Welcome to Cornerstone Counseling Services, LLC.

Child/Adolescent Therapy Client Form

Welcome and thank you for choosing Cornerstone Counseling Services, LLC. This document is designed to answer some frequently asked questions about me, the counseling process, my professional relationship with your child and the caregiver(s), confidentially and your financial obligation. As you read this document, feel free to mark any places which are not clear to you or with any question you would like to further discuss.

Counseling is designed to increase the coping skills of your child/adolescent, and allow for healing and growth. Success cannot be guaranteed with counseling; however I am committed to using a number of highly researched approaches during the counseling process. The nature of the counseling process is very personal. Therefore, we maintain a professional relationship consistent with accepted ethical standards. You are in complete control and may end out professional relationship at any time. I do not take on a client whom, in my professional opinion, I cannot help using the knowledge and techniques I have available. If necessary, I will make these referrals at our initial conversation on the telephone or in our initial meetings. In some cases it takes multiple meetings to assess one's needs or we may come to a point where I feel that I can no longer meet your child's needs. If I do not feel that your child will benefit from my services, I will refer you to others or agencies which would be better able to serve your child's individual needs.

Parents have the right to any and all information regarding your child. Because the presence of trust is important in the therapeutic relationship between your child and me, it is generally best that we do not share specifics of individual sessions with you. However, you have the right and responsibility to question and understand the nature of your child's treatment and the progress being made. If your child is able to understand the issues of confidentiality, I will discuss with him/her the type of information that will be shared with you. If you have any objections to the manner in which information is shared with you regarding your child, we will need to address and resolve those concerns before therapy begins.

What to expect at the first appointment:

The initial meeting will be 60 minutes in length. There will be an initial "intake session" with the counselor and caregiver(s) only. The initial session is designed to obtain the family history, a history of the child's development, background, reason for referral, and concerns the caregiver may have. During the initial session, caregivers have the opportunity to ask questions, and become educated on the therapeutic process. At the end of the session, the counselor will provide recommendations. It will be helpful at that time for you and the counselor to discuss and decide on the options and recommendations you want to pursue. Sessions with your child/adolescent will be with the counselor and the child only; however, there may be occasions where the counselor invites other family members to participate in counseling sessions. Counseling sessions will be 50 minutes in duration. Extended sessions can be arranged as needed by prior agreement with your counselor.

Cornerstone Counseling Services, LLC.

Child/Adolescent Client Information

The purpose of the following questionnaire is to help your counselor understand some important things about your child in order to help your child and your family most effectively. Please complete all pages.

Child's Full Name:____ Date: ______________________

Child's date of birth: ____________________ Age ________________ Gender: ________M ________F

Address____

City_____________________ Zip Code ____________ E-mail ___________________________________

Phone (H) ______________________________ Permission to call ___Y ___N Leave Message ___ Y ___N

Phone (W) ______________________________ Permission to call ___Y ___N Leave Message ___ Y ___N

Cell phone ______________________________ Permission to call ___Y ___N Leave Message ___ Y ___N

Caregiver/Parent Information

(1) Caregiver/Parent Name: ____ Age ________________

Marital Status:

Single____ Married ____ Divorced____ Engaged____ Separated____ Widowed____ Partnership____

Name of Spouse/Significant other: ______________________________________ Age ________________

Length of time together: _________ years ___________ months

(2) Caregiver/Parent Name: ____ Age ________________

Marital Status:

Single____ Married ____ Divorced____ Engaged____ Separated____ Widowed____ Partnership_____

Name of Spouse/Significant other: ______________________________________ Age ________________

Length of time together: _________ years ___________ months

If divorces or separated-

CustodyStatus:____

____

EmergencyContact:____

(Name) (Relation) (Phone)

How did you hear about CCS, LLC? ____

If referral, who referred you to CCS, LLC?____

Presenting Problem for Caregiver/Parent

Please circle stressors **you** have had in recent months-

Marital Issues   Health Issues   Job Issues   Financial Issues

Parent/Child Issues   Past Issues   Other:____

Child's Presenting Problem(s) * Please circle all that apply.

Sexual abuse	Physical abuse	Neglect	Delinquent behavior
Nightmares	Suicidal thoughts	Sexually acting out	Sleeping problems
Anxiety	Shyness	Academic problems	Change in appetite
Concentration	Bed wetting	Stealing	Clinging behavior
Impulsivity	Temper outbursts	Withdrawn	Lying
Peer conflict	Drug use	Alcohol use	Stubbornness
Running away	Missing school	Health issues	Strange thoughts
Legal trouble	Harming self	Head banging	Overactive
Skipping school	Sexual problems	Fearful	

Other problems and/or concerns: ____

____

How long have these problems occurred (number of weeks, months, years): ______________________

Why did you decide to seek counseling at this time? ____

____

Describe how you hope counseling will help your child? _____________________________________

____

Describe how you hope counseling will help you and your family? ______________________________

