



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center Office Policies and Consent for Treatment

WELCOME!

Thank you for choosing FairView Counseling and The Play Therapy Center. As a non-profit counseling agency, our mission is to foster the health and welfare of children by providing quality, mental health treatment. This document is designed to ensure that you understand our professional relationship.

CANCELLATION & ATTENDANCE

Our office is open Monday through Thursday 8:30am – 7:30pm, appointment times vary by clinician. Appointments are approximately 50-55 minutes. Therapy appointments, particularly evening appointments, are in high demand. Your cancelled appointment may be a valuable scheduling opportunity for another client. In the event that you cannot make your scheduled appointment, please contact our office at least 24 hours in advance.

You may leave a voicemail 24 hours a day, 7 days a week.
There is a fee for NO SHOW or SAME DAY CANCELLATIONS.
Inconsistent attendance may result in the termination of service.

Illness - We want to keep everyone healthy. If your child arrives for therapy and is visibly ill and potentially contagious, we reserve the right to refuse treatment in order to protect the wellness of other children and our staff. If your child is ill and stays home from school on the day of your scheduled appointment, please call us as soon as possible. Please **DO NOT BRING YOUR CHILD** if he/she is SICK. Exceptions to the late cancellation fee would be made in such situations.

Weather - Our office is generally open and DOES NOT follow school district closings for inclement weather. You may refer to the WFMZ-TV STORMCENTER online at www.WFMZ.com or Channel 69 news for weather closing.

Emergencies - As a client in outpatient treatment, you are expected to manage your day-to-day functioning. However, in the case of a clinical crisis, call our after-hours coverage at 484-955-4113, leave a brief message, and a FVC therapist will return your call. In the case of a true emergency in which you fear you may harm yourself or someone else, call 911 or go to the emergency room.

CONFIDENTIALITY & RECORD KEEPING

Confidentiality pertains to the treatment of information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others without permission. FairView Counseling protects the confidentiality of client information in accordance with legal and ethical requirements of Pennsylvania Code and Federal Law.

On occasion, your therapist may seek the professional consultation of another therapist within the agency to better enhance your treatment. However, any communication outside of FairView Counseling and The Play Therapy Center requires your written consent.

Exceptions to confidentiality include child abuse, adult and domestic abuse and serious threat to health/ safety and are reviewed in detail in our Notice of Privacy Practices (HIPAA).

FairView Counseling maintains client records as required by law. Clients may request to review, inspect and/or obtain a copy of their records.



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COURT POLICY

FVC therapists do not provide custody evaluation services. Often parents in high conflict separations/divorces want their child therapist to make recommendations regarding custody. American Psychological Association (APA) guidelines make a clear distinction between forensic evaluations and the services that therapists provide to families, children and parents in the course of psychotherapy. In order for children to feel that their concerns can be safely discussed, they must know that the content of their therapy sessions will remain confidential and that their therapist will remain neutral and uninvolved in any parental custody determinations. *If you are looking for expert witness testimony regarding custody recommendations for your child, we can refer you to a forensic evaluator.*

If a therapist is asked by a parent or subpoenaed by an attorney to provide clinical input based on treatment intended for custody recommendations - doing so would be both a conflict of interest, beyond our bounds of competence, and would violate several provisions of Professional Ethical Principles and Code of Conduct. Such actions may result in termination of the therapeutic contact.

COMMUNICATION POLICY

If you need to speak with your therapist or change an appointment always do so by calling the front office. Emails and faxes are not private and this type of communication can be intercepted. It is your informed decision to email or fax documents to this office.

PSYCHOTHERAPY SERVICES

Our intake session allows your therapist to get to know you and assess your needs for treatment. After the intake session(s), your therapist will be able to offer you a clinical impression, what therapy will include, and a general treatment plan. If you have questions about your therapist's procedures, you should discuss them whenever they arise.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, psychotherapy may elicit uncomfortable thoughts and feelings. Psychotherapy also leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

There are many treatment methods that your therapist may use to deal with the concerns that you hope to address. Psychotherapy calls for an active effort on your part. For therapy to be successful, you will have to work on things we talk about both during our sessions and at home.

CONSENT FOR TREATMENT

FVC requires a signed 'Consent for Treatment' from BOTH PARENTS REGARDLESS of marital status. You must bring two signed consent forms with you on the day of intake or you will not be seen for your scheduled appointment.

