the BabbCenter
Hope Help Healing

Children/Youth Counseling Intake Form

For therapist use only
Intake paperwork reviewed Yes____ No____
Parenting plan received Yes____ No____ n/a ____
Non-custodial person(s) scheduling/paying for services Yes____ No____
Appropriate ROI secured Yes____ No____
Agreement to proceed Yes____ No____

About the Youth/Child

Name___________________________ **Prefers to be called**_____________

Gender: ☐ Male ☐ Female **Birth Date**_____/_____/_____ **Age**____

School_____________________________ **Grade**___ **Home Phone**____/____/_____

Address____

Reason for coming to counseling/assessment today____

____

Parent/Guardian Information

Name______________________ **Occupation**________________ **Place of employment**_______________

Relationship to client: ☐ Birth Parent ☐ Step Parent ☐ Adoptive Parent ☐ Legal Guardian

Home phone____/____/_____ **May we leave a message?** ☐ yes ☐ no

Cell phone_____/_____/_____ **May we leave a message?** ☐ yes ☐ no

Name______________________ **Occupation**________________ **Place of employment**_______________

Relationship to client: ☐ Birth Parent ☐ Step Parent ☐ Adoptive Parent ☐ Legal Guardian

Home phone____/____/_____ **May we leave a message?** ☐ yes ☐ no

Cell phone_____/_____/_____ **May we leave a message?** ☐ yes ☐ no

Name______________________ **Occupation**________________ **Place of employment**_______________

Relationship to client: ☐ Birth Parent ☐ Step Parent ☐ Adoptive Parent ☐ Legal Guardian

Home phone____/____/_____ **May we leave a message?** ☐ yes ☐ no

Cell phone_____/_____/_____ **May we leave a message?** ☐ yes ☐ no

Name______________________ **Occupation**________________ **Place of employment**_______________

Relationship to client: ☐ Birth Parent ☐ Step Parent ☐ Adoptive Parent ☐ Legal Guardian

Home phone____/____/_____ **May we leave a message?** ☐ yes ☐ no

Cell phone_____/_____/_____ **May we leave a message?** ☐ yes ☐ no

If biological parents divorced, please answer the following:

Year of divorce__________ **Which parent is the primary residential parent?**___________________

Is there a parenting plan in place? ☐ yes** ☐ no **please provide a copy

Who has non-emergency health care decision making? ☐ Mother ☐ Father ☐ Joint

What is parenting time schedule? ____

Has either parent remarried? Mother: ☐ yes ☐ no If yes, year of remarriage___________

Father: ☐ yes ☐ no If yes, year of remarriage___________

(over)

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Please list any siblings this child may have in order of their births.

Name	Age	Relationship	Active part in his/her life
		☐ biological ☐ adoptive ☐ half ☐ step ☐ foster	Y / N
		☐ biological ☐ adoptive ☐ half ☐ step ☐ foster	Y / N
		☐ biological ☐ adoptive ☐ half ☐ step ☐ foster	Y / N
		☐ biological ☐ adoptive ☐ half ☐ step ☐ foster	Y / N

Medical/Counseling History

Name of medical doctor_____
For what medical problems is the child being treated currently?_____
_____

Please list all medications currently being taken

Medication	Dosage	Frequency	Prescribed for…	Date began taking

Has the youth/child received counseling before ☐ yes ☐ no **Seen a psychiatrist before** ☐ yes ☐ no

Age	Duration	Counselor's Name	Reason for Counseling	Outcome

What do you hope to achieve through this counseling experience?
_____

_____

By whom was this child referred for counseling?_____

Religious Affiliation

If affiliated with a church/religious group/denomination, please give the name. _____

Actively involved? ☐ yes ☐ no

Do you give permission for the counselor to use prayer, scripture and spiritual conversations as part of your counseling?

☐ yes ☐ no

Has the minor ever been convicted of a sexual offense against another minor or are child sex abuse charges pending against the minor? ☐ yes ☐ no

Is the minor involved in an active abuse investigation? ☐ yes ☐ no

Note: Please take younger children to the restroom before session begins and do not leave the building during the time your child is with counselor.

The session will be fifty (50) minutes in length and the last ten minutes of the hour can be used to discuss the progress of your child.

_____ _____/_____/_____
(Signature) (Date)

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105 Music Village Boulevard
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GENERAL COUNSELING INFORMATION

Credentials
All counselors at The BabbCenter, with the exception of Practicum students and interns, have master's degrees or doctoral degrees with competence in the area of counseling. All counselors are Christians and members of various local churches.

