MINOR INTAKE FORM

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. Before we get started we need to collect some general information from you.

GENERAL INFORMATION

First Name | Last Name | Gender

Date of Birth (mm/dd/yyyy) | Social Security Number

Name of person completing this form

Relationship to patient

Mother's Information

First Name | Last Name | Gender

Date of Birth (mm/dd/yyyy) | Social Security Number

Address

City | State | Zip Code

Main Phone | Other Phone

Email address

Father's Information

First Name | Last Name | Gender

Date of Birth (mm/dd/yyyy) | Social Security Number

Address

City | State | Zip Code

Main Phone | Other Phone

Email address

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Parent Marital Status: ☐ Married ☐ Divorced ☐ Widowed

Who has legal/physical custody? _____

Please provide legal documentation if necessary for the information above (custody).

INSURANCE INFORMATION

PRIMARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

SECONDARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

MENTAL HEALTH HISTORY/STATUS

What are your concerns for this individual?

What are your expectations for treatment at this facility?

Past Mental Health Treatment

Has your child ever been hospitalized for psychiatric reasons? ☐ **YES** ☐ **NO**

If yes, when and where?

Has your child ever had outpatient treatment by a psychiatrist? ☐ **YES** ☐ **NO**

If yes, when and by whom?

Has your child ever received counseling or psychotherapy in the past? ☐ **YES** ☐ **NO**

If yes, when and by whom?

Please List any psychiatric medication your child has taken or are taking:

Medication	**Date**	**Side Effects/Benefits**

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Please check any symptoms your child may be experiencing:

- ☐ Depression (sad, irritable, hopeless, poor sleep, crying, social withdrawal, lack of interest)
- ☐ Mood swings (energetic, little sleep, pleasure seeking, racing thoughts, extremely talkative, inappropriate sexual behaviors, grandiose)
- ☐ Anxiety (worry, restless, scared, poor sleep, obsessive thoughts and/or compulsive behavior)
- ☐ Behavioral problems (fights, anger, arguing, truancy, destruction of property, fire setting)
- ☐ Attention/Hyperactivity problem (difficulty with attention, hyperactive, impulsive, distractibility, not completing tasks)
- ☐ Abnormal Eating Behaviors (too much, too little, fear of weight gain, distorted body image, over exercising)
- ☐ Never tired
- ☐ Remembering Past Traumas (frequent nightmares, intrusive and/or recurring memories)
- ☐ Social/language impairment (limited vocabulary, mispronouncing words, under development of language ability for their age)
- ☐ Psychosis (hearing voices, seeing things, paranoia, delusions)
- ☐ Dissociation (feeling outside their body or thinking things are not real)
- ☐ Harming themselves intentionally
- ☐ Attempted suicide
- ☐ Harmed others

Drug and Alcohol History

Are you concerned about your child consuming alcohol or recreational drugs? ☐ **YES** ☐ **NO**

Details: _____

GENERAL MEDICAL HISTORY

Primary Care Physician: _____

Please list any medical problems your child may have below:

_____

_____

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Please list any serious medical procedures your child has had in the past:

Is your child on any medications for any general medical problems they may have?

☐ **YES** ☐ **NO**

If yes, which ones?

Does your child have any allergies to medications? ☐ **YES** ☐ **NO**

If yes, which ones?

Family Medical History

List any history of illness (mental or other) and substance abuse among blood relatives:

Mother's side **Father's side**

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SOCIAL HISTORY

Birth place: Is this your biological child?

Does your child have siblings? ☐ **YES** ☐ **NO** How many?_____

Please list your child's siblings, ages and anyone else who may be living in the house with your child:

Name	Age	Relationship

Mother's occupation:

Father's occupation:

Has your child ever been a victim of abuse or neglect? ☐ **YES** ☐ **NO**

If yes, what is or was the nature of the abuse (check all that apply):

- ☐ Physical
- ☐ Emotional
- ☐ Neglect
- ☐ Sexual
- ☐ Other:
- ☐ Witnessing violence
- ☐ Accidents
- ☐ Disasters

As a parent, are you experiencing issues with marriage or parenting? ☐ **YES** ☐ **NO**

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SCHOOL HISTORY

Where does your child go to school?

Grade level:_____ Typical Grades:_____

What are your child's academic strengths?

What areas are you concerned about?

Have you noticed a change in your child's performance at school? ☐ **YES** ☐ **NO**
Details

Has your child ever participated in any of the following:

Resource	☐ **YES**	☐ **NO**
Accelerated/Honors Program	☐ **YES**	☐ **NO**
504 Plan	☐ **YES**	☐ **NO**
Individual Education Plan (IEP)	☐ **YES**	☐ **NO**

Details:

Activities/Friendships
What activities does your child participate in/enjoy doing?

How would you describe your child's social tendencies?