____

____

Current Family Situation

List the occupants in the home, even if temporary: ____

____

Biological siblings (list names and ages in order of oldest to youngest) ______________________________

____

Are there any current concerns regarding siblings? (Please list concerns.)____________________________

____

Has the child ever been exposed to domestic violence? ___ Y ___N

Traumas or losses (please indicate the loss or trauma and the age of the child):______________________

____

Living Arrangements

Is there currently a custody dispute? ____yes ____no _____possibly

Is there weekend visitation with a non-custodial parent? ______yes ______no

Has your child recently moved? _____yes _____ no Number of moves in child's life? _____

Who makes the decisions regarding the household money, discipline, routine?______________________

What is your major form of discipline? (Example: grounding, spanking, taking away TV, etc.) __________

____

Who is the major disciplinarian? ____

Physical/Mental Health of Client and Family Members:

Please note all health problems your child has had or has now:

	Age		**Age**		**Age**		**Age**
High fever	_____	Dental problems	_____	Dizziness	_____	Sinus problems	_____
Pneumonia	_____	Weight problems	_____	Tonsils out	_____	Heart problems	_____
Flu	_____	Vision problems	_____	Allergies	_____	Hyperactivity	_____
Encephalitis	_____	Skin problems	_____	Meningitis	_____	Asthma	_____
Earaches	_____	Hearing problems	_____	Blood pressure	_____	Convulsions	_____

Age	Age	Age	Age
Headaches _____	Fainting _____	Unconsciousness _____	Accident prone _____
Head injury _____	Anemia _____	Stomach problems _____	

Major illness or physical limitations:____

____

Has your child ever been hospitalized? If so please explain? ___________________________________

____

Please list all medications your child is taking:____

Name of Primary Care physician: ____

Name of other physicians your child is seeing, especially psychiatrists:___________________________

____

Has your child ever seen a counselor before? ____yes ____no

Duration of therapy: ______________________

Name of counselor: ____

What was the presenting problem?____

Has your child ever had a psychiatric diagnosis?_______ If yes, what was the diagnosis? _____________

Family Medical and Psychiatric History

Medical problems or disabilities in the family:____

____

Psychiatric history in family:____

____

Substance abuse history: ____

____

Developmental History

Prenatal

Please list any problems or complications with pregnancy or delivery

____

____

Developmental Milestones
(Referring to age when the child walked, talked, potty trained, etc.)

____

____

____

Educational History

Name of child's school: _____________________________________ Grade: ______________

Teacher(s) name: ____

Average grades: ____

Concerns regarding school academics or behavior:____

____

Have there been any significant changes or problems in school behavior or grades? ________________

____

Child's best subject: ______________________ Child's most challenging Subject:_________________

Please check the following according to your child:

Learning disabilities: _____yes ______no If yes, please explain? _________________________________

____

Gifted program: _____yes ______no

ADD _____yes ______no ADHD _____yes ______no

Participate in extracurricular activities? _____yes ______no

If yes, please explain? ____

____

Social history

In school how many friends does your child have? _____a lot (more than 5) ______a few (1-5) ______none

How much time does your child spend with other children outside of school during the week?

0-1 day______ 2-3 days______ 4-5 days_______ more than 5 days________

Please list child's special interests, hobbies, skills:____

____

How does your child get along with…

Peers-

Adults-

Teachers-

Parents-

Other-

Is your family connected with any groups, churches, or religious organizations? ____________________

____

Has your child ever had difficulty with the police? _____yes ______no If yes, please explain? _________

____

Has your child ever been on probation? ______yes ______no

Is your child employed? ______yes _______no

Additional comments, questions, or concerns:

____

____

____

Print Full Name: ______________________________________

Signature: ____ Date:______________________

Policies

Please initial where indicated, stating you have read and understand the information provided.

Confidentiality- A very important aspect of developing the openness, honesty, and trust between counselor and client is confidentiality. Whatever you share with your counselor will be kept in the strictest confidence and will not be disclosed to anyone without your express, written consent. At the same time, it is important for you to know that, under Georgia law; a few situations sometimes arise in which your counselor is both legally and ethically required to make disclosures that are necessary to ensure the safety of yourself or others. Those situations include: suspected child abuse, threat of physical violence to others, and/or suicidal intent. Your counselor will further discuss any aspect of confidentiality, which may concern you.

Initials ___________________

Court- Your counselor will not participate in divorce or child custody proceedings because the same professional should not perform evaluation and therapy. If subpoenaed by the court of law, I will first assert client-counselor privilege. However, if ordered by a judge to disclose information, my fees for appearing in court are an hourly rate of $200 and must be paid at the end of each day in attendance.

Initials ___________________

Emergencies- If you have an emergency (something that cannot wait for your next appointment), please call 678-954-5814. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you feel that you cannot wait, please call 911 or go to the nearest Hospital Emergency Room for help. Please do not wait for your counselor to contact you to utilize those resources.

