DX CODE: _____
INTAKE DATE: _____
(OFFICE USE ONLY)

Child Intake Form

Please provide the following information and answer all questions below. Please note: information you provide here is protected as confidential information.

Child's Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian:

_____
(Last) (First) (Middle Initial)

Birthdate: ____/____/____ Age: _____ Gender ☐ Male ☐ Female

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (____) _____ May we leave a message? ☐ Yes ☐ No

Cell/Other (____) _____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we e-mail you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

-Office Use Only-
Dx Code: _____
Intake Date: _____

Child Intake Form

Child's name: _____ Date of Birth: _____
Child's School: _____ Teacher: _____ Grade: _____
Mother's name: _____ Date of Birth: _____ Occupation: _____
Father's name: _____ Date of Birth: _____ Occupation: _____

List all those living in the child's home:
Name: _____ Relationship: _____ Age/School/Occupation

List other persons closely involved in child's life but not living in the home: _____

What are your concerns about your child that made you bring him/her to therapy? _____

Please describe any concerns that are listed below that your child is displaying:
Difficulty sleeping/frequent nightmares : _____
Bed-wetting or soiling: _____
Unusually clingy or immature behavior: _____
Excessive fears, anxiety: _____
Physical complaints (stomachaches, headaches): _____
Change in eating habits: _____
Little sense of joy/happiness: _____
Hurts self on purpose/talks of wanting to die: _____
Blatant misbehavior: _____
Aggression towards others: _____
Hurts animals on purpose: _____
Sets fires: _____
Lies/steals: _____
Hides food: _____
School difficulties: _____
Difficulties with peers or bullying: _____
Inappropriate sexual behavior: _____
Poor self-esteem: _____
Overwhelming sadness: _____
Overwhelming anxiety or worry: _____

Please describe any other concerns you have about your child?

What are your child's strengths?

What are your child's interests and/or participation in after school activities?

Describe your child's school experience:

Does your child have an IEP or any other behavioral modifications strategies currently in place at school:

Describe your child's relationship with his/her siblings:

List any complications at birth and delays in development or difficulties when child was an infant/toddler:

List any ongoing health concerns/allergies your child has:

List any medications your child is taking and describe for what purpose:

Describe any serious difficulties or life stresses child has experienced and when they occured: _____

_____

_____

_____

_____

Describe your child's ability to complete tasks and follow directions: _____

_____

_____

_____

Who referred you for treatment? (teacher, school counselor, pediatrician, or other professional) _____

Describe any prior assessment/therapy child has received (name of professional, date of services, diagnosis): _____

_____

_____

Family Mental Health history: The following is to provide information about your family history. Please mark yes or no. If yes, please indicate family member affected.

Autism Spectrum	Yes	No	_____
Attention Deficit	Yes	No	_____
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Privacy and Rights Acknowledgement

Patient Name:_____ Date:_____

Please read the following polices and initial below:

Initial_____ I have read and understand my **Patient Rights**, stating as a patient of Hope for a Better Tomorrow, I have specific rights that are enumerated in Wisconsin Statutes 51.61 and Wisconsin Administrative Code HHS 94.

Initial_____ I have read and understand the **Cancellation Policy** stating that I can be charged a $50.00 cancellation fee if I cancel my appointment with less than a 24 hour notice. (Unless due to illness or emergency)

Initial_____ I have read and understand my **Limits of Liability Policy** stating therapy services carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of my life are considered risks of therapy sessions.

Initial_____ I have read and understand my **Limits of Confidentiality** stating what I discuss during my therapy session are kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of my legal guardian. The following is a list of exceptions: Duty to Warn and Protect, Abuse of Children and Vulnerable Adults, Prenatal Exposure to Controlled Substances, Minors/Guardianship and Insurance Providers and Hope for a Better Tomorrow Clinician Collaboration

Initial_____ I have read and understand the **HIPAA** stating how therapeutic and medical information about you may be used and disclosed, your rights as a patient and ways for you to get additional information on our policies. Our clinic has always been very protective of your personal information. Under new federal regulations (HIPAA Privacy Act), we have adopted additional guidelines to ensure proper use, confidentiality, and disclosure of your health information.

