Grace C. Graham, Psy.D.
Charis Counseling and Psychological Services
2301 Ohio Dr., Suite 138A
Plano, TX 75093
Tel: 469-467-7595
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chariscounseling@tx.rr.com

CHILDRENS / PARENTS INTAKE FORM (3yrs. – 12yrs.)

Patient Information

Date Completed: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: ____ Zip: _____ Parent's Driver's License #: _____

Date of Birth: _____ SSN: _____ Sex: M F

Parent's Name: Mother _____ Father _____

Parents are: Married Separated Divorced

If Separated or Divorced:

Child lives with: _____

Custody arrangements are: _____

_____

Mother's Home Phone: _____ Work Phone: _____ Cell: _____

Mother's Employer _____Mothers SS# _____

Mother's Home Address (if different than child): _____

Mother's email: _____

Father's Home Phone: _____ Work Phone: _____ Cell: _____

Father's Employer _____Fathers SS#_____

Father's Home Address (if different than child): _____

Father's email: _____

Stepmother: _____ Stepfather: _____

Emergency Contact: (name & phone #): _____

Who is financially responsible for co pays and amounts not covered by insurance?

_____

How did you hear of us?_____

I authorize Dr. Graham/Dr. Chock to speak with my child's Primary Care Physician:

_____ at _____
Doctor's Name Address

_____ _____
Signature Date

Insurance Information

Insurance Carrier:
_____

Phone: _____ Policy ID: _____

Group: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relationship to Patient: _____

Subscriber's SS# _____

Any other insurance? ____ Authorization Number for Today's Visit: _____

Assignment of Benefits

I authorize the release of any medical or other information necessary to process this claim to my insurance company. This may also include case managers with your insurance company. I also authorize payment of medical benefits to Dr. Grace Graham for services rendered to me.

_____ _____
Patient Name (Please print) Date

_____ _____
Signature of legal guardian Relationship to Patient

Financial Policy

* The “Patient Intake Form” must be completed before the first visit.

* Co payments and deductibles are expected at the time of service.

* Initial Authorizations from your insurance company are your responsibility to obtain and failure to do so may result in your having to pay for the visit in full.

* We accept Cash
Checks (returned check fee is $35.00)
Master Card / Visa

*Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments and late cancellations at the rate of a $125.00 fee. 24 hours is a LITERAL 24 hours required for canceling, not just “the day before”.

* Psychological testing requires a FIVE DAY advance notice for cancellation. Failure to cancel without a five day notice will result in your being charged for all of the time reserved for you. This cannot be billed to your insurance company.

*Dr. Graham charges $250.00 per hour for her regular services. Additionally, she charges $62.50 for every increment of 15 mins. for their time outside of sessions. This fee will apply to phone consultations, returning phone calls, responding to emails, non-insurance related paperwork, letters, and reports. I understand these fees are not reimbursed by insurance.

*For court appearances and depositions (either as a fact or expert witness), my hourly rate is $350.00/hour. A retainer is required in advanced in increments of either half of a day (4 hrs. x $350/hr. = $1400.00) or a whole day (8 hrs. x $350/hr. = $2800.00). Depending on the complexity of and the volume of documents involved in the case, an additional 1 or 2 hours (at the rate of $250/hr.) may be required for review of records. Please be advised that my primary duty as a witness is to be impartial and fair regardless of whichever party pays for the retainer. The retainer requested in advance is for the reimbursement for my (billable) time away from my office and not for my testimony.

*Our office reserves the discretion to increase the fees charged as deemed necessary by our office. This consideration may be applied to all fees including fees charged for counseling, telephone calls, record requests, consultation with other providers, and litigation

I have read, understand and will abide by the above financial policy.

_____ _____

Signature Date

IMPORTANT

Most insurance companies handle mental health benefits differently than your other health benefits. In **MANY** cases, **pre-authorization** is required and **needs to be initiated by the patient.**

It is very important that you call your insurance company prior to your first visit to see if authorization is required and if so to set it up. Failure to obtain authorization may result in your insurance company not paying your claim.

Therefore, it is our office policy that you call your insurance company prior to your first visit and obtain the following information. **Please bring this sheet with you to your first visit. If you do not return this sheet, you will be required to pay for your visits in full until this information is provided.**

Patient Name: _____

I called my insurance company on _____ and spoke with

_____.

Authorization:

_____ Is not required

_____ Is required and the authorization number is: _____

Thank you for your understanding and cooperation in this matter.

You must return this form at your first visit

I have read and understand about the authorization process.

