Student Counseling Intake Form

Please Submit Completed Forms to JAKS Counseling Services:
Fax to: 775-295-5087
Email to: info@jakscounseling.com
Mail to: 10702 Manchester Rd., Ste. 201
Kirkwood, MO 63122

Main Office:
314-529-1595

DEMOGRAPHIC & CONTACT INFORMATION

Date _____ Homeroom Teacher _____ Room # _____

School _____ Counselor _____

Student Name _____ Male _____ Female _____

SSN _____ D.O.B. _____

Parent/Guardian Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

OK to leave messages? (Check all that apply) Home ____ Cell ____Text Msg. ____ Work ____ Email ____ All ____

Address _____ City _____ State _____ Zip _____

Black _____ White _____ Hispanic _____ Other (list) _____

Referred by: _____ Teacher _____ Counselor _____ Principal _____Parent/Guardian

INSURANCE INFORMATION

Primary Insurance Company_____ Phone_____

Member ID# _____ Group ID# _____

Secondary Insurance Company_____ Phone _____

Member ID# _____ Group ID# _____

MEDICAL INFORMATION

Primary Care Physician _____ Phone _____

Psychiatrist _____ Phone _____

Description of past medical problems _____

_____

_____

Please list current medications/dosage Reason Prescribed

_____ _____

_____ _____

Please contact your child's school to add JAKS Counseling Services to the list of approved visitors for your child.

HIPAA Notice of Privacy Practices

I have received or been provided the opportunity to review a copy of *HIPAA Notice of Privacy Practices.* I understand JAKS Counseling Services may use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations.

This authorization permits JAKS Counseling Services to use and/or disclose individually identifiable health information about me.

1. JAKS Counseling Services is authorized to disclose my individually identifiable health information to partnering counseling therapists/agencies.
2. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign this authorization will not affect my ability to obtain treatment, or eligibility for benefits unless allowed by law.
3. I understand that I may inspect or copy the information to be disclosed.
4. I understand that I may revoke this authorization at any time by notifying JAKS Counseling Services in writing, except to the extent that: (a) JAKS Counseling Services has taken action in reliance on this authorization; or (b) If this authorization is obtained as a condition for obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy.

Financial Responsibilities

(1) The client (or client's guardian, if a minor) is responsible for the payment for all services rendered. (2) The client is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. (3) Clients are responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service.

Child Custody Issues

JAKS Counseling Services does not make recommendations for custody of children in disputed cases. Such recommendations are beyond the scope of our services.

Supervision Disclosure Statement and Recording Consent

I understand that in addition to Licensed Professional Therapists; JAKS contracts with Provisionally Licensed Therapists who are working toward completing their full licensure in the State of Missouri. These individuals have passed the appropriate board examinations and are either in the process of receiving or have received their provisional license to practice therapy in the State of Missouri.

I understand that JAKS offers placement, training and supervision for Master's Level Counseling interns.

I understand that all Provisional Practitioners and Interns who provide counseling services to clients do so under the clinical supervision of a licensed professional therapist who is fully credentialed in the State of Missouri who is also contracted with the JAKS.

I give my consent for JAKS Counseling Services to record my counseling sessions for educational purposes. I understand counseling sessions may be taped and reviewed by the therapist/supervisor and/or team members in effort to provide the most beneficial services.

X _____ _____

Signature of Parent/Legal Guardian **Relationship to Client**

_____ _____

Student's Name **Date**

CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned _____, parent(s) and/or legal guardian(s)
(name of parent(s)/guardian)
of a minor child _____, give you full and unconditional authority
(name of child)
to proceed with a clinical evaluation and treatment as your judgment indicates.

This consent is given by me/us as parent(s) and/or legal guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, related to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

We/I give you consent to release/obtain information and reports from the teachers, counselors, administrators, and any associated school staff of _____,
(name of school)
about the progress of _____,the minor child noted above for the
(name of child)
benefit of the therapeutic process. We/I give consent for this information to be shared with JAKS verbally or via email or fax communication. JAKS will not be responsible for information that may be compromised in electronic transmission.

X _____ _____

Signature of Parent/Legal Guardian **Relationship to Client**

_____ _____

Student's Name **Date**

Intake Release of Personal Information

I hereby authorize (School /Person/Facility): _____

Address: _____

Phone: _____ Fax: _____

to release information from records about:

Client Name: _____

Date of Birth: _____ SSN: _____

for the following purpose(s):

- ❑ Further mental health evaluation, treatment, or care
- ❑ Treatment planning
- ❑ Communication between JAKS Therapist and School –Based Staff/Authorized Person/Facility
- ❑ Research
- ❑ Other: _____

.
In the boxes below, the information to be disclosed is marked by an **X**, the items not to be released have a line drawn through them

Information authorized to be disclosed:

- ❑ Intake Packet
- ❑ Educational records
- ❑ Communication: third-party consultations about the client (i.e. School–Based Staff/Authorized Person/Facility)
- ❑ Developmental and/or social history
- ❑ Monthly/Quarterly Reports
- ❑ Discharge Summaries

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

Select only one:

- ❑ Please forward the records to JAKS Counseling Services (address noted below)
- ❑ Please forward the records from JAKS Counseling Services to the address written above

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed.

Signature of legal parent/legal guardian	Printed name	Date

STUDENT BACKGROUND INFORMATION

Student's Name _____ **Date** _____

Client is being referred for the following reasons:
(Circle all that apply.)

Anger Management	Anxiety	Abuse/Violence
Depression	Inattentiveness	Self Esteem
Hyperactive	Trauma	Bullying
Family Concerns	Withdrawn	Eating Disorder
Substance Abuse	Grief & Loss	Attachment Issues
Divorce/Separation of parents	Sexuality/Homosexuality Concerns	Suicidal/Homicidal
School-Related Transition Issues	Adoption/Foster-care Adjustment Issues	Crisis Intervention
Peer Issues/Social Skills	Sibling Rivalry	Relationship Concerns
Sleeping Problems	Chronic Pain/Illness	Power/Control Challenges

Current/Presenting Issues: _____

Strategies Used Prior to Referral: _____

10702 Manchester Rd, Ste 201 – Kirkwood, MO 63122 **314.529.1595**

The parent/legal guardian acknowledges receipt of the *JAKS Counseling Services Policies and Procedures Handbook* on the date shown below.

The parent/legal guardian understands that the *JAKS Counseling Services Parent/Guardian Policies and Procedures Handbook* is current as of the time given and supersedes any previous manual or single copies of policies or procedures.

From time to time, new situations may develop that may require changes, additions, or eliminations of the policies or procedures in this manual. The parent/legal guardian will be notified in writing of these changes and understands that he/she is responsible for all amendments.

In addition, JAKS Counseling Services reserves the right to amend or to terminate any of the policies and/or procedures.

ACKNOWLEDGEMENT

I ACKNOWLEDGE ALL OF THE ABOVE:

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

PLEASE RETURN THIS FORM TO JAKS COUNSELING SERVICES

The parent/guardian acknowledges receipt of the *JAKS Counseling Services Policies and Procedures Handbook* on the date shown below.

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In addition, JAKS Counseling Services reserves the right to amend or to terminate any of the policies and/or procedures.

ACKNOWLEDGEMENT

I ACKNOWLEDGE ALL OF THE ABOVE:

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

PLEASE RETAIN THIS FORM FOR YOUR RECORDS