By signing below, I am acknowledging that I have read and understand the above polices. Paper or electronic copies can be obtained per request.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Administrative use only

By signing below, I, administration, have gone through the above statements with the client or the guardian of the client, in person and offered them a copy of these polices.

_____ _____

Administrative Signature Date

Payment Acknowledgement Agreement

Patient Name: _____ Date:_____

Please read the following statements and initial below:

Initial ____ I understand and agree that my co-payment, co-insurance and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility and will be subject to the therapists self-pay amount of $_____. I understand that co-payment and deductible amounts may change depending on my mental health benefits within my insurance policy.

Initial ____ I understand that any unpaid services will be considered delinquent and will be sent to a collection agency.

Initial ____ I understand and agree that I will be charged a $50.00 cancellation fee if I cancel my appointment with less than a **24 hour notice**. (Unless due to illness or emergency)

Initial ____ I understand and agree to the $3 fee when using a credit or debit card other than medical cards to pay for any and all services. Cash and check are no charge. There will be a $20+ fee for any bounced checks.

By signing below, I understand and agree to the above statements. *I authorize my insurance benefits to be paid directly to Hope for a Better Tomorrow.*

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Administrative use only

By signing below, I, administration, have gone through the above statements with the client or the guardian of the client, in person.

_____ _____

Administrative Signature Date

HOPE FOR A BETTER TOMORROW

TREATMENT PLAN ACKNOWLEDGEMENT FORM

At Hope for a Better Tomorrow, you will participate in the development of your treatment plan. The treatment plan is your "map of care" which includes specific goals that you wish to accomplish. With your therapist, you will discuss frequency of treatment and what types of services and modalities will help you reach your goals.

Therapists at Hope for a Better Tomorrow strive to deliver the best possible care for their clients. In order to uphold this high standard, we ask for your signature to acknowledge that you have played an active role in the treatment planning process.

If you have further questions regarding this form, please consult with your therapist.

Client Print Name:_____ Date:_____

Client Signature: _____ Date:_____

(Parent or Guardian if under 18)

Health Risk Assessment – Child
*Age 0 to 17 years old

Name: _____ Date: _____

Please circle the number which best identifies your response to each corresponding question-
1. Never or Almost Never; 2. Occasionally;
3. Often; 4. Very Often; or 5. Always or Almost Always

1. My child engages in moderate physical activity for at least 20 to 30 minutes at least 5 days of the week.

   N/A 1 2 3 4 5

2. My child enjoys physical activities rather than sedentary activities.

   N/A 1 2 3 4 5

3. My child eats at least five servings of fruits and vegetables every day (one serving equals one half cup).

   N/A 1 2 3 4 5

4. My child eats at fast food restaurants more than three times per week.

   N/A 1 2 3 4 5

5. My child sees a physician for routine check-ups, health screenings, and disease prevention.

   N/A 1 2 3 4 5

6. My child is in a car or booster seat when traveling in a vehicle.

   N/A 1 2 3 4 5

7. My child and I take time to have meaningful interactions with one another.

   N/A 1 2 3 4 5

8. My child is able to develop close, personal relationships with others.

   N/A 1 2 3 4 5

9. My child demonstrates self-confidence and/or a positive self-esteem.

   N/A 1 2 3 4 5

10. My child expresses his or her feelings of anger and frustration in ways that are not hurtful to themselves or others.

    N/A 1 2 3 4 5

11. My child feels comfortable confiding in family or friends to assist in managing stress.

    N/A 1 2 3 4 5

12. My child seeks opportunities to learn new things through different mediums such as television, books, newspaper, internet, etc.

