Date: _____ Client number: _____

# FairView Counseling and The Play Therapy Center

## Office Policies and Consent for Treatment

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### 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. 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: ____/____/___

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**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.

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**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

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Name of person completing this form _____

| Cell / Home / Work | Cell / Home / Work | Cell / Home / Work |
|---|---|---|
| # 1 _____ | # 2 _____ | # 3 _____ |
| Day / Evening | Day / Evening | 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: _____

(PAGE LEFT BLANK INTENTIONALLY)

Date: _____ Client number: _____

**FairView Counseling and The Play Therapy Center**

Acknowledgement of Privacy Practices

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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: _____

(PAGE LEFT BLANK INTENTIONALLY)

Date: _____ Client number: _____

# FairView Counseling and The Play Therapy Center

## Financial Policy & Contract For Clients Utilizing Sliding Fee Scale

We accept cash, check, and most credit cards.
If you are using our Slide Fee Scale, your contracted fee is due at the beginning of each session.
Fees incurred for returned checks are the client's responsibility.

Client name _____

- **Verification of income is required at the initial session or full fee will be charged.**
- If there is a change in your financial situation, please contact our office manager so that your information can be updated.
- **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. *FVC reserves the right to change fees without notice.

| **Household Member Name** | **Relationship to You** | **Gross Income** (before deductions) |
|---|---|---|
| | Self | $ □ Weekly □ Bi-Weekly □ Monthly □ Yearly |
| | Spouse / Significant Other | $ □ Weekly □ Bi-Weekly □ Monthly □ Yearly |
| | Other | $ □ Weekly □ Bi-Weekly □ Monthly □ Yearly |

Do you receive child support and/or alimony? No Yes If Yes, amount per week $ _____
Do you receive unemployment compensation? No Yes If Yes, amount per week $ _____
Do you receive any other income? No Yes If Yes, amount per week $ _____
(Worker's compensation, social security, etc) **Total Gross Income**: $_____

To be completed by office staff only

I agree to pay the sliding scale rate of $ _____ for the initial evaluation and $ _____ for regular therapy sessions.
I understand that this rate will be reviewed every 6 months and could change, depending on my financial situation.
Effective Date_____/_____/_____

**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: _____

(PAGE LEFT BLANK INTENTIONALLY)

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
□ Phone Book
□ Insurance Company
□ Lawyer
□ Internet
□ Current/ Previous FairView Client
□ Friend/Family
□ EAP
□ 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 Play Therapy Center

## Consent for Teacher Feedback

FairView Counseling emphasizes communication among treating professionals. We would like to send this confidential Teacher Feedback form to your child's teacher and/or guidance counselor so that we may better understand how he/she functions at school. Feel free to bring this up with your therapist.

_____ Yes, I authorize FVC to communicate with my child's school. _____ No, I do not authorize.

Name of School _____

Name of teacher/guidance _____

Address _____

PRINT Client name _____

Client signature (age 14+)_____ Date_____

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

Parent/Guardian signature _____Date_____

Do not write below this line – to be completed by school

To _____

From:
- □ Elizabeth W. Gonzalez, LPC, RPT-S
- □ Kathryn Davis, PsyD, RPT-S
- □ Kimberly Ring, LPC
- □ Melissa B. Reber, LCSW, RPT
- □ Amanda L. Latshaw, LSW

The above-named child is a client of mine in play therapy at FairView Counseling and The Play Therapy Center. I would appreciate your feedback so that I can develop a comprehensive treatment plan to best help this child make progress on therapeutic goals.

## Teacher Feedback

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

| | | | | |
|---|---|---|---|---|
| □ Speech/language | □ Anxiety | □ Slow learner | □ Shy/timid | □ Sleep |
| □ Trouble with friends | □ Organization | □ Sadness | □ Anger | □ Aggression |
| □ Prefers to be alone | □ Memory | □ Stomach trouble | □ Nervous | □ Handwriting |
| □ Difficult to engage | □ Social Skills | □ Reckless behavior | □ Depressed | □ Coordination |
| □ Fights with peers | □ Tantrums | □ Can't relax | □ Overactive | □ Odd habits |
| □ Fights with adults | □ Transitions | □ Attention | □ Obsessive | □ Stealing |
| □ Destroys property | □ Self-esteem | □ Impulsive | □ Stealing | □ Anger |

