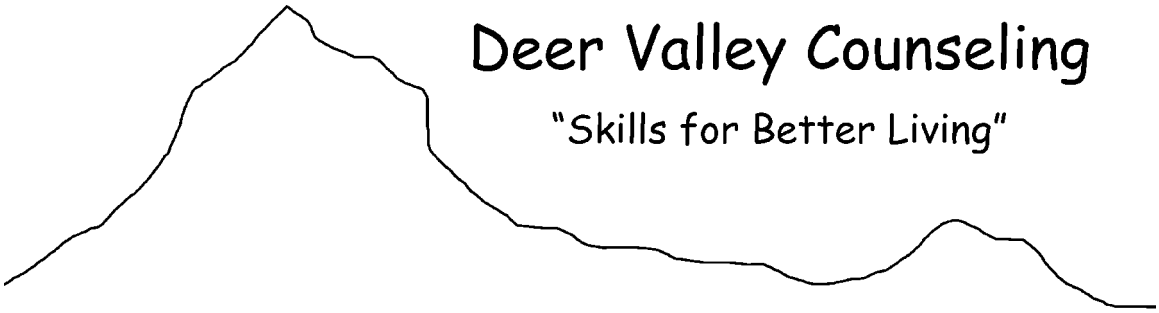

Client Information Sheet – Child or Adolescent – Insurance

Child's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Parent/Guardian: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____

Preferred Method for Courtesy Appointment Reminders to Parent:

☐ **Text Message to Mobile Phone** ☐ Call to Home Phone ☐ Call to Mobile Phone ☐ Do Not Remind

Note: You are responsible for appointments you schedule whether you receive a courtesy reminder or not.

Employer: _____ Work Phone _____

Emergency Contact: _____ Phone: _____

Referral Source:

☐ Searched Provider Directory on Insurance Company Website

☐ General Internet Search. Search Terms: _____

☐ Bing ☐ Yahoo ☐ Google ☐ Yelp ☐ Counsel-Search.com ☐ Family-Marriage-Counseling.com

☐ Psychology Today ☐ Theravive.com ☐ GoodTherapy.org ☐ Find-a-Therapist.com

☐ Verizon Superpages ☐ DEX Knows ☐ Other

_____

☐ Phone Book: ☐ DEX ☐ Verizon ☐ Other: _____

☐ Another client: _____

☐ Friend, relative, or acquaintance: _____

☐ Doctor or other professional: _____

☐ Other: _____

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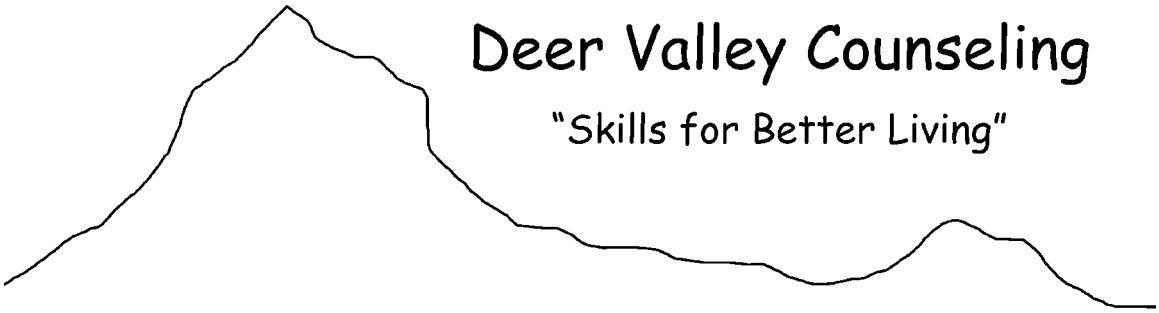

Acknowledgments, Permissions & Consents

Child's Name: _____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read copies of Deer Valley Counseling's Payment Policy, Consent to Treat, Notice of Privacy Practices, Fee Schedule and Clinician's Notice. I understand that if I have any questions regarding privacy rights, I can contact James Nettles, Privacy Officer, Deer Valley Counseling, 2301 W Dunlap Ave, Suite 206, Phoenix, AZ 85021.

I authorize Deer Valley Counseling to bill my insurance company and for my insurance company to pay Deer Valley Counseling directly. I understand that insurance companies do not reimburse for missed appointments or appointments where my child arrives late and that I will be financially responsible for missed appointments or late arrivals. I hereby give my permission for Deer Valley Counseling to charge my credit card on file the full rate for any missed appointments not canceled or rescheduled 48 hours in advance, for late arrivals and for any copay, coinsurance, deductible or other fees not paid at time of service.

