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

School Name Teacher's Name

Patient Gender Female

Parent's Marital Status Married

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? No Initials

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

Select "Yes" or "No" in the following. If you select 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	No	
Allergies	No	
Diabetes	No	
Asthma	No	
Abdominal/Stomach Pains	No	
Diarrhea/Constipation	No	
Vomiting	No	
Bleeding easily	No	
Bruising easily	No	
Chest Colds	No	
Chronic Cough	No	
Wheezing	No	
Fever	No	
Earaches	No	
Nose Bleeds	No	
Sinus Problems	No	
Skin Rash	No	
Difficulty Urinating	No	
Bedwetting	No	
Convulsions	No	
Frequent or Severe Headache	No	
Difficulty Sleeping	No	
Numbness or Tingling	No	
Pneumonia	No	
Bronchitis	No	
Measles	No	
Heart Murmur	No	
Seizures	No	
Headaches	No	
Dizziness/Vertigo	No	
Celiac Disease/Gluten Intolerance	No	
Weight gain of 10 lbs. or more in the last 3 months	No	
Weight loss of 10 lbs. or more in the last 3 months	No	
Decrease in food intake and/or appetite	No	
Food binging or induced vomiting	No	
Dental problems	No	

Date of last physical exam

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.

Survey

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.

Assignment of Benefits/Payment Authorization

Client's Name _____ Date _____

Dear Client/Partner:

Please fill out this form in its entirety. Thank you in advance for your cooperation.

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 (CA: 15375 Barranca Parkway Suite A-207 Irvine, CA 92618 NJ: 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 the 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 _____

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

_____ _____
Print Name Date

_____ _____
Signature Date

Authorization to Release/Obtain Information

I, _____ , give staff from Stepping Forward Counseling Center permission to disclose and or obtain information from: Be Specific (organization(s) or name of person(s) and phone number(s))

_____

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

Parent/Guardian Signature

Date

Notice of Patient Information Practices

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

LEGAL DUTY

Stepping Forward Counseling Center, LLC is required by law to protect the privacy of your personal health information, provide this notice about my information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Stepping Forward Counseling Center, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that is provided. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

In any other situation my policy is to obtain your written authorization before disclosing your personal health information. If you provide SFCC with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of my Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that SFCC correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where SFCC have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that SFCC not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. SFCC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that SFCC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the US Department of Health and Human Services

REPORT A PATIENT SAFTEY EVENT TO THE JOINT COMMISSON

Do you have a patient safety event or concern about SFCC? As an accredited Mental Health facility you have the option to report any patient safety concerns you may have to the following www.jointcommission.org Fax 630-792-5636, E-mail: patientsafetyreport@jointcommission.org or mail to: OFFICE OF QUALITY and PATIENT SAFTEY The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181

Patient Information Consent Form

I have read and fully understand the Notice of Information Practices provided by Stepping Forward Counseling Center, LLC. I understand that Stepping Forward Counseling Center, LLC *may* use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Notice of Information Practices provided by Stepping Forward Counseling Center, LLC. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

Telehealth Consent Form

Telehealth services are a form of therapy services provided via internet technology, which can include assessment, consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communication. I also understand that telehealth involves the communication of my medical/mental health information, both orally and/or visually.

Due to the nature of the technology used I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to telehealth:

1. I, the client, need to be a resident of and be located in the state at the time services are held (this is a legal requirement for providers practicing under a state license). I also have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. I understand that the laws that protect the confidentiality of my medical information also applies to telehealth.

3. I understand that there are risks in participating in telehealth sessions, including, but not limited to: the possibility that the transmission of my information could be disrupted or distorted by technical failure, the transmission of my information could be interrupted by unauthorized persons, and/or the electronic storage of my medical information could be accessed by unauthorized persons. I understand that there is a risk of being overheard by anyone near me if I am not in a private room. I am responsible for providing the necessary computer, telecommunications equipment, and internet access for my telehealth sessions, and arranging a location with sufficient lighting and privacy for my telehealth session.

4. I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that my provider believes telehealth services are appropriate until the recommencement of face-to-face services. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some case may even get worse.

5. I accept that telehealth services are not emergency services. If I, the client, am experiencing an emergency, I should call 911 or proceed to the nearest hospital emergency room for help. Clients who are actively at risk of harm to their selves or others are not suitable for telehealth services. If this is the case or becomes the case in the future, my provider will recommend more appropriate services.

6. I understand that dissemination of any personally identifiable information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

I have read, understand, and agree to the information provided above regarding telehealth.

Client's Name

Client or Legal Guardian's Signature

Date

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 and 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.

_____ Date

Signature of Patient/Client

_____ Date

Signature of Parent, Guardian, or Personal Representative

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:

_____ Date

Signature of Staff Member