Signing below indicates that you have reviewed and understand the information described above and agree to abide by the contents and terms of this agreement.

PRINT Client name _____

Client signature (age 14+) _____ **Date** _____

PRINT Parent/Guardian name (if client is a child) _____

Parent/Guardian signature _____ **Date** _____

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PRINT Parent/Guardian name (if client is a child) _____

Parent/Guardian signature _____ **Date** _____

Copy Given to Client _____ Date: ____/____/____



Date: _____

Client number: _____

FairView Counseling and Play Therapy Center
Client Information Form

Name of person completing this form _____

Cell / Home / Work

Cell / Home / Work

Cell / Home / Work

1 _____
Day / Evening

2 _____
Day / Evening

3 _____
Day / Evening

Adult Client

Client's name _____ DOB _____ Age _____

Address _____

Phone _____ Employer _____

Emergency Contact and Phone _____

Child Client

Client's name _____ DOB _____ Age _____

Parents are Unmarried Married Separated Divorced Other

Emergency Contact and Phone _____

Biological Mother's name _____ DOB _____ Age _____

Address _____

Phone _____ Employer _____

Biological Father's name _____ DOB _____ Age _____

Address _____

Phone _____ Employer _____



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center
Acknowledgement of Privacy Practices

A copy of the Privacy Practices is provided in the waiting room and at reception and is located on our website.

I acknowledge Notice of Privacy Practices, (HIPAA) effective April 14, 2003.

PRINT Client name _____

Client signature (age 14+) _____ **Date** _____

PRINT Parent/Guardian name (if client is a child) _____

Parent/Guardian signature _____ **Date** _____



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center Financial Policy & Contract For Clients Utilizing Insurance

We accept cash, check, and most credit cards.
If you are using an insurance plan, your co-pay is due at the beginning of each session.
Fees incurred for returned checks are the client's responsibility.

Client Name _____ Effective Date of Policy Coverage ____/____/____

Insurance Company Name _____ Ins. Phone # _____

Policy/ID # _____ Group # _____ Subscriber's Employer _____

Insurance Subscriber's Name _____ Relationship to Client _____

Subscriber's SS # _____ Subscriber's Phone _____ Subscriber's DOB ____/____/____

Subscriber's Address _____

- You are responsible to know the coverage for services and levels of payment by your insurance company. You are responsible for any amounts not covered by your plan.
- If Fairview Counseling is an in-network provider with your insurance plan, we will bill your insurance company for reimbursement. If our charges apply to your deductible or are not covered by your plan, you will be responsible for the unpaid amounts.
- If Fairview Counseling is not an in-network provider with your insurance plan, you will be charged the full fee for our services, and a receipt will be provided for you to submit to your insurance company for reimbursement.
- **Supplementary Correspondence** such as completing forms, writing letters, copying therapy records, etc. requires therapist time away from patient care. We may require payment at a rate of \$25.00 per 15-minute unit of time depending on the length and complexity of your request. *These fees are your direct responsibility and will not be billed to your insurance company.
*FVC reserves the right to change fees without notice.

I give FairView Counseling and The Play Therapy Center permission to release any information that is necessary to support any insurance claims on my account and secure timely payments due to the assignee or myself. I hereby assign medical benefits, including those from government sponsored programs and other health plans, to be paid to FairView Counseling. I have read, understand, and agree to abide by this financial contract.

PRINT Client name _____

Client signature (age 14+) _____ **Date** _____

PRINT Parent/Guardian name (if client is a child) _____

Parent/Guardian signature _____ **Date** _____

Copy Given to Client _____ Date: ____/____/____



Date: _____

Client number: _____

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Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center
Consent to Release Information to Primary Care Physician/ Referral

FairView Counseling emphasizes communication among treating professionals; specifically, with your Primary Care Physician. We often send a summary after the intake session so that your PCP is aware of your diagnosis and treatment plan and can better address your needs.