I understand that Deer Valley Counseling does not perform evaluations or make recommendations related to custody, divorce or other court cases. I agree to pay Deer Valley Counseling $2000 plus expenses for each day that a Deer Valley Counseling clinician or employee is required to be present at a legal proceeding, including but not limited to a deposition, hearing, or court, regardless of whether or not the clinician or employee is actually called to speak that day.

I hereby give my permission and consent for my child to participate in the treatment provided by Deer Valley Counseling.

I attest that I am the parent/legal decision-maker for the child named above.

_____

Parent/Guardian Name

_____

Parent/Guardian Signature **Date**

_____

Therapist Signature **Date**

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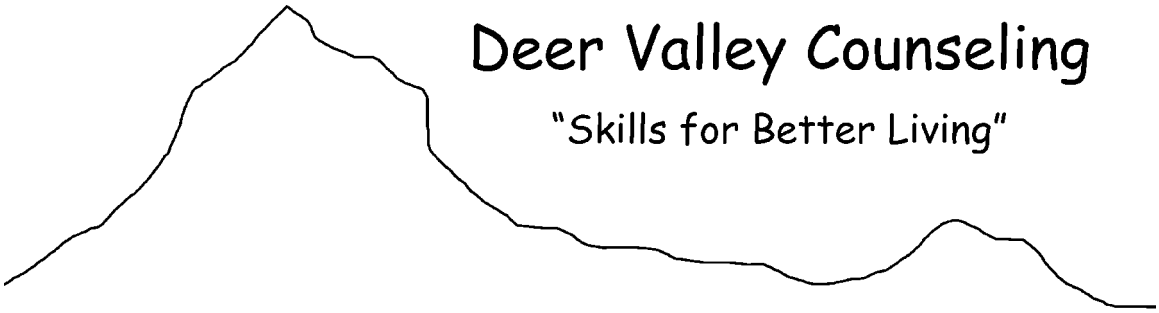

Authorization for Release of Confidential Information To Primary Care Physician

☐ Client declines to authorize release of confidential information to PCP or has no PCP.

I, _____ Date of Birth of Client: _____
(Client's Name or Person Authorized to Sign for Client)

hereby authorize Deer Valley Counseling to release information to the client's Primary Care Physician (PCP) and for the client's PCP to release information to Deer Valley Counseling.

Required: PCP Name: _____

And One of the Following: PCP Telephone Number: _____

PCP Fax Number: _____

PCP Address: _____

PCP Clinic Name: _____

I understand that the purpose of these disclosures is to coordinate treatment.

Information to be disclosed includes evaluations, recommendations, diagnosis, treatment plan, progress, progress notes as well as:

☐ Alcohol and drug abuse evaluation and treatment information **(if your file contains any substance abuse information, we will not release your record unless this box is checked).**

☐ Other: _____

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be redisclosed by the recipient and at that time would no longer be protected by the originator. I understand that Deer Valley Counseling may not condition services upon my signing this authorization unless the services are provided to me for the purpose of creating health information for a third party. This authorization for release of information will expire on _____ (if left blank, one year from the date it was signed).

_____	_____	_____
Printed name of Client	Signature of Client	Date Signed
_____	_____	_____
Person Authorized to Sign for Client	Signature of Person Authorized to Sign	Date Signed

Reason person may sign for client: ☐ Parent ☐ Guardian ☐ Other: _____

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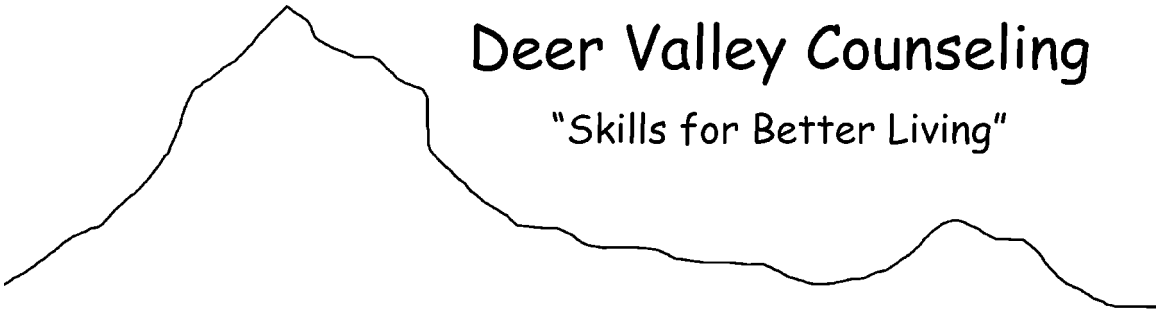

