

**Child/Adolescent History Information**

Name: \_\_\_\_\_  
                                    First                                    Middle                                    Last

Social Security Number: \_\_\_\_\_ Gender: \_\_\_\_\_

Current Age: \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Is it okay to leave a messages?

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name and relationship of person bringing in patient: \_\_\_\_\_

Referred by: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of patient’s parents: \_\_\_\_\_

Parent’s marital Status: Single Engaged Married Divorced  
Separated Living Together Remarried Widowed

Parent’s Occupations: \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

People who currently live in child/adolescent’s household:

Name	Sex	Age	Relationship
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_____			
_____			
_____			
_____			

Reason for seeking help at this time:

\_\_\_\_\_

**Advance Professional Counseling, LLC**

Mull Center  
1025 Main St. Suite 317  
Wheeling, WV 26003  
**(304) 650-3820**

Significant people or family members not currently living with Child/ Adolescent:

<u>Name</u>	<u>gender</u>	<u>age</u>	<u>relationship</u>

Please check each item which is a concern to you or your child/adolescent about him/her:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Appetite/weight  | <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Health problems            |
| <input type="checkbox"/> Bowel problems   | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Sleep-too little/much      |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Loneliness         | <input type="checkbox"/> Suicidal thoughts          |
| <input type="checkbox"/> Low energy       | <input type="checkbox"/> Unhappiness        | <input type="checkbox"/> Tiredness                  |
| <input type="checkbox"/> Feeling inferior | <input type="checkbox"/> Shyness            | <input type="checkbox"/> Making decisions           |
| <input type="checkbox"/> Work             | <input type="checkbox"/> Career             | <input type="checkbox"/> Ambition – too little/much |
| <input type="checkbox"/> Concentration    | <input type="checkbox"/> Education          | <input type="checkbox"/> Difficulty relaxing        |
| <input type="checkbox"/> Anger            | <input type="checkbox"/> Temper             | <input type="checkbox"/> Self-control               |
| <input type="checkbox"/> Children         | <input type="checkbox"/> Discipline         | <input type="checkbox"/> Being a parent             |
| <input type="checkbox"/> Nervousness      | <input type="checkbox"/> Stress             | <input type="checkbox"/> Fears                      |
| <input type="checkbox"/> Legal matters    | <input type="checkbox"/> Finances           | <input type="checkbox"/> Friends                    |
| <input type="checkbox"/> Nightmares       | <input type="checkbox"/> Dreams             | <input type="checkbox"/> Memories                   |
| <input type="checkbox"/> Alcohol use      | <input type="checkbox"/> Thoughts           | <input type="checkbox"/> Drug use                   |
| <input type="checkbox"/> Separation       | <input type="checkbox"/> Marriage           | <input type="checkbox"/> Sexual problems            |
| <input type="checkbox"/> Moves            | <input type="checkbox"/> Deaths             | <input type="checkbox"/> Other losses               |
| <input type="checkbox"/> Abuse, physical  | <input type="checkbox"/> Abuse, sexual      | <input type="checkbox"/> Abuse, verbal              |
| <input type="checkbox"/> Neglect          | <input type="checkbox"/> Visitation/custody |   |
| <input type="checkbox"/> Other changes    |   |   |

Other: \_\_\_\_\_

Circle symptoms your child has and number of times per week:

- |               |                       |                     |                                       |
|---------------|-----------------------|---------------------|---------------------------------------|
| Anxiety__     | Anger__               | Overeating__        | Acts out sexually with others__       |
| Bedwetting__  | Defiance__            | Under eating__      | Masturbates excessively__             |
| Day wetting__ | Controlling__         | Sleeplessness__     | Unusual or excessive sexual knowledge |
| Day pooping__ | Lack of empathy__     | Nightmares__        | Plays out sexual themes__             |
| Obsesses__    | Lying__               | Hyper vigilance__   | Plays out violent themes__            |
| Depression__  | Low impulse control__ | Startles easily__   | Homicidal themes or actions__         |
| Low energy__  | Stealing__            | Fears/Phobias__     | Suicidal thoughts or actions__        |
| Shy__         | Drug/alcohol use__    | Running away__      | Stomach aches/ head aches__           |
| Tantrums__    | Impaired conscience__ | Peer problems__     | Spacing out__                         |
| Violent__     | Excessive crying__    | Low concentration__ | Feelings of inferiority__             |
| Grief__       | Putting self down__   | Memories__          | Academic problems__                   |

