Identifying Information:

Patient Name_____

Parent Names (minor)_____

Address_____

City_____ State_____ Zip _____

Phone: Home_____ Cell_____ Work_____

Date of Birth _____Age _____Patient's Social Security#_____

Contact email address_____

Grade Level: _____ School District_____

Patient Sex: Male_____ Female_____

Parent's Marital Status: Married_____ Single _____ Divorced _____ Separated_____

Date of Birth: Mother_____ Father_____

Emergency Contact person:

Name_____

Address_____

Phone _____Relationship_____

Insurance Company Information:

Member Name_____ Social Security # _____

Member Employer_____

Employer Address_____

Employer Phone Number_____

Carrier Name _____ Policy #_____

Group # _____Effective Date _____

How did you hear about us?_____

Primary Care Physician & Phone _____

To provide excellent care we request to contact your PCP Yes_____ No_____ Initial_____

Psychiatrist/and Neurologist_____

Address and Phone_____

Current Medications (All): _____

_____

Previous Therapist, Address and Phone _____

_____

Past Treatment Outcome: What worked? What didn't?_____

_____

What **goals** would you like to accomplish for your child?_____

_____

_____

_____

What are your child's nutritional concerns? _____

_____

_____

Health Comments/Screening

Circle "Yes" or "No" to the following. If you circle yes please list any special instruction or health comments.

In the past six months has your child had any of the following symptoms:

Diet/Nutrition .....Poor/Fussy/Needs Improvement/Good/Healthy

Allergies.....Yes or No _____

Diabetes.....Yes or No _____

Asthma.....Yes or No _____

Abdominal/Stomach Pains.....Yes or No _____

Diarrhea/Constipation.....Yes or No _____

Vomiting.....Yes or No _____

Bleeding easily.....Yes or No _____

Bruising easily.....Yes or No _____

Chest Colds.....Yes or No _____

Chronic Cough.....Yes or No _____

Wheezing.....Yes or No _____

Fever.....Yes or No _____

Earaches.....Yes or No _____

Nose Bleeds.....Yes or No _____

Sinus Problems.....Yes or No _____

Skin Rash.....Yes or No _____

Difficulty Urinating.....Yes or No _____

Bedwetting.....Yes or No _____

Convulsions.....Yes or No _____

Frequent or Severe Headache.....Yes or No _____

Difficulty Sleeping.....Yes or No _____

Numbness or Tingling.....Yes or No _____

Pneumonia.....Yes or No _____

Bronchitis.....Yes or No _____

Diabetes.....Yes or No _____

Measles.....Yes or No _____

Heart Murmur.....Yes or No _____

Seizures.....Yes or No _____

Headaches.....Yes or No _____

Dizziness/Vertigo.....Yes or No _____

Celiac Disease/Gluten Intolerance.....Yes or No _____

Date of last physical exam _____

Assignment of Benefits/Payment Authorization

Client's Name_____Date_____

Dear Client/Partner:

Please fill out this form in its entirety.

It is your responsibility to know your member benefits. Logos appearing on insurance cards can be misleading. Please notify your insurance company to know what your coverage is and as to whether or not you need authorization for treatment. It is your responsibility to know your mental health claims address, deductible, coinsurance, and or co-pay. Payment for non-covered services for any reason is your responsibility.

Payment for appointments not cancelled with 24 hour notice is your responsibility.

I authorize Stepping Forward Counseling Center, LLC to release any medical or other information necessary to process claims.

I assign to Stepping Forward Counseling Center, LLC all rights and benefits under my policy or plan including, but not limited to, the right to direct payment of medical benefits for all services provided. I further assign all rights and benefits under my policy or plan to Stepping Forward Counseling Center, LLC to legally enforce the right to direct payment of medical benefits for all services provided.

I will forward upon receipt any payments received along with the explanation of benefits to Stepping Forward Counseling Center, LLC 26 Main Street, Chatham, NJ 07928. Please endorse the back of the check as follows: Pay to the order of Stepping Forward Counseling Center.

Stepping Forward Counseling Center is authorized to charge my credit card if a balance is due and agreed upon by both parties or if I have not forwarded any insurance payments to them within 15 days upon my receiving it.