Client History – Child or Adolescent

Name: _____

Employer/School: _____ Grade: _____

Occupation/Studying: _____

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Deceased

Number of Sisters: ___ Number of Brothers: ___ Birth Order: ☐ Eldest ☐ Middle ☐ Youngest ☐ Only

With Whom Does Youth Live: _____

	First Name	Frequency of Contact	Quality of Relationship
Parent/Guardian			
Parent/Guardian			
Step Parent			
Grandparents			
Aunts/Uncles			
Brothers			
Sisters			
Friends			

Family History of:
☐ Depression ☐ Suicide Attempts ☐ Anxiety
☐ Chronic Illness ☐ Mental Illness ☐ Eating Disorders ☐ Alcoholism
☐ Violence ☐ Sexual Abuse ☐ Emotional Abuse ☐ Drug Addiction

Please explain any items checked above: _____

_____

_____

_____

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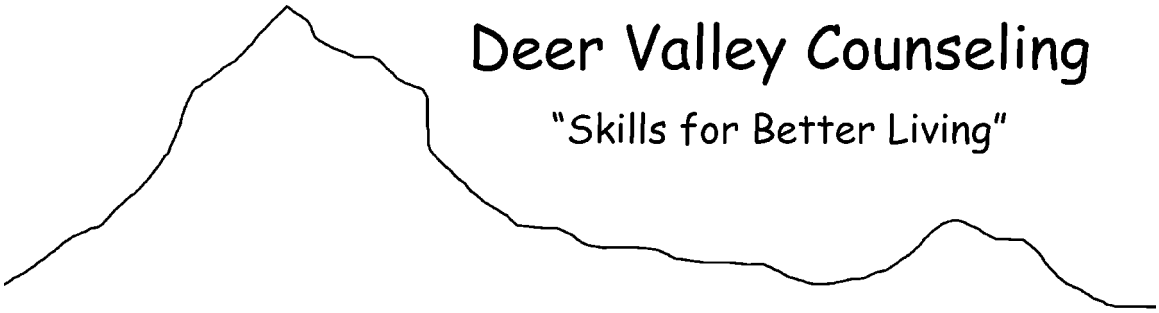

Deer Valley Counseling

"Skills for Better Living"

Name: _____

How often does the youth experience the following thoughts or behaviors?

	Never	Rarely	Sometimes	Frequently	Please Explain
Depression					
Restless or easily annoyed					
Uncontrolled crying					
Suicidal thoughts or attempts					
Fatigue or difficulty sleeping					
Difficulty concentrating					
Lack of interest in old activities					
Harms self					
Anxiety					
Panic attacks or nightmares					
Specific fears					
Startles easily					
Low self-esteem or shyness					
Peer problems					
Learning difficulties					
Bed-wetting/day-wetting					
Inappropriate sexual behavior					
Verbally/physically aggressive					
Tantrums or defiance					
Running away					
Conduct problems/lying/stealing					
Alcohol or drug use					
Persistent thoughts/behaviors					
Excessive energy or activity					
Hears voices					
Excessive weight gain or loss					
Questions about gender					
Questions about orientation					

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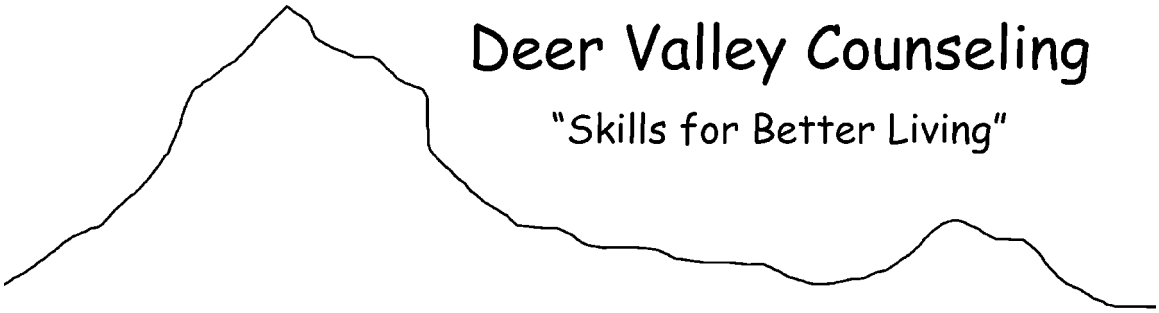

Deer Valley Counseling

"Skills for Better Living"

Name: _____

Has the youth experienced any of the following?

