CenterPoint Counseling

MINOR Client Information

Date of Initial Session:_____________ Therapist:___________________________

Client/Child's Name__________________________________ Date of Birth_______________________

Address__________________________________ City_______________State_______Zip __________

Current Grade _________ School_________________________

Emergency Contact ____

Name Relationship Phone

Parent/Guardian Name_______________________________ Date of Birth_______________________

Address (If Different)____________________________ City_______________State_______Zip __________

Home Phone(____)__________________ Work Phone (____)_________________

Cell Phone (____)__________________ Other Phone (____)_________________

Employer ___________________________ Email:_____________________________

Marital Status: ☐Married ☐Remarried ☐Single ☐Separated ☐Divorced ☐Divorced/Single ☐Divorced/Dating

If Divorced: date(s) final ___________________

Age of child at separation(s)________________

Used for statistical analysis only. Information is compiled and anonymity of all clients is maintained.

Annual Household Income
- ☐Under $30,000
- ☐$30,000 - $40,000
- ☐$40,000 - $50,000
- ☐$50,000 - $60,000
- ☐$60,000 - $70,000
- ☐$70,000 - $80,000
- ☐$80,000 - $100,000
- ☐Over $100,000

How did you hear about us? (please identify)
- ☐Attorney____________________
- ☐Friend ____________________
- ☐Family ____________________
- ☐Pastor ____________________
- ☐Physician___________________
- ☐Insurance___________________
- ☐Yellow Pages or Internet
- ☐Other______________________

Are you a member of, or do you regularly attend Second Presbyterian Church? ☐Yes ☐No

If not at Second, do you regularly attend another church? ☐Yes ☐No

Would you like to be added to our mailing list to receive newsletters from CenterPoint Counseling? ☐Yes ☐No

Communication of Private Mental Health Information Authorization

Please (✓) all acceptable forms of communication to provide quality client care.

☐ I authorize the staff of CenterPoint to leave a message regarding my Private Health Information on home voicemail/answering machine.

☐ I authorize the staff of CenterPoint to leave a message regarding my Private Health Information on work voicemail/answering machine.

☐ I authorize the staff of CenterPoint to leave a message regarding my Private Health Information on mobile voicemail.

Minor/Child Consent

I have legal authority to do all things necessary with regards to seeking therapy/counseling for my child(ren). I give my permission of treatment for my child(ren) to receive therapy/counseling from CenterPoint Counseling. I also acknowledge that the above information is correct and hereby give permission for communication of my child's private mental health information by the acceptable forms checked above.

Parent/Guardian Signature **Printed Name** **Date**

Parent/Guardian Signature **Printed Name** **Date**

Client/Child Name__________________________________

1. Who does child talk to when they need positive, emotional support?

☐Mother ☐Father ☐Adult Relative ☐Friend ☐Sibling ☐Teacher ☐Other________________

2. Has child ever been involved on any of the following services?

☐Support Groups ☐Treatment Program ☐Mental Health Counseling ☐Anger Mgmt. Classes
☐Family Counseling ☐Other________________

3. Please list any physical disabilities your child may have.____

____

4. Please list any medications your child may currently be taking and for what reason.
Medication(s)____________________________________Reason____________________________________

5. Please list any health concerns you have about your child. ____

____

____

6. Briefly describe your child's current school experience (i.e. relationship with teachers, grades and school work, concentration, relationship with peers, etc…).

____

____

____

7. Briefly describe how your child is currently functioning at home (i.e. relationship with sibling/s, relationship with parent/s, etc…).

____

____

____

8. Briefly describe your child's current peer relationships (in and outside of school).

____

____

____

9. As a parent, what do you believe are the greatest challenges for your child currently?

____

____

____

10. Please list the members of your current household (In order of age).

Name	Age	Relationship (i.e. mother, step-father, child #)

CenterPoint Counseling
7700 North Meridian St.
Indianapolis, IN 46260
(317) 252-5518

Therapeutic Disclosure Form

Welcome to CenterPoint Counseling! Entering into a therapeutic relationship is unique and is guided by professional governing ethical standards that we feel are important to share with you at this time.

1) Confidentiality:

The therapeutic relationship is a privileged relationship and the content of all discussions, testing, notes and evaluations are protected. This information can only be released by your signed consent.

2) Exceptions to Confidentiality:

While the therapeutic relationship is confidential, the professional standards and Indiana law require these exceptions:

a) When physical harm is threatened against another person,
b) When physical harm is threatened against one's self,
c) When physical abuse or neglect is directed at a child or adult,
d) When records are subpoenaed by a state or federal court,
e) Any other provision covered under Indiana Code 25-23.6 et. Seq.

3) Fee Policy:

The standard counseling fee at CenterPoint Counseling is $125 for Doctoral level clinicians, $100 for Master's level clinicians, and $70 for Intern level clinicians per 50 minutes session. Sessions that exceed the 50-minute session will be billed in 15-minute increments at ¼ of the appropriate standard 50-minute rate for each additional increment. CenterPoint does offer a fee subsidy through our Samaritan Fund in cases of financial hardship.
Payment for counseling services are your responsibility and due at the time of your counseling appointment. If filing with insurance, you are ultimately responsible for any claims not paid by your insurance company for any reason.

4) Cancellation Policy

The cancellation of a counseling appointment requires 48-hours notice to offer time to refill the time slot. Failure to give adequate notice will result in your being billed for your reserved appointment time.

I have read and understand the policies of CenterPoint Counseling and the additional information provided in this document. Please have all persons seeking counseling sign this form.

Name____Date_________

Name____Date_________

Witness____Date_________

If you will be filing for insurance reimbursement, please check with the Office Coordinator regarding coverage and fill out the "Insurance for Mental Health Services" form.

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Insurance for Mental Health Services

1) **Insurance Considerations**

The filing of an insurance claim usually requires that we provide a diagnosis to your insurance company. There have been occasions when a clinical diagnosis to your insurance has resulted in persons experiencing difficulty in obtaining life, medical or disability insurance.

Do you plan to file for insurance reimbursement?

____Yes ____No (If Yes, please read and complete the remainder of this form)

2) **Insurance Information**

There are numerous insurance companies that offer mental health benefits as part of their coverage. We suggest you check with your insurance provider to determine the requirements for insurance coverage. Your insurance company will want to know the credentials of the Provider of Service. You will want to ask your insurance company about deductible requirements, percentage of co-payment, number of sessions per year and "In-Network" vs. "Out-of Network" benefits. CenterPoint Counseling will be glad to assist you by providing and filing the necessary information for insurance reimbursement. **Be aware that if you are seeing a provider who is not licensed or out-of network, filing for insurance may not be an option.**

3) **Insurance With Regards To Our Cancellation Policy**

Again, the cancellation of a counseling appointment requires 48-hours notice to offer time to refill the time slot. Failure to give adequate notice will result in your being billed for your reserved appointment time.

Please understand that if you file insurance, appointments in which you are not present, but still charged for (i.e. failure to arrive for your appointment or failure to give adequate notice of cancellation) cannot be filed for insurance reimbursement.

Therefore, you will be responsible for full payment of the contracted fee.

4) **Authorization to Release Information**

I hereby authorize CenterPoint Counseling to release my clinical diagnosis, prognosis and treatment request information acquired in the course of my examination or treatment to my insurance carrier. I am also aware that payment is ultimately my responsibility and should my insurance fail to pay for services for any reason, I am required to pay CenterPoint Counseling for services and to reconciling with insurance is my responsibility. I have read and understand the information regarding insurance filing.

Signed ____Date_____________
(Client or Parent if Minor) (Expires six months after last session)

Witness____Date_____________