Do you have concerns regarding your child's friendship ☐ **YES** ☐ **NO**
Explain

Are you concerned about your child's sexual activities? ☐ **YES** ☐ **NO**
Explain

Please list any additional notes that you think would be helpful for treatment below:

MINOR CONSENT TO TREATMENT

First Name Last Name

I give Healing Minds, LLC my consent to treat my child. If we are treating your child, we will do our best to accurately diagnose them and design a comprehensive treatment plan that will enable your child to continue with a normal emotional development. This may include recommendations of therapy, medications, and/or calling the school to try and help arrange your child to receive optimal education. This is all part of the service of a mental health professional. We will also work with his/her primary care physician to assure coordination of care.

_____ (Initial)

It is important to note that when we are seeing your child, you consent to treatment for them. They are our client and have confidentially rights. Confidentiality does not apply under certain situations: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

_____ (Initial)

If I require or think it is in you or your child's best interest to communicate with an outside source, such as his/her school, I will request a release of information. We do not perform custody evaluations. If there is a question of custody, there will need to be a separate, neutral evaluation that both parties can agree on. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, clients that have not been seen in 3 months will be considered inactive. A new evaluation will be required for any inactive client to be seen

_____ (Initial)

Client Signature (or Representative) Date

Signature of Guardian/Parent Relationship

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LIFETIME INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

First Name Last Name

Release of Information: I, the subscriber named below, authorize Healing Minds, LLC and any physicians working under Healing Minds, LLC examining or treating me to release any and all information pertaining to my treatment to any third party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and or diagnosis.

Physician Insurance Assignment: I, the below named subscriber, herby authorize payment directly to Healing Minds, LLC for my treatment at this office that is otherwise payable to me for their services as described.

Medicare/Medicaid – Client's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I herby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me writing.

Please remember that insurance is considered a method of reimbursing the client for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 90 days.

Client Name (please print)

Client/Guardian Signature Date

Insurance Company

HIPPA NOTICE/PRIVACY PRACTICES

First Name Last Name

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Healing Minds, LLC 6490 S. McCarran Blvd A-6, Reno NV, 89509, 775 448-9760

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice please contact our office.

See front office for "HIPPA Detail" forms.

Client Name (please print)

Client/Guardian Signature Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

First Name Last Name

Date of Birth (mm/dd/yyyy)

We respect your personal information and want you to know your rights as a client of Healing Minds. Please read the information below.

PATIENT RIGHTS

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

PATIENT AUTHORIZATION

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ **I hereby authorize Healing Minds, LLC to RELEASE my protected health information (PHI) to:**

☐ **I hereby authorize Healing Minds, LLC to OBTAIN my protected health information (PHI) from:**

DISCLOSURE SCOPE FOR PHI RELEASE:

Disclosure may include the following verbal or written information: (check all that apply)

- ☐ Face sheet
- ☐ Laboratory/diagnostic testing results
- ☐ Discharge summary
- ☐ Behavioral health/psychological consult
- ☐ ER record report
- ☐ Substance abuse treatment records
- ☐ Progress & Case Notes
- ☐ Psychological evaluation/testing results
- ☐ Afraid to leave home
- ☐ Inflated self esteem
- ☐ Feel guilty or worthless
- ☐ History & physical
- ☐ School information
- ☐ Medication records
- ☐ Psychosocial assessment/Family history
- ☐ Psychiatric evaluation
- ☐ HIV/AIDS lab results & treatment history
- ☐ Summary of treatment records & contact dated
- ☐ Tense/unable to relax
- ☐ Excessive worry
- ☐ Panic attacks
- ☐ Thoughts of death or suicide
- ☐ Other: _____
- ☐ Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by Healing Minds, LLC without my written consent. I understand that this authorization will remain in effect for:

- ☐ The period necessary to complete all transactions on accounts related to services provided to me.
- ☐ One (1) year
- ☐ Other: _____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative *Date*

_____ _____

Witness *Date*

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APPOINTMENT CANCELLATION AGREEMENT

First Name Last Name

Each meeting is another opportunity to help you confidently take charge and start living the life that's important to you. We understand things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, the office of Healing Minds requires **24 business hours notification (Monday through Friday 8:00 am to 5:00 pm).** Please understand that we set aside this time for you, and if you are unable to make it, we will have missed an opportunity to meet with another valuable client. This policy is in place to give the office enough time to schedule another client in that time slot. If you fail to cancel within the 48 hours prior to your appointment **a $60 fee will be charged to the card below** or the credit card on file. If you are a Medicaid or Amerigroup patient you are not subject to the $60 fee, however after 1 violation of this agreement, services at this office will be terminated.

While we do call to remind you of your appointment, it is your responsibility to call the office at 775-448-9760, extension 1, to cancel.

I authorize the following card to be used for co-pays and fee's incurred during the time I am a patient with Healing Minds LLC.

Card Number

Expires CVV

Printed Name

Signature Date

I understand that the office of Healing Minds LLC will attempt to bill my insurance, however **if my insurance does not pay, for whatever reason, I am responsible for any remaining balance.** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency I will call 911 or go to the nearest hospital
- 7 days notification is preferred for any prescription renewals.
- I will adhere to the guidelines above to the best of my ability.

Client Name (please print)

Client/Guardian Signature Date