□ Neglect: _____

□ Physical, sexual or emotional abuse: _____

□ Trauma or assault: _____

□ Witness trauma, assault or domestic violence: _____

□ Death of a someone important: _____

□ Physical illness (self or family): _____

□ Mental illness (self or family): _____

□ Legal issues (self or family): _____

□ Alcohol or drug abuse (self or family): _____

□ Other family problems: _____

□ School problems: _____

□ Bullying: _____

□ Head trauma or injury: _____

Previous counseling, inpatient mental health treatment or drug/alcohol treatment –

Who or Where	Problem Addressed	How Many Sessions	Result

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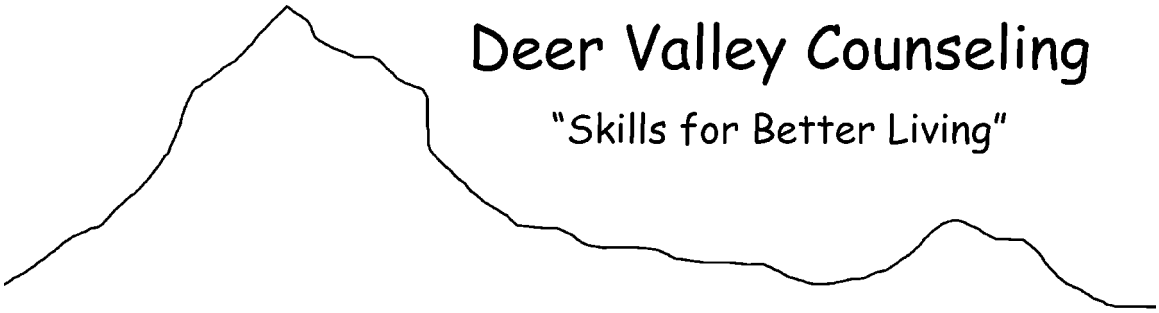

Deer Valley Counseling

"Skills for Better Living"

Treatment Plan, Original or Revised

Name: _____

Client Statement of Problems: _____

_____

_____

_____

_____

_____

_____

_____

_____

Goal 1: _____

_____

Goal 2: _____

_____

Goal 3: _____

_____

Attach additional sheets if necessary.

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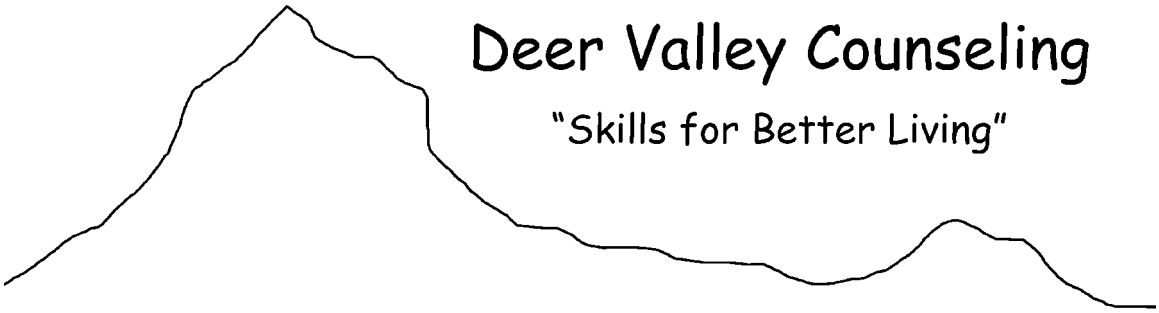

Deer Valley Counseling

"Skills for Better Living"

Name: _____

The therapist will fill out this portion.

Treatment Method: _____

_____

Treatment Method: _____

_____

Treatment Method: _____

_____

Treatment Method: _____

_____

Aftercare Requirements: _____

I have met with staff and participated in the planning process of this treatment plan. It has been explained to me in language that I understand. I understand the risks and benefits of these services. I agree and consent to receive services as outlined in this plan. This plan will be reviewed one year from the date it is signed or sooner if clinically indicated.

_____

Client's Signature Date

_____

Parent or Guardian's Signature Date

_____

Therapist's Signature Date

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