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Allergies \_\_ Specific Fears \_\_\_\_\_

Hallucinations (hearing/seeing things) \_\_

Other \_\_\_\_\_

Has your child ever been in counseling before? If so when? Was it helpful?

What would your child/adolescent or you like as a result of counseling?

**Health History:**

Overall Health condition of child/ adolescent: very good good average poor

Recent weight gain or loss? \_\_\_\_\_

Last physical exam: \_\_\_\_\_ Report: \_\_\_\_\_

Significant medical conditions: \_\_\_\_\_

List any childhood diseases: \_\_\_\_\_

List any allergies: \_\_\_\_\_

Any prolonged fever of more than 104 degrees? \_\_\_\_\_

Head Injuries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

**School History**

Name of school child/adolescent is attending:

Grade:

Average Grade Point:

Has your child/adolescent's behavior ever been a concern of one of his/her teachers? If so please describe:

Does your child/adolescent have any difficulties learning?

Does or did your child/adolescent have any difficulties at school with any of the following:

writing reading arithmetic poor coordination memories of letters or numbers

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making friends    bullying    being bullied    keeping friends    concentration

What are your child/adolescent's strengths in school?

**Legal History**

Are there custody disputes or current custody arrangements in place for the child/adolescent?

Are there any restraining orders in place which affect the child adolescent?

Is child/adolescent currently on probation or parole: Y / N

Are any family members currently on probation or parole or currently incarcerated: Y / N  
(please comment):

**Family History**

What types of discipline are used within the family?

Describe the relationship between the child/adolescent's parents:

Describe how the child/adolescent gets along with others within the family:

Is there a history of mental illness, or emotional problems within the family or extended family?

Please list anyone in the child/adolescent's family, including the child/adolescent and extended family who used or uses alcohol or drugs (prescription or street drugs)

relationship to child	types of drugs	purpose	for how long
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**Personality of Child/Adolescent:**

tense	relaxed	restless	calm	daydreamer	self starter	active	sluggish
stubborn	eager to please	easy to manage	disobedient	happy	sad	angry	
loving	aloof	friendly	secure	easily frightened	bold	cautious	whining
generous	jealous	cruel	aggressive	affectionate	relates easily to adults		
relates poorly to adults		attached to certain toys/objects to point of not being able to leave at home.					

Have there been noticeable changes in behavior or personality at any time in his/her life?

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Child/adolescent's life in general:   very happy          happy          average          unhappy          very unhappy

Child/adolescent's life in past 6 months:   very happy          happy          average          unhappy          very unhappy

What is your child/adolescent's greatest fear: \_\_\_\_\_

What is your child/adolescent's greatest hope: \_\_\_\_\_

**Please describe in detail the reason for having this child seen professionally.**

    Indicate the age the problem began and probable causes

    What has made the problem better or worse?

    Describe feelings and moods observed

    In what way does this problem interfere with the life of the child or family?

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### Insurance Information

<b>Client Name:</b> _____	<b>Date of birth:</b> ___/___/___
<b>Address:</b> _____ _____	<b>Gender:</b> _____ <b>Relationship to Policy Holder:</b> self      child      spouse/partner  <b>Employment:</b> full, part, student, un-employed
<b>City/Zip:</b> _____	
<b>Phone #:</b> (    )      -	
<b>Primary Insurance:</b> _____	
<b>Address of Insurance:</b> _____	<b>Secondary Insurance:</b> _____
<b>Telephone number:</b> _____	<b>Address of Insurance:</b> _____
<b>Policy Holder's name:</b> _____	<b>Telephone number:</b> _____
<b>Policy Holder's date of birth:</b> ___/___/___	<b>Insured's name:</b> _____
<b>Policy Holder's Address:</b> _____ _____	<b>Insured's date of birth:</b> ___/___/___
<b>Policy or ID #:</b> _____	<b>Policy or ID #:</b> _____
<b>Group #:</b> _____	<b>Group #:</b> _____
<b>Effective date of policy:</b> ___/___/___	<b>Effective date of policy:</b> ___/___/___
<b>Employer or School :</b> _____	<b>Employer or School :</b> _____
<b>Policy Holder's SS number:</b> _____	<b>Policy Holder's SS number:</b> _____

