ADOLESCENT PATIENT INFORMATION

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Full Name: _____ Preferred Name: _____
DOB: ____ /_____/ _____ Age: _____ Sex: _____
Live with: _____
Address:_____
Parents are ☐ Married ☐ Divorced ☐ Other, please specify:_____.
Parenting Plan/Custody Agreement: ___Yes ___No (if yes, the office will need copy to be on file).
Mother's name:_____ Phone Number: _____Email:_____
Father's name:_____ Phone Number: _____Email:_____
Number of siblings:_____ I am ___ in the birth order.
Emergency Contact: _____
Phone #: (___) _____ Relation to Patient: _____

Primary Care Physician: _____
PCP Phone #: (___) _____

Insurance/Payment Information

☐ Self-Pay (please check if you are not using insurance)

☐ Primary Insurance Company: _____
Subscriber Name: _____ Subscriber DOB: ____/____/____
Subscriber ID: _____ Group Number: _____
☐ Secondary Insurance Company: _____
Subscriber Name: _____ Subscriber DOB: ____/____/____
Subscriber ID: _____ Group Number: _____

Guarantor (person responsible for making payments on the account)

Guarantor Name: _____ DOB: ____/____/____
Phone #: (___) _____
Mailing Address: _____
_____

Office Use Only:

Parenting Plan/Custody Agreement on file: _____

Party/Parties responsible for copays, deductibles, and/or private pay amounts: _____

May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment ☐ Yes ☐ No
May we text the number you provided? ☐ Yes ☐ No
If no, is there another number at which we may try to reach you? _____
May we mail to your address information regarding your appointment? ☐ Yes ☐ No
If no, is there another address at which we may send you information? ☐ Yes ☐ No
Please provide the address: _____
Do you wish us to share health/mental information regarding you with a family member or friend? ☐ Yes ☐ No
If yes, please provide name of person(s): _____
May we email billing invoices to the email address provided? ☐ Yes ☐ No

EMERGENCY CONTACT RELEASE OF INFORMATION

By signing I authorize Grace Pointe Counseling Center to release information to my emergency contact, designated on page one of the Patient Information Packet, in the event of a serious and imminent safety concern as determined by my provider. I have been informed that, in order to protect the limited confidentiality of records, my agreement to release information is necessary.

_____ _____
Parent and Child Signatures Date

CONFIDENTIALITY

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person or a disabled person, 2) if your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3) if you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as the legal authorities, 4) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5) when your insurance company is involved (i.e. filing a claim, insurance audits, case review or appeals, etc.) 6) when otherwise required by law. With the exceptions of the above situations, your consent must be obtained prior to releasing any information about you. In situations where exchange of information is necessary, you may be asked to sign a Release of Information. By signing, I acknowledge that I have been offered a copy of the Practice's "Notice of Privacy Practices for Protected Health Information" as required by HIPPA.

_____ _____
Parent and Child Signatures Date

AUTHORIZATION

Patient and/or guarantor is responsible for charges incurred. It is a courtesy of our office to file your insurance, however you are responsible for your co-pay/percentage, and deductible which the insurance company is not liable for on the day of your visit. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before your visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. By signing, I acknowledge that I have read and understand the above statement of the payment policy. I hereby request any benefits on my behalf be paid to the physician/clinician(s) that has provided services for me. I also authorize the release of any information acquired during my treatment to my insurance company as needed to issue benefits. I authorize the physician/clinician(s) to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician/clinician(s) and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____
Parent and Child Signatures Date

Client Information and Office Policy Statement (Continued)

CANCELLATION/NO-SHOW POLICY

To accommodate the growing list of clients waiting to get an appointment, we ask that you call at least 24 hours prior to an appointment if cancellation is necessary. If you give less than 24 hours' notice for a cancellation or you do not show for your scheduled appointment you will be charged a $50.00 fee for the missed appointment. You will be required to pay this fee before being seen again by a provider. This fee is not paid for by insurance companies. Three (3) missed scheduled appointments without a 24-hour notice may result in dismissal from this practice. If a dismissal occurs, you will be given a list of three (3) providers in the area that you may contact for further services. I have read the cancellation / no show policy for Grace Pointe Counseling Center, and I understand that a 24-hour notice is required for cancellation of appointments.

_____ _____

Parent and Child Signatures Date

DISABILITY CLAIMS

The providers in this facility do not assist patients in filing for disability. Records can be requested for disability claims or to your primary care doctor to allow him/her to determine your disability status but are done so at the provider's discretion.

COPIES OF RECORDS

To obtain a copy of your medical records, it is required that you do so in writing. Pursuant to T.C.A. 63-2-102 law there will be a $20.00 charge for the first five (5) pages and a charge of $0.50 for each additional page after the first five. A $20.00 charge will apply to filling out forms as well. By signing below, you also understand there is a five to seven business day turn around for all records requests.

RETURNED CHECKS

A fee of $25.00, plus any additional bank fees and the original amount of the check will need to be paid in cash prior to the next appointment.