By executing the documents contained in this intake packet, the signing party agrees to pay all amounts invoiced and agreed to and set forth herein, including any and all fees and costs of collecting on any unpaid balances. In the event the executing/responsible party fails to pay all sums due and Stepping Forward Counseling Center's attempt to collect the amounts due are unsuccessful, then Stepping Forward shall retain the services of an attorney to collect those amount due. All legal fees and costs of collection shall become the responsibility of and paid for by the executing/responsible party and shall be added to those amounts due and owing.

Credit Card Type_____ Expiration Date_____

CV Code_____ Credit Card number_____

Thank you in advance for your cooperation.

I understand and agree to the above policies and procedures and assignment of benefits:

Signature Date

Print Name Date

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I, _____ give staff from Stepping Forward Counseling Center permission to disclose

and or obtain information from: (Organization or, Name of person(s)) and phone number) Be Specific:

_____

_____

Regarding (patient's name) _____.

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I understand that I have the right to revoke authorization in writing, at any time by sending written notification to Stepping Forward Counseling Center. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I further understand that Stepping Forward Counseling will not condition my treatment on whether or not I give authorization for the requested disclosure.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Federal prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42C.F.R. Part 2.

Information will be disclosed if information is of danger to the client or deemed necessary by clinician.
(Client will be notified prior to disclosure and encouraged to attend session with parent/guardian.

Expires one year after date of signature.

Thank you in advance for your cooperation.

Signature _____Date_____

_____Check here if patient/client refuses to sign authorization

Safety Policy Crisis Intervention and Prevention

Staff at Stepping Forward Counseling Center is trained in Crisis Management using techniques from the Handle With Care Behavior Management System to manage disruptive, assaultive and out of control behavior. This crisis intervention program has been proven effective in resolving potentially violent crises. It is designed to safely intervene without damaging the therapeutic relationship the client has formed with the staff. The program is a behavior management system based on the philosophy of providing the best *Care, Welfare, Safety, and Security* for staff and those in their care, even during violent moments. The program focuses on preventing disruptive behavior by communicating with individuals respectfully and with concern for their well-being. The program teaches physical interventions only as a last resort—when an individual presents an imminent danger to self or others—and all physical interventions taught are designed to be non-harmful, noninvasive, and to maintain the individual's dignity. Follow-up debriefing strategies are also key components of the training program.

Staff work to prevent violent outbursts, but in the event of a situation where the client is a danger to self or others staff will take the necessary steps to intervene and deescalate the situation. Any physical intervention has potential for medical risk and should be looked at as an emergency response procedure. Risks could include, but is not limited to, injuries ranging from bites, asphyxia, damaged joints, broken bones, friction burns, disability, or death. Additionally, there is the risk that a psychological injury may also occur, particularly for those children who have experienced prior abuse by adults.

Risks involved with physical intervention can be minimized when staff members regularly practice and rehearse procedures for team interventions. Physical interventions will only be used if one or more of the following conditions exist:

The individual is placing him or herself in clear physical danger

- The individual is placing others in clear physical danger
- The individual is engaging in property destruction that may lead to physical harm to him/herself or others.

SFCC has established a policy on Restrictive Behavior Management to identify risks and procedures associated with physical restraint.

Medical Clearance RBM

MEDICAL CLEARANCE FOR THE USE OF THERAPEUTIC HOLDING INTERVENTIONS

I have examined the above named child and accompanying medical records have found: (Check One)

☐ The child does not have a documented respiratory ailment, spinal condition, fracture, seizure disorder, or other physical condition that would preclude the use of physical restraint as utilized by Stepping Forward Counseling Center.

☐ The child has a documented medical condition called _____that precludes the use of any physical restraint.

☐ The child has a documented medical condition called _____that requires the use of physical restraint for behavior management purposes.

_____**I agree with Stepping Forward Counseling Center's Safety Policies**

Client Signature: _____Date_____

Parent Signature (if client is minor):_____Date: _____

Parental Consent for Photographs and Video Taping

During your child's stay at SFCC, we may wish to photograph and/or video and or audio tape your child engaged in therapeutic and related activities. Your help in training and educational purposes and sharing our pride in your child's accomplishments would be greatly appreciated. I hereby grant SFCC permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any other consideration. I understand and agree that these materials will become the property of SFCC and will not be returned. I hereby irrevocably authorize SFCC to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing SFCC's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release and forever discharge SFCC from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Please complete the information below:

_____I **DO** give permission to have my son/daughter photographed and/or videotaped during their stay at SFCC. These photographs and/or tapes may be used for therapy projects, instructional purposes and for publication in newspapers and/or brochures.