_____ _____

Signature Date

Missed Appointment / Late Cancellation & Reminder Call Policy

It is the policy of this office to charge $125.00 for missed appointments and appointments cancelled with less than a literal 24 hour notice.

As a courtesy to you, we would be happy to call you or email you the day before your appointment to remind you of your scheduled appointment. However, please note that if in some circumstances we cannot call you, *we will not be held responsible if you miss your appointment.* Please indicate below if you would like appointment reminders, and if so, how you would like to be contacted.

____ **NO,** I do not wish to receive appointment reminders at this time.

____ **Yes,** I would like appointment reminders.

Please **email** me at: _____

Please **call** me at: _____
Phone number

_____
Patient Name (Please print)

_____ _____
Patient Signature Date

Patient's Informed Consent

I have chosen to receive treatment services. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by my insurance company to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

I have read the basic rights of patients. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my therapist may disclose any and all records pertaining to my treatment to my insurance company (and to my primary care physician), if such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I **have read and understand the above.**

_____ _____

Signature of Parent or legal guardian Date

NOTICE OF PRIVACY PRACTICES

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

During the process of providing services to you, Charis Counseling and Psychological Services (CCPS) will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below. The purpose of this Notice is to describe how we may use and disclose your protected health information. CCPS is required to abide by the terms of this Notice, or any amended Notice that may follow.

Our Obligations

CCPS is required by State and Federal law to maintain the privacy of protected health information. CCPS is required by law to provide clients with notice of our legal duties and privacy practices with respect to protected health information. There are circumstances where state law is more stringent (strict) than federal law, and in such cases, we will follow state law with respect to the limitation on uses and disclosures of your information.

Uses and Disclosures: CCPS may use and disclose protected health information without your consent in the following ways.

Treatment: We will use your health information to provide, coordinate, or manage health care (including mental health care) and related services. For example, staff involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

Payment: We will use your health information for payment purposes. For example, we will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

Health Care Operations: Health Care Operations refers to activities undertaken by CCPS that are regular functions of management and administrative activities. For example, we may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning, and accreditation, certification, licensing and credentialing activities.

Contacting the Client: We may contact you to remind you of appointments; and to tell you about treatments or other services that might be of benefit to you.

Required by Law: CCPS will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when a client is a danger to self or others or gravely disabled; (e) when required to report certain communicable diseases and certain injuries; and (f) when a Coroner is investigating a client's death.

Health Oversight Activities: CCPS will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs, or determining compliance with program standards.

Crimes on the premises or observed by CCPS personnel. Crimes that are observed by our staff, that are directed toward staff, or occur on CCPS's premises will be reported to law enforcement.

Business Associates: Some of the functions of are provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. Business associates are required to enter into an agreement maintaining the privacy of protected health information.

Research: CCPS may use or disclose protected health information for research purposes if the review board has granted a waiver of the authorization requirement.

Involuntary Clients: Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

Family Members: Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

Emergencies: In life threatening emergencies we may disclose information necessary to avoid serious harm or death.

State Limitations

There are circumstances where state law is more stringent (strict) than federal law, and in such cases, we will follow state law with respect to the limitation on uses and disclosures of your information.

Authorizations

CCPS may not use or disclose protected health information in any way other than described in this Notice without a signed authorization or written consent. When you sign an authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent we have already taken action in reliance thereon.

Your Privacy Rights.

You have rights with respect to your protected health information. To exercise any of these rights, contact the CCPS Office Manager at (469) 467-7595.

Access to Your Information: You have the right to inspect and obtain a copy of the protected health information we maintain about you. There are some limitations to this right, which will be explained to you at the time of your request, if applicable.

You have the right to receive a listing of all disclosures of any PHI for the previous six years in which the information has been maintained as of 10/1/02. Individuals have the right to receive one free accounting per twelve-month period. For each additional accounting, a $25.00 fee will be incurred.

Amendment of Your Record: You have the right to request that CCPS amend (correct) your protected health information. We are not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be explained to you at the time of your request, if relevant, along with the appeal process available to you.

Accounting of Disclosures: You have the right to know when we have disclosed your information without your consent for purposes other than treatment, payment, and health care operations. There are other exceptions that will be explained to you, if applicable.

Request Restrictions: You have the right to request additional restrictions on the use or disclosure of your health information. We do not have to agree to that request unless, except as otherwise required by law, the request is to limit disclosure to a health plan and the purpose is related to payment or health care operations and the information pertains solely to a health care item or service for which you paid in full.

Confidential Communications: You have the right to request that we communicate with you by alternative means or at alternative locations. For example, if you do not want us to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be explained to you at the time of the request process, if applicable.

Copy of this Notice: You have a right to obtain another copy of this Notice upon request.