Please check one of the following:

_____ Yes, I authorize FairView Counseling to communicate with my Primary Care Physician.

Physician Name _____
Practice Name _____
Phone _____
Fax _____

_____ No, I do not authorize FairView Counseling to communicate with my Primary Care Physician.

PRINT Client name _____

Client signature (age 14+) _____ **Date** _____

PRINT Parent/Guardian name (if client is a child) _____

Parent/Guardian signature _____ **Date** _____

Referral Source

How did you hear about Fairview Counseling and The Play Therapy Center? PCP /Pediatrician (above)

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> School/ Guidance | <input type="checkbox"/> Phone Book | <input type="checkbox"/> Insurance Company |
| <input type="checkbox"/> Lawyer | <input type="checkbox"/> Internet | <input type="checkbox"/> Current/ Previous FairView Client |
| <input type="checkbox"/> Friend/Family | <input type="checkbox"/> EAP | <input type="checkbox"/> Other _____ |

If you were referred by a professional referral source, please provide their information.

Name /Agency _____
Address _____
Phone _____



Date: _____

Client number: _____

(PAGE LEFT BLANK INTENTIONALLY)



Date: _____

Client number: _____

FairView Counseling and The Play Therapy Center Child & Adolescent Questionnaire

Client name _____ Age _____ Gender _____ DOB _____

Person completing this form (relationship to child) _____

Describe the reason for seeking treatment for your child (developmental, behavioral, emotional, academic, relational issues, recent stressors)

Check any of the following that is currently or has been a concern for your child

<input type="checkbox"/> Speech/language	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Slow learner	<input type="checkbox"/> Shy/timid	<input type="checkbox"/> Sleep
<input type="checkbox"/> Trouble with friends	<input type="checkbox"/> Wets bed	<input type="checkbox"/> Sadness	<input type="checkbox"/> Self-injury	<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Prefers to be alone	<input type="checkbox"/> Bites nails	<input type="checkbox"/> Stomach trouble	<input type="checkbox"/> Nervous	<input type="checkbox"/> Attention
<input type="checkbox"/> Fights with siblings	<input type="checkbox"/> Sucks thumb	<input type="checkbox"/> Reckless behavior	<input type="checkbox"/> Depressed	<input type="checkbox"/> Coordination
<input type="checkbox"/> Fights with peers	<input type="checkbox"/> Tantrums	<input type="checkbox"/> Can't relax	<input type="checkbox"/> Overactive	<input type="checkbox"/> Odd habits
<input type="checkbox"/> Fights with adults	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Animal cruelty	<input type="checkbox"/> Obsessive	<input type="checkbox"/> Stubborn
<input type="checkbox"/> Aggression	<input type="checkbox"/> Self-esteem	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Head banging	<input type="checkbox"/> Anger
<input type="checkbox"/> Destroys property	<input type="checkbox"/> Suicidal thought	<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Indecisive	<input type="checkbox"/> Stealing

DEVELOPMENTAL/ MEDICAL/ SOCIAL HISTORY

Age of mother at pregnancy _____ Length of pregnancy _____ Birth weight _____ Type Vaginal C-section

Was this pregnancy planned? _____ Mother's health Good Fair Poor

Child's pediatrician _____ Date of last exam _____

Are your child's immunizations up to date? No Yes

Check the following

Any illness /complications during pregnancy?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)
Did mother use alcohol/drugs during pregnancy?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)
Any complications of delivery or birth defects?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)
Was mother depressed or sad after delivery?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)
Any problems with sleep or feeding?	<input type="checkbox"/> N <input type="checkbox"/> Y (explain)

Describe child as an infant Pleasant Fussy Calm Colicky Irritable Hard to manage

Notes:

Check the following developmental milestones

Respond to parent	<input type="checkbox"/> WNL <input type="checkbox"/> Late	Stood alone	<input type="checkbox"/> WNL <input type="checkbox"/> Late
Spoke single words	<input type="checkbox"/> WNL <input type="checkbox"/> Late	Walked	<input type="checkbox"/> WNL <input type="checkbox"/> Late
Put two words together	<input type="checkbox"/> WNL <input type="checkbox"/> Late	Toilet trained bladder	<input type="checkbox"/> WNL <input type="checkbox"/> Late
Sat up	<input type="checkbox"/> WNL <input type="checkbox"/> Late	Toilet trained bowel	<input type="checkbox"/> WNL <input type="checkbox"/> Late
Crawled	<input type="checkbox"/> WNL <input type="checkbox"/> Late		