    N/A 1 2 3 4 5

13. Before making decisions, my child gathers facts and considers all viable options.

    N/A 1 2 3 4 5

14. My child has a healthy balance between school work and leisure time.

    N/A 1 2 3 4 5

15. The level of stress in my child's life is manageable for him/her.

    N/A 1 2 3 4 5

16. My child has hopes and dreams for his or her future.

    N/A 1 2 3 4 5

17. My child's actions are guided by the family's own beliefs rather than the beliefs of others.

    N/A 1 2 3 4 5

HOPE FOR A BETTER TOMORROW

INFORMED CONSENT POLICY

It is the policy of this clinic that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive at all of our clinic locations. It is our agency's policy to offer this information in both verbal and written form. All patients will be provided, and should take, the necessary time to review this informed consent policy prior to the onset of treatment. You may also ask for additional information from your therapist regarding any particular treatment at any time during the course of treatment.

Completed and accurate information must be provided concerning each of the following areas:

1. The benefits of the proposed treatment.
2. The way in which the treatment will be administered, the treatment schedule, and my involvement in the development of my treatment plan.
3. The expected side effects from the treatment and/or risks of side effects from medications.
4. Alternative treatment modalities.
5. The probability of consequences of not receiving treatment.
6. The consequences of the continued use of alcohol or other drugs, unauthorized absences or any other evidence of noncompliance.
7. My financial obligations regarding my treatment cost.
8. Information regarding sexually transmitted diseases and communicable diseases.
9. The time period for which the informed consent is effective.
10. Your rights as a patient to withdraw the informed consent at any time in writing.
11. Hope for a Better Tomorrow provides mental health services at our facility. Mental health staff may be involved in your treatment planning and referrals may be made.
12. Client records are kept securely for mental health patients.
13. I understand that this informed consent is good for the course of treatment
14. I understand that this informed consent is to expire in 15 months.
15. I understand that I can withdraw my consent, in writing, at any time.

My signature indicates that (1) I have read and I understand the above policy and procedures pertaining to my granting of informed consent for the treatment which I choose to receive and (2) that I have been presented with the necessary and appropriate information either verbally or in writing, and that I have also had adequate time to consider this information, and that I do herby give my informed consent to participate in the recommended treatment. I have also received a copy of this document.

_____ _____

NAME (PRINT) DATE

_____ _____

SIGNATURE DATE

_____ _____

SIGNATURE (PARENT OR GUARDIAN) DATE

HOPE FOR A BETTER TOMORROW

PRIMARY PHYSICIAN & PSYCHIATRIST-PATIENT CARE COMMUNICATION FORM

Clinicians at Hope for a Better Tomorrow strive to deliver the best possible care for their clients. In order to uphold this high standard, we ask for permission to notify your primary care physician and/or psychiatrist. By signing this form, it gives your Hope for a Better Tomorrow therapist permission to contact your primary care physician and/or psychiatrist to introduce themselves as your behavioral health care practitioner and work directly with them when necessary (for example: strategies for better medication management, coordination of care and treatment recommendations).

If you have further questions regarding this form, please consult with your therapist.

Physician or Psychiatrist Name:_____

Address:_____

Phone:_____ **Fax:**_____

____ Yes, I want this information released to my Primary Care Physician or Psychiatrist.
____ No, I do not want this information released to my Primary Care Physician or Psychiatrist.
____ I do not have a Primary Care Physician or Psychiatrist at this time.

Authorization to Disclose Information

To the patient: Disclosure of the above information is for coordination of care between your physician and your behavioral health provider(s). The information released on this form is part of your protected health information and is protected under federal law. Releasing this information to your physician is strictly voluntary and does require your written consent for this form to be sent, it does not allow for any other information to be disclosed nor does it allow for any form of communication to take place. If you want your physician to receive additional information from your confidential records, a release of information for that purpose can be provided to you. To the party receiving the information: This information has been disclosed to you from records whose confidentially is protected by federal law. Federal regulations prohibit you from making further disclosure of this information.

This authorization can be terminated at any time in writing.
This authorization is valid for the duration of involvement, up to one year.

Print Patient Name: _____

Signed:_____ _____ _____
(Client 12 years of age and older) Date Witness

Signed:_____ _____ _____
(Parent or Guardian Signature, 12 years and younger) Date Witness

OFFICE USE ONLY
Letter and Form Sent: _____
Date & Initials