#### **AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize Advance Professional Counseling, LLC to:

- 1) Furnish my insurance company with any/all information requested concerning my present claim(s), including records if requested.
- 2) Bill my insurance company, and to accept payment from that company on my behalf, for all services relating to my care.

I acknowledge:

- 1) I am responsible for all charges not covered by my insurance, including missed appointments.
- 2) Any money credited as overpayment due to me will be refunded after completion of treatment.
- 3) I will be charged for any appointment that I fail to keep or cancel within 24 hours prior to that appointment time.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

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## Fees and Insurance

The established fee for individual counseling is \$140.00 per session.  
A 30% discount is offered for payment at the time of service (\$98.00)

Marital and relationship counseling is available at \$65.00 per session. No discount available

Payment plans are available upon request when meeting the required income guidelines. Proof must be supplied.

Co-pays should be paid at the end of every session. Advance Professional Counseling, LLC accepts cash and checks, and all major credit cards.

Clients are responsible for payment of any services not covered by insurance.

When an appointment is scheduled for you, 1 hour is set aside specifically for you.  
Because of this commitment of time, if you cannot keep this appointment, you must cancel at least 24 hours in advance by calling the office, unless it is an **Emergency!** Insurance companies do not pay for missed sessions. Therefore, you will be billed for all appointments not properly canceled.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Client Request**

Counselor Request

**Authorization to Release Protected Health Information**

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I, \_\_\_\_\_, hereby authorize

Name of Client/Guardian

William R. Coburn of Advance Professional Counseling, LLC, 1025 Main Street, Wheeling, WV (304) 242-8095, to disclose or receive, a copy of specific health/mental health information initialed below regarding

\_\_\_\_\_ consisting of:

- Therapy/case notes     Psychological reports     Progress reviews     Psychiatric reports
- Medical reports         Treatment Plans             Medications used in treatments
- Assessments     School reports             Discharge Summary                     Psycho-educational reports
- Results of court proceedings (other than expunged records)
- Other (specify): \_\_\_\_\_

to or from (name and address of recipient or sender):

\_\_\_\_\_  
Name, Title, Business Name, Address, and Phone Number

I have been informed and fully understand that this protected health information may be in written, oral, or report form. I understand that the information used or disclosed related to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/ AIDS information, mental health information, and drug/alcohol diagnosis, treatment, or referral information.

I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits. You may revoke this authorization in writing anytime, but such revocation may not be retroactive. If you revoke your authorization, the information described above may no longer be disclosed for the purposes described above. To revoke this authorization, please send a written statement that you are revoking this authorization to Advance Professional Counseling at the address listed above.

I have read this authorization and I understand it. Unless revoked, this authorization expires in 180 days from the date of the signature below.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Individual, Legal guardian, or Personal representative

Description of personal representative's authority: \_\_\_\_\_



## **Parental Consent to Counseling**

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I, \_\_\_\_\_, give consent to have my daughter/son  
(Name of parent or guardian)

\_\_\_\_\_ enter into counseling with  
(Name of client)

William R. Coburn at Advance Professional Counseling.  
(Name of counselor)

I understand that the communication between \_\_\_\_\_  
(name of client)

and her/his counselor is confidential, and that confidentiality will be broken only in the case of her/his being a danger to herself/himself or to others, or if she/her is involved in illegal activity, or if otherwise required by law. Therefore, I fully understand that even I as parent will not be provided with any information regarding communication between

\_\_\_\_\_  
(name of client)

and his/her counselor. I have had the opportunity to fully discuss with said counselor the risks and benefits of treatment, as well as treatment choices and methods. I have had all my questions answered and I understand and approve the treatment that is planned.

