _____

_____

_____

When did the problems/symptoms first occur or begin to develop? _____

What are your expectations or desired outcome for treatment? _____

_____

Has the child ever received counseling before? Yes No
If yes, please list name(s) of counselor(s)/facility(facilities), when seen, how long counseling lasted, and the outcome.

_____

_____

MEDICAL HISTORY

Primary Care Physician: _____ Phone: _____

Practice Name: _____ Address: _____

I grant permission to discuss this child's care with doctor listed above. Yes No Signature:
_____

Current medical diagnosis: _____

Current medications (complete below or bring a list of medications):

1) _____ Dosage/Frequency _____

2) _____ Dosage/Frequency _____

3) _____ Dosage/Frequency _____

4) _____ Dosage/Frequency _____

Current supplements/vitamins/herbs: _____

_____

INFORMED CONSENT FOR TREATMENT

Professionals at DCMHC Include: Psychologists, Professional Counselors, Social Workers, Marriage and Family Therapists, Interns, and any other licensed or limited licensed therapist.

CLIENT THERAPIST RELATIONSHIP

The child and their therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. The therapist can best serve the child's needs by focusing solely on therapy and avoiding any type of social or business relationships with you or them. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES

Donarski Center for Mental Health Counseling, LLC offers a wide array of counseling services, including individual, family, couples, group counseling, and reunification counseling. These services are provided respectively by licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, and doctors of psychology.

RISKS AND BENEFITS

Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, there will be discussions about personal issues which may bring to the surface uncomfortable emotions such as anxiety, anger, guilt, and sadness. The benefits of counseling, however, can far outweigh any discomfort encountered during the process. Some of the possible benefits include, but are not limited to:

- improved personal relationships
- reduced feelings of emotional distress
- specific problem-solving

We cannot guarantee these benefits. It is our desire, however, to work with the child to attain the goals set for counseling, and psychotherapy.

COUNSELING

We provide outpatient counseling designed to address many of the issues our clients are dealing with. The first visit will be an assessment session in which the child and their therapist will determine concerns with input from parents/guardians and, if it is agreed the current therapist can meet the therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided by the child's therapist, services may be terminated.

The therapist's goal is to provide an effective therapeutic experience. If at any time you feel the child and their current therapist are not a good fit, please discuss this matter with the therapist to determine if a transfer to a more suitable therapist is right. You may also consult with Edwin R. Vergara MA, LPC. If it is decided that other services would be more appropriate, we can assist you in finding a provider that may meet your child's needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieve health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our

services are designed to provide our clients an integrated solution for their mind, body, spirit, and life, to enhance their lives and resolve issues.

APPOINTMENTS

Appointments are typically scheduled on a weekly basis and are approximately 45-50 minutes. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your child's therapist.

If you must cancel or reschedule an appointment, we ask that you call our office at (269) 982-3832 at least 24 hours in advance, whenever possible. This will free their appointment time for another client.

Please note that you may be charged up to an $85.00 fee for a non-cancelled/missed appointment with a masters level clinician, and a $150.00 fee for a non-cancelled/missed appointment with a doctoral level clinician. Clinicians are at discretion to charge a fee not to exceed the above amount. Your insurance company is not responsible for this payment and cannot be billed for a missed appointment. It is our policy and option to not honor future scheduled appointments following repeated missed appointments or refusal to pay fee.

DCMHC reserves the right to override arrangements for recurring appointments after repeated no-call/no-show events. You will be notified by our office staff that the child is being removed from the recurrent schedule, at which time, any future appointments will be nullified. If you would like to be placed back on the schedule, feel free to call our office and one of our staff members will be able to assist you. Bear in mind the possibility that your recurrent slot may have been granted to another client.

EMERGENCIES

The child may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule them as soon as possible or to offer other options or referrals.

It is not always possible to return a call immediately. However, we will make every effort to respond to the emergency in a timely and efficient manner. If the emergency arises after hours or on a weekend, please call our office and leave a message. Furthermore, if the child experiences a life-threatening emergency, call 9-1-1 or take them to the nearest emergency room for help. When their therapist is not available, you will be advised and given the name of an on-call therapist for assistance until their therapist returns.