_____I **DO NOT** give permission to have my son/daughter photographed and/or videotaped during their stay at SFCC. These photographs and/or tapes may be used for therapy projects, instructional purposes and for publication in newspapers and/or brochures.

Family involvement

The importance of family involvement in the therapeutic process has been well documented. As such, Stepping Forward Counseling Center (SFCC) feels strongly that regular parental and family participation is an inherent component of the therapies we offer. We subsequently require that all parents and families of children participating in our SFCC programs attend parenting programs and family sessions as recommended by our clinical team. We additionally require that parents provide regular updates on their child's progress via scheduled sessions with our clinicians.

By signing this form, I acknowledge that I have been made aware of the requirement for family participation and that I consent to be actively involved in my child's treatment.

Art Therapy Projects

Your child will participate in many different Art Medias at SFCC. This work may be displayed or presented from time to time in different professional settings. This work created by your child or a group of children is used for therapeutic purposeS.

I have read and understand the above mentioned information:

Child's Name: _____Date:_____

Parent/Guardian Signature_____

Receipt of Policies

Dear Parent/Guardian and Client:

Please sign below confirming that you have read and/or received copies of the following: (Please see the Parent Orientation book in the lobby).

- Payment Authorization/Consent Procedures
- Notice of Privacy Practices/HIPPA
- Client Rights
- Client Complaint/Grievance Procedures
- Medical Clearance
- Safety Policy Crisis Intervention Prevention/Metal Detector Wand Policy 3.1
- Permission to Photograph/Video/Audio Tape
- Client Procedures Handbook
- Confirmation of Participation in Comprehensive Mental Health & Assessment & Follow-up Treatment Meeting

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Stepping Forward Counseling Center's Notice of the above information. I understand that if I have any questions regarding any of the information provided I can contact Stepping Forward Counseling Center. My child has also been explained his/her rights and grievance procedures and understands the above.

☐ I explained the rights and grievances to the client and he/she acknowledges an understanding of them.

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian, or Personal Representative * **Date**

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

_____ **Signature of Staff Member** **Date**

Medication Management Quality Assurance Checklist

This checklist has been developed as a tool to evaluate and monitor areas pertaining to medication administration and pharmaceutical services provided at Stepping Forward Counseling Center. We would like you to participate in this portion of our program by providing us with your feedback regarding medication management.

	Yes	No	Comments
1. Is your child currently receiving medication? If so which medications?			
2. Does your child currently take any vitamins on a daily basis? If so, which ones?			
3. If your child is not receiving medication, do you feel he or she would benefit from beginning a medication regimen?			
4. If your child is on medication, has he or she been on medication for over 3 months?			
5. If your child is on medication, has he or she been on medication for less than 3 months?			
6. Have you noticed any change in your child's behavior since he or she has started using medication?			
7. If you have noticed a change in behavior, has it been a positive change? If "No," please explain.			
8. If not, do you think your child should still be taking the prescribed medication?			
9. Do you feel as though the medication is helping your child?			
10. Do you feel the dosage should be adjusted for your child?			
11. Do you feel involved with the medication management process?			
12. If you do not feel involved, do you want to be more involved with the process?			
13. What interventions were tried before medications were started?			
Please let us know if there are any additional questions or concerns you have regarding your child's medication, or lack of medication.			

Child's Name_____

Parents, this survey is to be filled out by your child. If you have a child who is unable to read, please read it to them and have your child provide you with the answers. We appreciate your assistance.

Please follow the instructions below in order to help us create an individualized program just for you!

1. Please tell us what activities you have tried and or are interested in

_____

2. In the lines provided, please tell us whether you like this activity or have ever tried it.

Yoga/Tai Chi _____

Art_____

Journaling_____

Talking to a trusted adult or friend_____

Board Games (Please specify which ones)_____

Sports (Please specify which ones)_____

Dance_____

Music (singing, listening, playing)_____

Acting/Drama Therapy_____

3. Please let us know if there are any activities you have not yet experienced but would like to try:

_____

4. Is there anything else you would like us to know about you?

_____

5. What would you like to learn about yourself at SFCC?_____

_____

6. Please list 3 goals you would like to work on at SFCC?

1. _____

2. _____

3. _____

☺Thanks for participating ☺