Complaints

If you believe CCPS has violated your privacy rights, you have the right to file a complaint with CCPS. To file your complaint, call the CCPS Office Manager at (469) 467-7595. You may also complain to Dr. Graham at (214) 536-6888, or the United States Secretary of Health and Human Services.

Changes to this Notice

This Notice is effective November 1, 2012. CCPS reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in CCPS website.

By signing below, I _____ am indicating that I have been given the opportunity to read this "Notice Of Privacy Practices" and that I agreed to the terms and conditions of the Privacy Practices of CCPS.

Print Patient's Name	Relationship to Patient	Date

Signature	Please print your name here if signing for a minor

Psychological Testing
Information and Policies

Psycho educational testing can be expensive. Some insurance companies will cover the expense, but most will not. Be advised that unless the psychological testing is medically necessary for differential diagnosis, many insurance carriers will not cover testing for purely psycho educational purposes, such as Attention Deficit Disorder. Our office will call your insurance company to verify your benefits, but it is also your responsibility to know your plan's coverage and ultimately provide payment if your insurance carrier does not. We highly recommend you call your insurance company, in addition to us, to verify coverage for this service.

While we appreciate payment in full the day of testing, if you would like to make payments you can pay the balance interest-free within 90 days of testing. After 90 days, any balance will be considered delinquent and will be sent to collections.

If you must cancel your appointment for testing, a minimum of 5 business days is required to avoid being charged for the time reserved.

Please feel free to discuss any questions and concerns you may have about the above information with our office personnel or Dr. Graham.

_____

Please sign that you have read and understand these policies.

Charis Counseling & Psychological Services
Grace C. Graham, Psy.D.
6220 Chase Oaks Blvd., Suite 104
Plano, TX 75023
(469) 467-7595

Child's Life History Questionnaire

Purpose of this questionnaire:

The purpose of this questionnaire is to obtain a full picture of your child's background. In therapeutic work, records are necessary, since they permit a better dealing with one's problems. By completing these questions as fully and as accurately as you can, you will help the therapeutic program. You are requested to answer these routine questions in your own time instead of using up your actual consulting time.

It is understandable that you might be concerned about what happens to the information about your child because much or all of this information is highly personal. Case records are strictly confidential. No outsider is permitted to see your child's case record without your permission.

****

Date_____

1. General

Name: _____

Address: _____

_____

Telephone Number: (day) _____ (cell) _____

Age: _____ School: _____Grade: _____

Who referred you? _____

Family Members:

Name	Age	Sex	Relationship

Does your child live in a: House Apartment Other ? (circle one)

Are parents: Married Separated Divorced (circle one)

Religious activities (circle as many that apply)

church youth group campus fellowship other (explain) _____

_____

2. Clinical

a) Tell in your own words what do you think are the main problems and how long they have been occurring?

b) Target Symptoms:

	Symptom	Frequency/ Duration	Degree of Impairment
Symptom #1			
Symptom #2			
Symptom #3			
Symptom # 4			

c) With whom have you previously talked about your child's present problem(s)?

d) List any medications they are taking

3. Personal Data

a) Date of birth:_____ Place of birth:_____

b) Mother's condition during pregnancy (as far as you know):_____

_____

_____

c) Circle any of the following that have taken place:

Night terrors	Bedwetting	Sleepwalking
Thumb sucking	Nail biting	Stammering
Fears	Friendship problems	Attention Issues
Aggressive behavior	Cries easily	Disturbing other children

Others: _____

d) Childs health during early childhood? Good Bad (circle one)

List any illnesses:

e) Childs health now:

f) What is the child's height? _____ weight? _____

g) Any surgical operations? (Please list them and give their age at the time)

h) Any accidents?

i) Are they allergic to anything? _____ If yes, what? _____

j.) List any fears they may have:

1. _____

2. _____

3. _____

4. Parental History

How long have parents been married? _____

Fathers age: _____ Mothers age: _____

Occupation of father_____

Occupation of mother _____

5. Family Data

a) Father:
Living or deceased? _____

If deceased, their age at the time of his death? _____

Cause of death? _____

Health: _____

b) Mother:
Living or deceased? _____

If deceased, their age at the time of her death? _____

Cause of death? _____

Health: _____

c) Number of brothers: _____ brothers ages: _____

Number of sisters: _____ sisters ages: _____

d) How do they get along with their brothers and sisters?

e) Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a “mental disorder?”_____

f) Are there any other members of the family about whom information regarding illness, etc., is relevant? _____

_____

r) Tell about a tearful or distressing experience not previously mentioned: _____

_____

_____