CONFIDENTIALITY

DCMHC follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of their counseling. These records are confidential with the exceptions noted below and in the notice of privacy practices provided to you.

Discussions between a therapist and a client are confidential. No information will be released without the parent/guardian's written consent unless mandated by law. Verbal consent will be used in cases of emergency. Possible exceptions to confidentiality include, but are not limited to, the following situations:

- Child, elder, or disabled abuse or neglect
- Harm to self or others
- Abuse of patients in mental facilities
- Sexual exploitation
- AIDS or HIV infection and possible transmission

- Criminal prosecutions
- Child custody cases
- Suits in which the mental health of a party is in question

If you have any questions regarding confidentiality, please broach the subject with the child's therapist.

By signing this information and consent form, you are giving consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the insurance carrier responsible for providing the child's mental health care services and payment for those services. You are also releasing and holding harmless the child's therapist from any departure from the child's right of confidentiality that may result.

DUTY TO WARN/PROTECT

If the child's therapist believes they are in any physical or emotional danger to themself or someone else, I hereby specifically give consent to the therapist to contact any person who is in a position to prevent harm to them or another, including, but not limited to, the person in danger.

INCAPACITY OR DEATH

I understand that, in the event of the death or incapacitation of the child's therapist, it will be necessary to assign their case to another therapist and for that therapist to have possession of the treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of the child's records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT

By signing this Informed Consent for Treatment, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given an appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to the child receiving mental health treatment and services and I understand that I may stop such treatment or services at any time.

Parent/Guardian Signature: _____

Date: _____

TEXTING AND EMAIL NOTIFICATION

By listing information below and by signing this agreement, I authorize DCMHC to contact me by SMS text, call, or email message for health related notifications which may include appointment reminders. I accept potential risks of potential loss of the child's privacy/Protected Health Information (PHI) if my phone, tablet, or computer is lost or someone else accesses such devices. I understand that message and data rates may apply to messages sent by DCMHC under my cell phone plan. I accept any charges that my service carrier may charge.

I know that I am under no obligation to authorize DCMHC to send me text or emails. I may opt out of receiving these communications at any time by calling the office. I understand that text and email messages are not a substitute for professional or medical attention. By signing below, I indicate that I am the person legally responsible for all use of mobile or computer accounts associated with the information I share below, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text and email messaging services.

I authorize the office staff to leave detailed information regarding the child's appointments or other information regarding business with this office with the following telephone number(s) and email address:

Phone number:

Additional phone number (optional):

Additional phone number (optional):

Email address:

Parent/Guardian Signature: _____

Date: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTIFICATION

I consent to the use or disclosure of the child's protected health information (PHI) by Donarski Center for Mental Health Counseling (DCMHC) for the purpose of diagnosing or providing treatment to them, obtaining payment for their health care bills, or to conduct health care operations of DCMHC.

I understand that diagnosis or treatment of them by DCMHC may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how the child's PHI is used or disclosed to carry out treatment, payment, or health care operations. DCMHC is not required to agree to the restrictions I may request. However, if DCMHC agrees to said restriction, the restriction is binding with DCMHC.

I have the right to revoke this consent, in writing, at any time, except to the extent that DCMHC has taken action in reliance on this consent.

Protected Health Information means health information, including demographic information, collected from me or the child and created or received by their physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to past, present or future physical or mental health or condition and identifies the child, or there is a reasonable basis to believe the information may identify them.

I understand that I have a right to review DCMHC's Notice of Privacy Practices before signing this document. A copy of the DCMHC Notice of Privacy practices is available to me by request. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in the child's treatment, payment of their bills or in the performance of health care operations of DCMHC.

This Notice of Privacy Practices also describes the child's rights and the duties of DCMHC with respect to their PHI. DCMHC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain revised notice of the privacy practices by contacting the DCMHC offices at (269) 982-3832 and requesting a revised copy be sent in the mail, email or asking for one at the time of their next appointment.

Parent/Guardian Signature: _____

Date: _____

Print Parent/Guardian Name: _____

PAYMENT AND INSURANCE

INSURANCE

We participate with most local insurance plans and will provide services within their fee schedule. Your/the child's Health Insurance, however, is a contract between you and the insurance company. You are ultimately responsible for the payment of their bill. We cannot change or waive the insurance payment contract.

We will submit claims on your behalf to the insurance carrier as a courtesy. If we do not participate with your carrier, you will need to pay in full at the time of service and be reimbursed by your insurance company by submitting the appropriate documentation required for your reimbursement.

Insurance cards and relevant billing information must be presented for submission of claims. We require both a copy of your or the child's insurance card and your identification card or driver's license, and will require your date of birth and social security number as well as the child's date of birth, as this is standard protocol for medical practices in the State of Michigan. This is also needed for billing purposes and reimbursement for services rendered.

FEE SCHEDULE

- Diagnostic & Evaluation Session (first visit) $250.00
- Regular office visits (45-50 minutes of individual Therapy) $165.00
- Family and Couples Sessions (45-50 minutes) $180.00 (90 minutes) $230.00
- Outside Office Work (Inpatient visits, court, collaborative law services, etc.) $300.00/hour
  Fees begin at this amount and can go upward to $600/hr depending upon service.
- Letters/reports (insurance companies, supervisors, etc.) $15-$150.00 per report
- Returned check fee $35.00
- No-show fee (missing an appointment without notifying the office prior) $85
- A reasonable fee will be charged for copies of any records requested by client

PAYMENT AGREEMENT

Donarski Center for Mental Health Counseling, LLC will bill the insurance carrier for payment they cover per your contract with them. You are responsible for all deductibles, copays, and coinsurance per your insurance contract. You are responsible for knowing your insurance coverage/contract prior to the child's visit. Any outstanding balances following insurance payment for services rendered are your responsibility.

All Copays, Co insurances, Deductibles, and Non-Covered Benefits are due the day service is provided. If you are uncertain of your payment on the date of service, we will aid you the best we can. Any overpayments will be returned to you. Any past due DCMHC account billings will be paid first by any overpayments. DCMHC also offers a sliding scale for cash payments. This will require a 1099 and/or W-4.

You may request a payment plan. This will require other information such as banking, credit card, and/or other forms for regular payment. Clients may have a credit card recurring payment authorization when there is a balance on the account. We can have a credit card on file in order to maintain current status on the account.

DCMHC cannot waive CoPays, Co-Insurances or Deductibles. Doing so would be a breach of contract between you and the insurance carrier. It is your responsibility to know and understand the provisions for

co-pays and deductibles as well as non-covered items, as this is a contract between you and the insurance carrier.

Account Statements will detail the amount owed by you after insurance has processed the claim. Accounts not paid in full within 30 days of the date of invoice/statement, will be considered delinquent and will be assessed a $10.00 late fee each month they are not paid in full.

In the event the child's account becomes 60 days past due, we may call and remind you of your financial obligation. If you have questions regarding the statement, you should direct them to the billing department for clarification. We will work with you to pay off your financial obligation.

In the event the child's account becomes 90 days past due, we reserve the right to refer the account to Small Claims Court, begin garnishment, or utilize collection services where you will be responsible for all collection, mailing, small claims, service, and legal fees accrued.

By signing this document, you agree to not place any of your DCMHC financial obligations into bankruptcy, chapter 7, 11, 13, or any other form of not being responsible for your services rendered.

The child's mental health care is very important to us, and your compliance with your financial responsibilities are appreciated. Please understand that our financial staff at the billing office are always happy to work with you. The counselors do not get involved in client accounts (other than to accept payments at the time of service if needed) so as to keep their focus on client care. Please respect this policy. If a payment plan is needed, or you need to speak with someone regarding payment, please call the front office at (269)-982-3832.

All CoPays are due at the time of visit. By signing this document, you agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. You agree to honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

By signing, you agree to the following statement: I understand the above statements regarding insurance, fees, and payments and agree with them.

Signature of Person Responsible for Bill:_____

Date: _____