Risks in Counseling
Counseling may be tremendously beneficial, while at the same time, there are some risks. These risks include the experience of intense and unwanted feelings, including sadness, fear, anger, guilt, or anxiety. It is important to remember that these feeling may be natural and normal and are an important part of the counseling process. Other risks may include recalling unpleasant life events; facing unpleasant thoughts and beliefs; increased awareness of feelings, values and experiences; alteration of an individual's thinking; and calling into question some or many of your beliefs and values. Your counselor will be available to discuss any of your assumptions, problems or these possible side effects of your work together.

Client Rights
You have the right to ask questions about any part of the counseling session.
You have the right to end the counseling process at any time without moral, legal, or financial obligations other than those already accrued.
You have the right to review information in your files at any time with proper notification and in consultation with your counselor.
You have the right to request a release of the information in your counseling files to any person or agency you designate.

Grievances/Complaints
We are aware that dissatisfaction with our services may occur, and we will work with you to reach the best possible outcome for all involved. If, however, you have discussed your concern with your counselor and remain dissatisfied, please contact The **Babb**Center's Director. We want to resolve your concerns to your satisfaction, if possible.

Termination
Termination of counseling may occur at any time and may be initiated by either the client or the counselor. We request that if a decision is being made to terminate, a minimum of seven (7) days notice be given in order that a final termination session may be scheduled.

Clients Who Are Dependents
If you are requesting our services as the guardian or parent of a child or of a dependent adult, the same general principles as above will apply. However, it is important that your child be able to trust his/her counselor completely. That being true, we keep confidential what the child says in the same way that we keep confidential what an adult says. As the parent/guardian you have the right and responsibility to question and understand the nature of our progress with your child, and we must use our discretion as to what is an appropriate disclosure. In general, we will not release specific information that the child provides to us; however, we feel it is appropriate to discuss your child's progress in broader terms and value your participation in their counseling experience. You will be asked to sign a consent form allowing us to counsel your minor child.

We welcome you to The BabbCenter! We look forward to our work together, and we anticipate that it will be an experience that God blesses and that will be beneficial for both of us.

Please note: No weapons are allowed on the BabbCenter premises. No unauthorized audio or video recording is allowed.

Initial Here_____**Date**_____

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Client Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA (The Health Insurance Portability and Accountability Act) and state law very clearly defines what kind of information is to be included in your "designated medical record" as well as some material known as "Psychotherapy Notes" which is not available to outside sources and in some cases, not to the client.

HIPAA provides privacy protections about your personal health information, which is called "protected health information" which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations.

TREATMENT refers to activities provided by a counselor to coordinate your health care.
PAYMENT refers to cases where reimbursement is sought from an outside source. Since we do not file insurance this situation would be extremely rare.
HEALTH CARE OPERATIONS refers to activities that relate to the operation of the counseling center.

The use of your protected health information refers to activities that The BabbCenter conducts for scheduling appointments, keeping records and other tasks within The BabbCenter related to your care. DISCLOSURES refers to activities you authorize which occur outside The BabbCenter such as sending your protected health information to other parties such as your primary care physician or in the case of children to the school guidance counselor.

Initial Here_____**Date**_____

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USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING AUTHORIZATION

Tennessee requires authorization and consent for treatment, payment, and healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. With your consent The BabbCenter may disclose personal health information for the purposes of treatment, payment, and healthcare operations. You have signed this general consent to care and authorization to conduct services associated with this care.

Additionally, if you ever want The BabbCenter to send any of your protected health information to anyone outside The BabbCenter, you will always sign a specific **authorization to release** information to this outside party. A copy of the authorization form is available upon request. The requirement of you signing an additional authorization form is an added protection to help insure that your protected health information is kept strictly confidential.
There is a **third, special authorization** provision potentially relevant to the privacy of your records: psychotherapy notes. In recognition of the importance of the confidentiality of conversations between the counselor and the client in treatment settings, HIPAA permits keeping **"psychotherapy notes"** separate from the overall "designated medical record". "Psychotherapy notes" are not the same as your "progress notes" which provide general information about your care and progress each time you have an appointment at The BabbCenter. Any time that psychotherapy notes are requested this will require an additional authorization for their release. When psychological testing is completed please be aware that actual test questions or raw data of psychological tests is protected by copyright laws and is not part of your designated mental health record.

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done.

BUSINESS ASSOCIATES DISCLOSURES

HIPAA requires that The BabbCenter train and monitor the conduct of those performing ancillary administrative services. These business associates would include receptionists and cleaning staff. The receptionists only have access to the information that pertains to financial arrangements and information related to establishing and maintaining contact with the client. The counselor is the only person who has access to the protected health information. In compliance with HIPAA, the receptionists and cleaning personnel have signed confidentiality agreements that stipulate that protecting your mental health information is an absolute condition for employment. The BabbCenter trains personnel in privacy practices, monitors their compliance, and correct any errors, if they should occur.

USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

By law, protected health information may be released without your consent or authorization for the following:

Child abuse
Suspected sexual abuse of a child
Adult and domestic abuse
Court order
Serious threat to health or safety – "Duty to Warn" law
Workers Compensation claims – All of your protected health information is automatically subject to review by your employer and/or insurer(s).

Initial Here_____**Date**_____

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Client's Rights and The BabbCenter Duties

You have a right to the following:

The right to request restrictions on certain uses and disclosures of your protected health information which your counselor may or may not agree to but if the counselor does, such restrictions shall apply unless our agreement is changed in writing;

The right to receive confidential communication by alternative means and at alternative locations;

The right to inspect and copy your protected health information in your designated medical record set for as long as protected health information is maintained in the record except in cases where it would not be in your best interest as determined by the counselor.

The right to amend material in your protected health information, although counselor may deny an improper request and/or respond to any amendment(s) you make to your record of care;

The right to an accounting of non-authorized disclosures of your protected health information;

The right to a paper copy of notices/information from your counselor, even if you have previously requested electronic transmission of notices/information;

The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

Initial Here_____**Date**_____

COMPLAINTS

Dr. Ray Cleek, Administrator/Assistant Director of The BabbCenter is the "Privacy Officer" for HIPAA regulations. If you have any concerns related to your privacy rights, please do not hesitate to speak to him immediately about this matter.

EFFECTIVE DATE: APRIL 14, 2003

Initial Here_____**Date**_____

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Client Confidentiality Policy

The counselors at The BabbCenter strive to provide each client with the highest quality of counseling services, including a level of confidentiality that makes the counseling experience safe and comforting to the client. Counseling session information will not be released without your prior consent or the one who has the legal authority to consent on your behalf.

There are national and state laws that define necessary limits to that confidentiality. Counselors at The BabbCenter are committed to conforming to these laws that require a counselor to report any suspicions of abuse of a child or incapacitated adult and threats of homicide or suicide. In addition, occasionally judges will subpoena a counselor for testimony or order the release of confidential information in court proceedings. In these instances, the client is notified of the subpoena and/or court order, and every effort is made to protect confidential information.

All Client records will be stored in a locked filing cabinet and secured according to Center policy & procedure. Access to the Client record is limited to the Counselor and the Center Director or their agent, under supervision and review and during the course of health care operations. Information contained within the file shall never be released to anyone outside the Center absent your consent.

If you understand these disclosure statements and desire to proceed with the counseling relationship, please indicate this below with your signature and today's date. If you have any questions, please feel free to ask our staff.

Thank you.

_____ _____

Client printed name & signature **Date**

_____

Parent if Minor- printed name & signature **Date**

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CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout our country are now required to provide clients with a notification of their privacy rights as it relates to their health care records.

Please read this document as it is important that you know what client protections HIPAA affords all of us. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, we are required to secure your signature indicating that you have received this "Client Notification of Privacy Rights" document. Thank you for choosing our services here at The BabbCenter.

I, _____(print your name) understand and have been provided a copy of the "Client Notification of Privacy Rights" document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights concerning these matters. I understand that I have the right to review this document before signing this acknowledgement form.

_____ _____/_____/_____
(Client signature or Parent Signature if Minor or Legal Charge) **(Date)**

If legal charge, describe representative authority: _____

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AUTHORIZATION TO COUNSEL MINOR CHILDREN

I (We), _____ give my (our) permission to
[Name of Parent(s) or Guardian]

_____ to see my our son/daughter,
(Counselor)

_____ for counseling with and/or
(Name of Minor Child)

without me being present in the same session. I (We) understand that we are the holder of confidential privilege – the right to withhold disclosure or private counseling information about my child. However, in the interest of developing a trust relationship between the counselor and my (our) child(ren), I (we) give the counselor permission to reveal or withhold information which, in his/her clinical judgment, is necessary to protect my (our) minor child. The only exception to this discretion would be in the case of:

_____

_____.

Please initial

- I(We) have legal custody of the child and have authorization to provide counseling for the child named above. Yes ____ No ____
- Does another person or party have the authority to provide consent for medical and mental health treatment? Yes ____ No ____
- Is the consent of this other person or party required for treatment to begin? Yes ____ No ____
- Please provide any documentation concerning this authority to consent for treatment

_____ _____/_____/_____
(Parent/Guardian Signature) (date)

_____ _____/_____/_____
(Parent/Guardian Signature) (date)

_____ _____/_____/_____
(Counselor/Witness Signature) (date)

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