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. DO NOT BRING YOUR CHILD if he/she is SICK. Exceptions to the late cancellation fee would be made in such situations.
FVC requires our clients to follow the immunization guidelines recommended by the American Academy of Pediatrics. *Parents who choose to not vaccinate are advised to seek treatment for their children elsewhere.*

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

For children under 14, 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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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.

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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 The Play Therapy Center

Informed Consent for Telemental Health Services

This consent is specific to **Telemental Health Services** provided during the COVID-19 Public Health Emergency. It covers the following scenarios:

- Intake sessions conducted over Microsoft Teams
- Sessions provided when a client would have to quarantine due to COVID-19 exposure
- Regulation changes preventing FairView Counseling from providing in-person sessions (ie shelter in place)

**If FVC is unable to provide in-person services, we will transition to telemental health services using Microsoft Teams. You would be notified of the change by the email that you have provided and would continue to receive a Microsoft Teams invite for your scheduled appointment time as usual.*

Overview

- You will need access to the certain technological services and tools to engage in telemental health-based services with your provider.
- Telemental health has both benefits and risks, which you and your provider will be monitoring as you proceed with your work.
- It is possible that receiving services by telemental health will turn out to be inappropriate for you, and that you and your provider may have to cease work by telemental health.
- You can stop work by telemental health at any time without prejudice.
- You will need to participate in creating an appropriate space for your telemental health sessions.
- You will need to participate in making a plan for managing technology failures, mental health crises, and medical emergencies.
- Your provider follows security best practices and legal standards in order to protect your health care information, but you will also need to participate in maintaining your own security and privacy.

What is Telemental Health?

Telemental health is the provision of mental health services with the provider and recipient of services being in separate locations, and the services being delivered over electronic media. Services delivered via telemental health can rely on a number of HIPAA compliant electronic, often Internet-based, technology tools. Your FVC provider provides telemental health services using the following: telephone and/or Microsoft Teams.

Benefits and Risks of Telemental Health

Receiving services via telemental health allows you to receive services at times or in places where the service may not otherwise be available, or when you are unable to travel to the service provider's office.

Receiving services via telemental health can come with some risks such as services can be impacted by technical failures, may introduce risks to your privacy, and may reduce your service provider's ability to directly intervene in crises or emergencies.

There may be additional benefits and risks to telemental health services that arise from the lack of in-person contact or presence, the distance between you and your provider at the time of service, and the technological tools used to deliver services. Your provider will assess these potential benefits and risks, sometimes in collaboration with you, as your relationship progresses.

Date: _____ Client number: _____

Assessing Telemental Health's Fit for You

It is well validated by research, service delivery via telemental health is not a good fit for every person. Your provider will continuously assess if working via telemental health is appropriate for your situation. You also have a right to stop receiving services by telemental health at any time without prejudice.

Your Telemental Health Environment

You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. For child clients, "other people" means anyone not already involved in treatment. It should also be difficult for people outside the space to see or hear your interactions with your provider during the session.

Our Communication/ Safety and Emergency Plan

We will develop a plan for backup communications in case of technology failures and a plan for responding to emergencies and mental health crises.

- The best way to contact your provider between sessions is to call the office at 610-396-9091.
- Please note that your provider is not available on weekends or holidays.
- Our work is done during our appointed sessions, Monday -Thursday.

As a recipient of telemental health-based services, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with your provider. During mental health crises and emergencies, call 911, or go to the emergency room.

Your Security and Privacy

Your provider employs software and hardware tools that adhere to security best practices and applicable legal standards for the purposes of protecting your privacy and ensuring that records of your health care services are not lost or damaged.

As with all things in telemental health, however, you also have a role to play in maintaining your security. Please use reasonable security protocols to protect the privacy of your own health care information. For example: when communicating with your provider, use devices and service accounts that are protected by unique passwords that only you know. Also, use the secure tools that your provider has supplied for communications.

Payment

You are responsible for any copayments, coinsurances, portions applied to deductible or uncovered amounts under your insurance coverage that apply to your telehealth sessions.

Recordings

Do not record video or audio sessions without your provider's consent.

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

Parent/Guardian signature _____ **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

Primary email contact _____

Adult Client (if client is a child- skip this section)

Client's name _____DOB _____Age_____ Gender _____

Address _____

Phone _____ Employer _____

Emergency Contact and Phone_____

Child Client (if client is an adult- skip this section)

Client's name _____DOB _____Age_____ Gender _____

Address _____

Parents status: Unmarried Married Separated Divorced Other

Emergency Contact and Phone_____

Biological Mother/Legal Guardian Name _____DOB _____Age_____

Address _____

Phone _____ Employer _____

Biological Father/Legal Guardian Name _____DOB _____Age_____

Address _____

Phone _____ Employer _____

Intentionally Blank

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

Consent to Exchange Information with PCP/ School

FairView Counseling emphasizes communication among treating professionals. We would like to send a brief summary after the intake session so that your Primary Care Physician is aware of your diagnosis and treatment plan and can better address your needs.

_____ Yes, I authorize FVC to communicate with my PCP **_____ No, I do not authorize.**

Physician Name _____
Practice Name _____
Fax _____

(if client is an adult- skip this section)

We would like to send a Teacher Feedback form to your child's teacher and/or guidance counselor so that we may better understand how he/she functions at school. Your therapist will discuss the feedback with you.

_____ 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**_____

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: _____

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.**
- **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.*

Household Member Name	**Gross Income Amount** (before deductions) **Pay Frequency**	**Yearly Income**
	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
Child Support and/or Alimony	Weekly Amount $ _____ x 52 =	$_____
Unemployment Compensation	Weekly Amount $ _____ x 52=	$_____
Other Income:_____ (Worker's compensation, social security, etc)	$_____ □ Weekly(x 52)□ Bi-Weekly(x26) □Monthly(x12)	$_____
	Total Yearly Household Income:	**$_____**

To be completed by office staff only

Effective Date_____/_____/_____

I agree to pay the sliding scale rates of:

$ _____ for the initial intake evaluation/s (For clients 13 yrs & under the initial intake evaluation consists of 2 sessions)

$ _____ for regular therapy sessions.

I understand that this rate will be reviewed every 6 months and could change, depending on my financial situation. If there is a change in your financial situation, prior to your 6 month review, please notify us so that your information can be updated appropriately. * FVC reserves the right to change fees without notice.

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 The Play Therapy Center

Child / Teen 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? □ Yes □ No □ Exempt

*FVC requires our clients to follow the immunization guidelines recommended by the American Academy of Pediatrics.

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 **2**

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 **3**

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 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	

* Separated / Divorced Families ONLY (skip if not applicable) 4

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 *Example: sun -wed – mom's house, thurs- sat – dad's house*			

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

_____

_____

_____

_____