Under penalty of law, I hereby declare that I am the parent of this child. Parent means a biological or adoptive parent having legal custody of the child or a person or agency judicially appointed as legal guardian of the child.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signature of Parent or Guardian: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

# HIPAA Privacy Notice

Notice of Privacy Practices

Effective Date: November 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**What is this Notice and Why is it Important?** As of April of 2003, a new federal law (“HIPAA”) went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how the practitioners at Advance Professional Counseling required to be HIPAA compliant will protect your medical information, how I may use or disclose this information, and describes your rights. If you have any questions about this notice, please contact me directly at (304) 650-3820.

**Understanding Your Health Information** During each appointment, I record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed
- A tool with which I can assess and work to improve the care I provide

**Your Health Information Rights** You have the following rights related to your medical record:

- *Obtain a copy of this notice.*  
You can read this notice in the waiting room, and you can also obtain your own copy if you would like.
- *Authorization to use your health information.*  
Before I use or disclose your health information, other than as described below, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- *Access to your health information.*  
You may request a copy of your medical record from me at any time.
- *Change your health information.*  
If you believe the information in your record is inaccurate or incomplete, you may request that I correct or add information.
- *Request confidential communications.*  
You may request that when I communicate with you about your health information, I do so in a specific way (e.g. at a certain mail address or phone number). I will make every reasonable effort to agree to your request.
- *Accounting of disclosures.*  
You may request a list of disclosures of your health information that I have made for reasons other than treatment, payment or healthcare operations.

## My Responsibilities

- I am required by law to protect the privacy of your health information, to provide this notice about my privacy practices, and to abide by the terms of this notice.
- I reserve the right to change my policies and procedures for protecting health information. When I make a significant change in how I use or disclose your health information, I will also change this notice.

- Except for the purposes related to your treatment, to collect payment for my services, to perform necessary business functions, or when otherwise permitted or required by law, I will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.

### **When Can I Legally Disclose Your Health Information Without Your Specific Consent?**

- *In order to facilitate your medical treatment.*  
For example: Your primary care physician or your psychotherapist might call me to discuss your treatment, and in that situation I would disclose information about your diagnosis, your medications, and so on.
- *In order to collect payment for health care services that I provide.*  
For example: In order to get paid for my services, I have my billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, I fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis.
- *In order to facilitate routine office operations.*  
For example: Occasionally, I dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.

**Will I Disclose Your Health Information to Family and Friends?** While the new law allows such disclosures without your specific consent (as long as it contributes to your treatment), my office policy is that I will *never* share your clinical information with your family without a signed authorization from you. The BIG EXCEPTION to this is if I believe you pose an immediate danger to yourself or someone else—in that case, I will do whatever is necessary, even if that means breaching confidentiality.

### **Less Common Situations in Which I Might Disclose Your Health Information**

- Workers compensation: I may disclose your health information to comply with laws relating to worker's compensation or other similar programs.
- Law enforcement: I may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order. This includes any information requested by the Department of Social Services (DSS) related to cases of neglect or abuse of children.
- Food and Drug Administration (FDA): I may disclose to the FDA your health information relating to adverse events due to medications.
- Business associates: I hire a billing company to send out bills to insurance companies. Some of the employees of this company have access to a small portion of your health information in order to allow them to do their job.

**For More Information or to Report a Problem.** If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us any time at (304) 650-3820. If you feel your privacy rights have been violated in any way, please let me know and I will take appropriate action. You may also send a written complaint to:

Department of Health & Human Services, Office of Civil Rights,  
Hubert H. Humphrey Building 200 Independence Avenue  
S.W. Room 509 HHH Building  
Washington, D.C. 20201

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Mull Center

1025 Main St. Suite 317

Wheeling, WV 26003

**(304) 650-3820**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_