Initials ___________________

Insurance- Cornerstone Counseling Services, LLC. files for insurance reimbursement. Since each insurance company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although your counselor is a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with your counselor in order to reimburse you for services provided at Cornerstone Counseling Services, LLC, you will be asked to provide specific written consent for the counselor to communicate with your insurance company. Please let your counselor know if you intend to file a claim.
Are you planning to file a claim for reimbursement of services with your mental health insurance provider?
_________ Y ________ N

Initials ___________________

Cancellation Policy- All cancellations should be made via email. Your counselor will confirm your cancelled appointment via email. For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours prior to your appointment time, the full charge for your scheduled session will be applied. For appointments not kept (and not cancelled) the full amount will be charged.

Initials ___________________

Payment- Payment in full is due when services are rendered unless other arrangements have been made in advance. Fees are charged for in office sessions and phone consultations. Credit cards (Visa and MasterCard), Debit cards, and cash are accepted. Checks are not accepted.

Initials ___________________

Please sign below, indicating that you have read, understood, and received a copy of this information. If you have any questions or concerns, please discuss before signing.

Print Full Name: ____

Signature: ____ **Date**: _____________________

Policies

Keep This Copy for Your Records

Confidentiality- A very important aspect of developing the openness, honesty, and trust between counselor and client is confidentiality. Whatever you share with your counselor will be kept in the strictest confidence and will not be disclosed to anyone without your express, written consent. At the same time, it is important for you to know that, under Georgia law; a few situations sometimes arise in which your counselor is both legally and ethically required to make disclosures that are necessary to ensure the safety of yourself or others. Those situations include: suspected child abuse, threat of physical violence to others, and/or suicidal intent. Your counselor will further discuss any aspect of confidentiality which may concern you.

Court- Your counselor will not participate in divorce or child custody proceedings because the same professional should not perform evaluation and therapy. If subpoenaed by the court of law, I will first assert client-counselor privilege. However, if ordered by a judge to disclose information, my fees for appearing in court are an hourly rate of $200 and must be paid at the end of each day in attendance.

Emergencies- If you have an emergency (something that cannot wait for your next appointment), please call 678-954-5814. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you feel that you cannot wait, please call 911 or go to the nearest Hospital Emergency Room for help. Please do not wait for your counselor to contact you to utilize those resources. If I am going to be unavailable for extended time, I will provide you with the name of a colleague to contact, if necessary.

Insurance- Cornerstone Counseling Services, LLC does file for insurance reimbursement. Since each insurance company is different in the health benefits it provides, there can be no guarantee that the counseling services you receive will be covered. Although your counselor is a qualified and licensed professional, exact requirements for payment vary. You should be able to ascertain your plan's eligibility from your agent, your insurance company, or your employer. In the event that your insurance company requires correspondence with your counselor in order to reimburse you for services provided at Cornerstone Counseling Services, LLC, you will be asked to provide specific written consent for the counselor to communicate with your insurance company. Please let your counselor know if you intend to file a claim.

Cancellation Policy- All cancellations should be made via email. Your counselor will confirm your cancelled appointment via email. For cancellations occurring at least 24 hours prior to your appointment time, no charges will be incurred. For cancellations occurring less than 24 hours prior to your appointment time, the full charge for your scheduled session will be applied. For appointments not kept (and not cancelled) the full amount will be charged.

Payment- Payment in full is due when services are rendered unless other arrangements have been made in advance. Fees are charged for in office sessions and phone consultations. Credit cards (Visa and MasterCard), Debit cards, and cash are accepted. Checks are not accepted.

Please sign below and keep the two subsequent pages of information for your records.

Georgia Notice Form:

By signing below, I am acknowledging that I have received a copy of the Georgia Notice Form concerning the policies and practices protecting my health information.

Print Full Name: ____

Signature: ____ Date______________________

Georgia Notice Form
Notice of Licensed Professional Counselor Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USEDAND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Heath Care Operations
I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as family physician or another psychologist.
- "Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health care insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Health Care Operations" are activities that relate to the performance and operation of my practice, Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization:
I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides that insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither consent nor Authorization
I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse - If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse - If I have reasonable cause to believe that a disabled adult or elder person has had physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight Activities - If I am the subject of an inquiry by the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Counselors Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.

• Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order.
• Serious Threat to Health or Safety - If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
• Workers Compensation - I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Licensed Counselor's Duties

Patient's Rights:

• Right to Request Restrictions - you have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction that you request.
• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations -- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
• Right to Inspect and Copy -- You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss the details of the request and denial process.
• Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
• Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
• Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Licensed Counselor's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
• If I revise my policies and procedures, I will inform you of that change in a session or on the phone, and that information may be also provided to you in written form while you are in a session or through the mail.

V. Complaints:

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please inform me. You may also contact the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Counselors. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, I will promptly distribute the revised Notice, post it in the waiting area of my office, and make copies available to my patients.