Date: _____ Client number: _____

**Rate and describe how the above difficulties impact this child in the following areas:**

**Relationships with peers** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
**No Problems** **Significant Problems**
Describe_____
_____

**Relationships with adults** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
**No Problems** **Significant Problems**
Describe_____
_____

**Academic Progress** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
**No Problems** **Significant Problems**
Describe_____
_____

**Classroom in general** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
**No Problems** **Significant Problems**
Describe_____
_____

**Self-esteem** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
**No Problems** **Significant Problems**
Describe_____
_____

**Describe what you see as this child's major difficulties. Please provide examples.**

_____
_____
_____
_____
_____
_____
_____

**Thank you so much for your feedback, I look forward to communicating with you in the future.**

1255 Perkiomen Avenue
Reading PA, 19602

Phone: 610-396-9091
Fax: 610-396-9092

www.fairviewcounseling.org

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**

| | | | | |
|---|---|---|---|---|
| □ Speech/language | □ Anxiety | □ Slow learner | □ Shy/timid | □ Sleep |
| □ Trouble with friends | □ Wets bed | □ Sadness | □ Self-injury | □ Poor appetite |
| □ Prefers to be alone | □ Bites nails | □ Stomach trouble | □ Nervous | □ Attention |
| □ Fights with siblings | □ Sucks thumb | □ Reckless behavior | □ Depressed | □ Coordination |
| □ Fights with peers | □ Tantrums | □ Can't relax | □ Overactive | □ Odd habits |
| □ Fights with adults | □ Nightmares | □ Animal cruelty | □ Obsessive | □ Stubborn |
| □ Aggression | □ Self-esteem | □ Impulsive | □ Head banging | □ Anger |
| □ Destroys property | □ Suicidal thought | □ Bowel problems | □ Indecisive | □ 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? | □ N | □ Y (explain) |
| Did mother use alcohol/drugs during pregnancy? | □ N | □ Y (explain) |
| Any complications of delivery or birth defects? | □ N | □ Y (explain) |
| Was mother depressed or sad after delivery? | □ N | □ Y (explain) |
| Any problems with sleep or feeding? | □ N | □ Y (explain) |

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

Notes:

**Check the following developmental milestones** 

| | | | | | |
|---|---|---|---|---|---|
| Respond to parent | □ WNL | □ Late | Stood alone | □ WNL | □ Late |
| Spoke single words | □ WNL | □ Late | Walked | □ WNL | □ Late |
| Put two words together | □ WNL | □ Late | Toilet trained bladder | □ WNL | □ Late |
| Sat up | □ WNL | □ Late | Toilet trained bowel | □ WNL | □ Late |
| Crawled | □ WNL | □ 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**

| | | | |
|---|---|---|---|
| □ Dizziness/fainting | □ Encephalitis | □ Hospitalizations | □ Seizures |
| □ Eating problems | □ Head injury | □ Broken bones | □ Diabetes |
| □ Visual problems | □ Cancer | □ Hearing problems | □ Surgeries |
| □ Vascular problems | □ Paralysis | □ Frequent nosebleeds | □ Loss of consciousness |
| □ Headaches | □ Skin conditions | □ Suicide attempt/thoughts | □ Memory problems |
| □ Allergies | □ 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) | □ N □ **Y** (describe) |
| Been suspended from school? | □ N □ **Y** (describe) |
| Been held back a grade? | □ N □ **Y** (describe) |
| Have an IEP/ 504 Plan? | □ N □ **Y** (describe) |
| Have any difficulties with<br>Notes: | □ Reading □ Math □ Spelling □ Writing □ Science □ Organization |

List your child's social/extracurricular activities _____

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

Amount of screen time per _____ day _____ week

## 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**

Name Age Relationship

_____

_____

_____

_____

**List any other siblings not in the home**

Name Age

_____

_____

_____

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

_____

| **Check 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 | |

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

**Mother's partner** □ **None**

Name _____ Status: □ Dating □ Cohabitating □ Married

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

**Father's partner** □ **None**

Name _____ Status: □ Dating □ Cohabitating □ Married

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

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

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

_____

_____

_____

_____