COMPLAINTS

You have a right to have your complaints heard and resolved in a timely matter. If you have a complaint about your treatment, your therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

I have read and understand the above polices for Grace Pointe Counseling Center and by signing below I agree to abide by the above policies.

_____ _____

Parent and Child Signatures Date

GracePointe Counseling Center

PATIENTS RIGHTS AND RESPONSIBILITIES

The following is a statement of rights and responsibilities of all patients eligible to use

Patients have the right to:

- Receive humane care and treatment, with respect and consideration
- Privacy and confidentiality when seeking or receiving care, except for life threatening situations or conditions
- Confidentiality of health records
- Be informed of and to exercise the option to refuse to participate in any research aspect of your care without compromising access to medical care and treatment
- Receive accurate information concerning diagnosis, treatment, risks involved, and prognosis of an illness or health-related condition
- Ask about reasonable alternatives to care at GracePointe Counseling Center or outside facilities
- A second professional opinion regarding diagnosis or treatment
- Participate actively in decisions regarding one's health care and treatment
- Access information regarding the scope and availability of services
- Be informed about any legal reporting requirements regarding any aspect of screening or care

Patients have a responsibility to:

- Provide complete information about one's illness/problem to enable proper evaluation and treatment.
- Ask questions so that an understanding of the condition or problem is ensured.
- Show respect to health personnel, GracePointe Counseling Center staff, and other patients.
- Reschedule/cancel an appointment so that another person may be given that time slot.
- Pay bills or file health claims in a timely manner.
- Inform the practitioner(s) if one's condition worsens, or an unexpected reaction occurs from a medication.
- Provide requests for permission to release health records in writing, to GracePointe Counseling Center.

_____ _____

Signature Date

Parental Authorization for Minor's Mental Health Treatment

To authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify the counselor immediately. You will need to provide the office with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is your responsibility to notify the other parent that the counselor is meeting with you. We believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, we will strive to listen carefully so that we can understand your perspectives and fully explain our perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress.

Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, we will honor that decision, unless there are extraordinary circumstances. However, in most cases, we will ask that you allow the counselor the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Counselors

During my treatment of your child, the counselor may meet with the child's parents/guardians either separately or together. Please be aware, however, that, always, the client is your child – not the parents/guardians nor any siblings or other family members of the child. If a counselor meets with you or other family members during your child's treatment, the counselor will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Tennessee statutes: A "minor child" is defined at TCA §33-1-101 as a person under 18 years of age, but TCA §33-8-202 that states if a child with serious emotional disturbance or mental illness is 16 years of age or older, the child has the same rights as an adult with respect to, among other things, confidential information. Further TCA §33-3-104 lists a service recipient 16 years of age and over as one of the persons authorized to consent to disclosure of confidential information (TDMHSAS Policies and procedures, 2011). Thus, adolescents 16 years of age and older in Tennessee are presumed to have the maturity to consent to medical care, including mental health care, and can sign their own consents for treatments, services, and/or tests (Tennessee Dept of Children's Services, 2011)

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is the counselor's policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to them without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then the counselor will need to use their professional judgment to decide whether your child is in serious and immediate danger of harm. If the counselor feel that your child is in such danger, they will communicate this information to you.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although the counselor's responsibility to your child may require my helping to address conflicts between the child's parents, their role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena the counselors' records or ask them to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring counselors' testimony, even though they will not do so unless legally compelled. If a counselor is required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, they will provide information as needed, if appropriate releases are signed or a court order is provided, but they will not

make any recommendation about the final decision(s). Furthermore, if a counselor is required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse the counselor at a rate of $200 per hour for time spent traveling, speaking with attorneys, phone calls, reviewing, and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Client:
By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask the counselor at any time.

Minor's Signature* _____ Date_____

Parent/Guardian of Minor Patient:
Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

_____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

_____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Medical History

Allergies (adverse reactions to medications/food/etc.) _____
_____
Date of Last Physical Exam_____
Findings from Exam _____
_____
Current Medications (include prescribed dosages, and name of doctor prescribing medications)
_____
_____
Hospitalizations/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes, etc.)
_____
_____
Any relevant medical conditions (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc)_____
_____
Past Psychiatric History (Mental Health and Chemical Dependency History)_____
_____
Hospilizations_____
_____
Prior Outpatient Therapy (include previous practitioners, dates of treatment, response to treatment)
_____
_____
Results of Recent Lab Test and Consultation Reports_____
_____
_____
Family Mental Health or Chemical Dependency History _____
_____

Psychosocial Information

Support Systems_____
School: _____ Grade Level: _____ Favorite Subject:_____
Least Favorite Subject:_____ One Thing I like about school:_____ One Thing I dislike about school:_____
Clubs/Sports/Groups I'm active in: _____
Favorite food:_____ Least Favorite Food:_____
In my free time I like to:_____
Spiritual Beliefs _____
Church Name_____

Developmental History (developmental milestones met early, late, normal)
_____
_____
Perinatal History (details of labor/delivery)
_____
_____
Prenatal History (medical problems during pregnancy, mother's use of medications)
_____
_____

Please circle feelings that you have often, meaning more than once a day or several times a week: