ELEVATION
CHRISTIAN COUNSELING

Child Intake

Father Information

Name _____
DOB/Age _____
Address _____
City, Zip _____
Mobile Phone _____
Home Phone _____
Email _____
Employer _____
Occupation _____

Mother Information

Name _____
DOB/Age _____
Address _____
City, Zip _____
Mobile Phone _____
Home Phone _____
Email _____
Employer _____
Occupation _____

Insurance _____
Policy Holder _____

Emergency Contact and Number _____

Circle all that apply:

Therapist may leave a detailed message: Mobile Phone Home Phone Email
Therapist may leave appointment reminders: Mobile Phone Home Phone Email

Child Information

Child's Name _____
Sex _____
Address _____
Birthplace _____
This Form Completed by _____

Preferred Name _____
Date of Birth _____
City, Zip _____
Ethnicity _____
Relationship to child _____

Summary of Circumstances that bring you in to Elevation Christian Counseling

_____
_____
_____
_____
_____

Mental Health History

Has your child received counseling before? YES NO
If yes, please list Previous therapist, Dates, Reasons, and any Mental Health Hospitalizations

_____
_____
_____
_____

Current Diagnosis' and Psychotropic Medications and Dosage

_____

_____

Family History of Mental Health? YES NO
If yes, please list Name, Relation, and Mental Health Diagnosis (including substance abuse struggles)

_____

_____

_____

_____

Medical History

Serious Illnesses

_____

_____

_____

Serious Injuries or Accidents and Dates

_____

_____

_____

Name and Date of any Operations and/or Hospitalizations

_____

_____

_____

Current Physical Diagnosis' and Medication/Supplements and Dosage

_____

_____

_____

Family History

Child's Primary Residence: Single Parent Home _____ Two Parent Home _____ Other_____

Custody: Sole _____ Joint _____

Married status of the Primary Caregiver (please provide the date)
Married _____ Divorced _____ Separated _____
Mother Remarried _____
Father Remarried _____

Please list other children and other relatives living in the home (give age and describe relation)

_____

_____

_____

_____

_____

_____

Is your child adopted or fostered? YES NO
If so, please describe the circumstances

_____
_____
_____
_____
_____

What is known about the biological parents? (Mental/Physical Health, Location, Age, etc.)

_____
_____
_____
_____
_____

Please describe your child's behavior at home

_____
_____
_____

Abuse/Legal History

Has your child been subjected or witness to a traumatic event? YES NO
If yes, please explain

_____
_____
_____

Does your child have a history of physical or sexual abuse? (Include if victim or perpetrator) YES NO
If yes, please explain and if it was reported to the appropriate authorities (include date and actions taken)

_____
_____
_____

Has your child ever been in any trouble with the police or other legal issues? YES NO
If yes, please explain and provide dates

_____
_____
_____

Does your child have a history of alcohol or other drug use? YES NO
If yes, please explain

_____
_____
_____

Is your child sexually active? YES NO
Has your minor child's sexual activity been reported to social services or to the police? YES NO
If yes, please provide the date and follow-up action

_____
_____
_____

School History

Current School _____ Phone Number _____
Name of teacher _____ Grade _____

Previous schools attended, dates attended, and overall performance
School _____ Performance: Poor Fair Good Excellent
School _____ Performance: Poor Fair Good Excellent
School _____ Performance: Poor Fair Good Excellent

Grade(s) Repeated _____ Skipped _____ Expelled _____
If any, please explain
_____
_____

Has your child been previously diagnosed with any learning disabilities? YES NO
If yes, please provide the diagnosis and date of diagnosis
_____
_____

Is your child in any special programs? (Speech, OT, Reading, IEP, etc.) YES NO
If yes, please explain
_____
_____

Does your child have issues with their classmates? YES NO
If yes, please explain
_____
_____

How do your child's teachers describe their behavior?
_____
_____

Describe your child's current academic performance
_____
_____

My child has the following issues in school:

_____Does not do homework	_____Poor reading	_____Does not remain seated
_____Starts but does not finish	_____Poor spelling	_____Carless errors
_____Fails to check homework	_____Poor handwriting	_____Test anxiety
_____Forgets homework	_____Poor attention	_____Disengaged
_____Disorganized/messy	_____Distracted/distracting	_____Other_____

My child has the following issues with peers:

_____No friends	_____Bullying/aggressive behavior	_____People pleasing
_____Few friends	_____Controlling behavior	_____Easily influenced
_____Loses friends	_____Risky behavior	_____Troubles with boundaries
_____Trouble making friends	_____Shy/Timid	_____Other_____
_____Bullied	_____Lying	

Birth History

Please describe the pregnancy of your child (Health of child and mother, substance use, medications, etc.)

_____
_____
_____
_____

Please describe the birth (Anesthesia, Cesarean Section, Breech, Induced, Complications, etc.)

_____
_____
_____
_____

Mother's age at time of birth _____
Father's age at time of birth _____
Length of labor _____
Child's weight at birth _____

At birth, did your child have…

Breathing problems?	YES	NO	Cord around neck?	YES	NO
The need for extra oxygen?	YES	NO	Normal Color?	YES	NO

Was your child premature? YES NO If yes, by how many weeks? _____
Was your hospital stay longer than usual? YES NO If yes, how long was it? _____
Were there problems with feeding? YES NO
If yes, please explain

_____

Developmental History

Motor development - List the age your child began:
Sitting _____ Crawling _____ Walking _____ Talking _____

Self-help skills – List the age your child began:
Dressing _____ Brushing _____ Toileting _____ Basic Hygiene _____

Please describe your child's temperament growing up (Attachment, Sleeping and Eating behavior, Social interactions, Emotions, Aggression, Curiosity, etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Has your child had any previous suicidal thoughts, and/or past attempts? YES NO
If yes, please explain

Is your child currently expressing suicidal thoughts/behaviors? YES No
If yes, please explain

Is there anything else you would like me to know about your child?

Client Signature Date

Therapist Signature Date

Parent/Guardian Signature Date

Supervisor/Collaborator Signature Date

Fee Schedule and Late Cancellation/No-Show Policy

Elevation Christian Counseling has no control over your individual rate when using insurance. Co-pay rates are subject to your insurance policy. If you are having an issue or believe your payment to be incorrect, please contact your insurance company to verify your rate. Please also know that we at Elevation Christian Counseling are willing to help you figure it out with our billing company, MED Management, if there are any further questions.

We understand there are times you must miss and appointment due to emergencies or obligations to work or family. However, if you do not notify your therapist you are unable to make your appointment, it hinders their ability to schedule another client. Therefore, if an appointment is not cancelled at least 24 hours in advance, you will be charged a $75 fee. If you do not cancel and you fail to show for your appointment, you will be charged a $100 fee. **Insurance companies do not cover late cancellation and no-show fees therefore making it each individual client's responsibility to make a payment.**

All clients will need to fill out a credit card on file/private pay form to help minimize missed payments, which affect you as the client and your therapist. MED Management will charge your card by the end of the week of your scheduled session.

Rates according to CPT codes:

90791 – Intake	$225
90847 – 38-52 min (Couples)	$220
90837 – 53-60 min	$200
90834 – 38-52 min	$150
90832 – 16-37 min	$100
90853 – Group 60 min	$100
Private Pay Rate	$100
Late Cancel Charge	$75
No-Show Charge	$100
Written Reports/Letters/ Exchange of Client info (60 Min)	$150
Required/Requested Provider Appearance (per hour)	$200

I have read the Fee Schedule and Late Cancellation/No-Show Policy. I understand and agree to this policy.

Client Signature Date

Therapist Signature Date

Parent/Guardian Signature Date

Supervisor/Collaborator Signature Date

Credit Card on File/Private Pay Form

All therapy sessions (Individual, Group, Family, and/or Marriage) vary from 45 minutes to 60 minutes. Insurance or private pay can be used for these services. Please read through the following information and defer to your therapist for any questions.

_____ Insurance: Credit card on file for copay/deductible/coinsurance payments for each appointment.

_____ Private Pay: Credit Card on file for the private pay agreement with my therapist for each appointment.

Client Name: _____

Therapist Name: _____

Private Pay Rate: _____

Credit Card information and authorization:

Name as it appears on the credit card: _____

Type of credit card: _____ MasterCard _____ Visa _____ Discover _____ Amex

Card Number: _____

Expiration Date: _____ CVV: _____

I, _____, authorize Elevation Christian Counseling to utilize their desired billing service of MED Management to process my credit card for my date of service. I have been made aware that MED Management will process my payment at the end of the week of my date of service. I agree to be charged the late cancellation fee of $75, and the no-show fee of $100, as stated in the financial agreement in the intake packet. I will update this form if credit card information changes at any time. If I have any questions, I understand that I may address said questions with my therapist, and we will work to resolve any issues.

_____ _____

Client Signature Date Therapist Signature Date

_____ _____

Parent/Guardian Signature Date Supervisor/Collaborator Signature Date

Insurance Information

Primary Insurance

Insurance Name: _____ Phone: _____

Member ID#: _____ Group #: _____

Policyholder's Name: _____ DOB: _____

Claims Address: _____

Ins. Rep. Name: _____ Effective Date: _____

Ded.: _____ Ded. Met: _____ OOP: _____ OOP Met: _____

Co-Pay: _____ Co Ins.: _____ Coverage Limits: _____

Secondary Insurance

Insurance Name: _____ Phone: _____

Member ID#: _____ Group #: _____

Policyholder's Name: _____ DOB: _____

Claims Address: _____

Ins. Rep. Name: _____ Effective Date: _____

Ded.: _____ Ded. Met: _____ OOP: _____ OOP Met: _____

Co-Pay: _____ Co Ins.: _____ Coverage Limits: _____

I verify the above insurance information is correct. I understand that at the time of my first appointment I am to provide a copy of my insurance card and drivers license.

_____ _____

Client Signature Date Therapist Signature Date

_____ _____

Parent/Guardian Signature Date Supervisor/Collaborator Signature Date

Client Acknowledgement and Authorization

- I have reviewed the *Client Rights* document available on the website.
- I have reviewed the *Consent to Treatment* document available on the website.
- I have reviewed and signed the *Fee Schedule and Late Cancellation/No-Show Policy*.
- I understand I will be charged the late cancellation/no-show fee as applicable, which is not covered by my insurance company.
- I have reviewed and signed the *Credit Card on File/Private Pay Form*.
- I understand if I have any questions regarding my rights and privacy, I may contact my therapist.
- I understand Elevation Christian Counseling and MED Management will be contacting my insurance regarding benefits, eligibility, and claim information.
- I understand any treatment charges not covered by my insurance plan will be my responsibility.
- I understand if I have 3 cancellations and/or no shows, I may be subject to discharge and referral for other therapeutic facilities.
- I understand Psychotherapy is done in person. If I am to reach out to my therapist via phone or email with a non-critical problem, I understand my therapist may suggest I meet with them.
- I understand email is not to be used for immediate attention or emergency care.
- I understand Elevation Christian Counseling is not a crisis prevention facility and **if there is an emergency**, I am to contact my primary care physician, 911, or an emergency crisis line:
    - National Alliance on Mental Illness (NAMI) – 24/7 crisis and suicide prevention counseling (800) 273-8255
- I understand recording of sessions is strictly forbidden.

Taking care of and being responsive to clients is your therapist's priority. However, they will not always be available. Please allow your therapist up to 24 hours to contact you if you reach out to them via phone or email. Your therapist will check his/her voicemail and email at least once a day and respond to you as soon as you call. Please discuss and respect appropriate boundaries with your therapist regarding contact.

I have read the Client Acknowledgement and Authorization Policy. I understand and agree to this policy.

Client Signature	Date	Therapist Signature	Date
Parent/Guardian Signature	Date	Supervisor/Collaborator Signature	Date