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.

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.

Date: _____ Client number: _____

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.

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.

When clinically appropriate, touch may be used in combination with other therapeutic interventions during Play Therapy. Physical contact often occurs naturally during a child's play but may also be used for modeling relaxation and coping skills and/or to help maintain your child's safety. You are encouraged to discuss this with your child's therapist if you have concerns.

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**_____

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 # 1 _____ Day / Evening

Cell / Home / Work # 2 _____ Day / Evening

Cell / Home / Work # 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: _____

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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: _____

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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)
□ School/ Guidance
□ Lawyer
□ Friend/Family
□ Phone Book
□ Internet
□ EAP
□ Insurance Company
□ Current/ Previous FairView Client
□ Other _____

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

Name /Agency _____
Address _____
Phone _____

Date: _____

Client number: _____

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Date: _____ Client number: _____

FairView Counseling and The Play Therapy Center

Adult Questionnaire

Client name_____ Age_____ Gender_____ DOB_____

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

_____

_____

_____

Check any of the following that is currently, or has been, a concern for you

□ Depressed mood	□ Weight/appetite	□ Sleep changes	□ Phobia/fears
□ Panic attacks	□ Worthlessness	□ Self-esteem	□ Concentration
□ Impulsivity	□ Fatigue	□ Distractibility	□ Hopelessness
□ Thoughts of death	□ Guilt	□ Helplessness	□ Suicidality
□ Fear of going crazy	□ Chills/flush	□ Nausea	□ Chest pain
□ Shortness of breath	□ Sweating	□ Obsessions	□ Anxiety/worry
□ Rage attacks	□ Dizzy	□ Compulsions	□ Anger
□ Aggression	□ Drug/alcohol	□ Relationship problems	□ Employment

MEDICAL HISTORY

CURRENTLY do you take prescription medications/over the counter/supplements/vitamins? □ None

Drug	Dosage/Frequency	Start Date	Reason	Prescribed by

Have you ever taken medication for emotional/behavioral reasons? □ None

Drug	Dosage/Frequency	Start Date	Reason	Prescribed by

Have you ever received mental health treatment? (psychiatrist/hospitalization/counseling) □ None

Agency /Provider	Dates	Reason

Are there any additional physicians/ therapists/professionals involved in your care? □ No □ Yes

If yes, describe_____

Have you been treated for any the following?

□ Dizziness/fainting	□ Encephalitis	□ Hospitalizations	□ Seizures
□ Eating problem	□ Head injury	□ Broken bones	□ Diabetes
□ Visual problems	□ Cancer	□ Hearing problems	□ Surgeries
□ Vascular problems	□ Paralysis	□ Frequent nosebleeds	□ Loss of consciousness
□ Headaches/migraines	□ Skin conditions	□ Suicide attempt/thoughts	□ Memory problems
□ Blood pressure	□ Allergies	□ Chronic conditions	□ Disability
□ Other (describe)			

EMPLOYMENT /ACADEMIC HISTORY

Are you a student? □ No □ Yes □ Part-time □ Full-time

School _____ Program/Degree _____

Are you employed? □ No □ Yes □ Part-time □ Full-time

Occupation _____ Employer _____

Length of time at current job _____ Job Satisfaction: □ Poor □ Fair □ Good □ Excellent

Highest level achieved in school: □ GED □ HS Diploma □ Associates □ Bachelors □ Graduate Degree

FAMILY /SOCIAL HISTORY

List family members and all others in the home

Name	**Age**	**Relationship**

Current marital status (check all that apply)

□ Single	□ Married	□ Divorced	□ Separated	□ Remarried	□ Cohabitating

Relationship Satisfaction □ Poor □ Fair □ Good □ Excellent _____

Check if applicable	(Describe)
□ Death of someone close	
□ Legal trouble	
□ Physical/ sexual abuse	
□ Domestic violence	
□ Emotional abuse	
□ Family moves	
□ Victim of a violent crime	
□ Motor vehicle accident	
□ Family drug/alcohol problems	
□ Family history of mental illness	
□ Family legal trouble	

What do you do for fun/hobbies/self-care? _____

Include any additional individual factors that may be relevant (cultural, financial) _____