How old was child when parent(s) returned to work? _____

Have there been any caregivers other than parent prior to kindergarten? No Yes

Caregiver _____ Age _____ Child's reaction/behavior _____

If your child has been treated for any the following, please check

<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Hospitalizations	<input type="checkbox"/> Seizures
<input type="checkbox"/> Eating problems	<input type="checkbox"/> Head injury	<input type="checkbox"/> Broken bones	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Visual problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Surgeries
<input type="checkbox"/> Vascular problems	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Frequent nosebleeds	<input type="checkbox"/> Loss of consciousness
<input type="checkbox"/> Headaches	<input type="checkbox"/> Skin conditions	<input type="checkbox"/> Suicide attempt/thoughts	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Allergies	<input type="checkbox"/> Other		

Is your child on a special diet? N Y (describe) _____

CURRENTLY does your child take prescription medications/over the counter/supplements/vitamins? None

Drug	Dosage/Frequency	Start Date	Reason	Prescribed by

In the PAST has your child taken any medication for emotional/behavioral reasons? None

Drug	Dosage/Frequency	Start Date	Reason	Prescribed by

Has your child ever received mental health treatment? (including school guidance) None

Agency /Provider	Dates	Reason

Are there any additional physicians/therapists/professionals involved in your child's care? No Yes

If yes, describe _____

EDUCATION HISTORY

School/ District child presently attends _____ Grade _____

Primary teacher _____ School refusal No Yes

Guidance counselor _____

Please note any difficulty your child has at school (academic, attendance, peer relations) _____

Does your child/has your child

Receive added services in school? (speech, resource room, separate classes)	<input type="checkbox"/> N	<input type="checkbox"/> Y (describe)
Been suspended from school?	<input type="checkbox"/> N	<input type="checkbox"/> Y (describe)
Been held back a grade?	<input type="checkbox"/> N	<input type="checkbox"/> Y (describe)
Have an IEP/ 504 Plan?	<input type="checkbox"/> N	<input type="checkbox"/> Y (describe)
Have any difficulties with Notes:	<input type="checkbox"/> Reading	<input type="checkbox"/> Math
	<input type="checkbox"/> Spelling	<input type="checkbox"/> Writing
	<input type="checkbox"/> Science	<input type="checkbox"/> Organization

List your child's social/extracurricular activities _____

List your child's close friends (school/neighborhood) _____

FAMILY HISTORY

Biological Mother's name _____ **DOB** _____ **Age** _____

Address _____

Phone _____ Occupation _____ Employer _____

Biological Father's name _____ **DOB** _____ **Age** _____

Address _____

Phone _____ Occupation _____ Employer _____

List family members and all others in the home

<u>Name</u>	<u>Age</u>	<u>Relationship</u>

List any other siblings not in the home

<u>Name</u>	<u>Age</u>

What type of discipline do you use in your home, and is it effective? _____

Check applicable

(Describe)

<input type="checkbox"/> Death of someone close	
<input type="checkbox"/> Legal trouble	
<input type="checkbox"/> Physical/ sexual abuse	
<input type="checkbox"/> Domestic violence	
<input type="checkbox"/> Emotional abuse	
<input type="checkbox"/> Family moves	
<input type="checkbox"/> Victim of a violent crime	
<input type="checkbox"/> Motor vehicle accident	
<input type="checkbox"/> Family drug/alcohol problems	
<input type="checkbox"/> Family history of mental illness	
<input type="checkbox"/> Family legal trouble	

*** Separated / Divorced Families ONLY** (skip if not applicable)

Mother's partner None

Name _____ Status: Dating Cohabiting Married

Age _____ City/state of residence _____ Quality of relationship with child _____

Father's partner None

Name _____ Status: Dating Cohabiting Married

Age _____ City/state of residence _____ Quality of relationship with child _____

Describe your separation/divorce	<input type="checkbox"/> Amicable	<input type="checkbox"/> Neutral	<input type="checkbox"/> High Conflict
Describe your co-parenting	<input type="checkbox"/> Amicable	<input type="checkbox"/> Neutral	<input type="checkbox"/> High Conflict
Is/Has CYS been involved with your family?	<input type="checkbox"/> N	<input type="checkbox"/> Y (Describe)	
Is there an official (legal) custody agreement?	<input type="checkbox"/> N	<input type="checkbox"/> Y (Describe)	
Are you involved in any legal action through which this treatment may become relevant?	<input type="checkbox"/> N	<input type="checkbox"/> Y (Describe)	
Describe your child's custody schedule below <i>Example: sun -wed – mom's house, thurs- sat – dad's house</i>			

List any additional individual /environmental factors that may be relevant (cultural, financial)
