Child Client Information

Client's Name (First MI Last):

Preferred Name or Nickname:

Date of Birth: Age: Gender:

Parent/Caregiver 1	Parent/Caregiver 2
Name:	Name:
☐ Biological ☐ Adoptive ☐ Guardian ☐ Other:	☐ Biological ☐ Adoptive ☐ Guardian ☐ Other:
Mailing Address:	Mailing Address:
Physical Address:	Physical Address:

Please DO NOT list any numbers where you would prefer not to receive calls or messages.

Home:	Home:
Cell:	Cell:
Work:	Work:
Email: *Check this box to receive email communication from Counseling Associates* ☐	Email: *Check this box to receive email communication from Counseling Associates* ☐

As a courtesy, we offer the option of appointment reminders by email, text, or landline phone message. These messages are delivered 48-hours in advance. These serve as reminders only and should not be relied upon exclusively.

Please also be sure to note your appointment in your own personal calendar.

Would you like to receive optional courtesy reminders? ☐ Yes ☐ No

Requested Method: ☐ Email ☐ Text ☐ Landline Phone Message *(select one only)*

Financial Information

I understand that I am responsible for charges incurred that are not covered by my insurance and that I am responsible for understanding my coverage and for knowing when the limits of my coverage are being exceeded. I authorize the release of information necessary to file a claim with my insurance company, including electronically, and assign benefits of Counseling Associates of New London, PLLC, Counseling Associates of Newport, Counseling Associates of Claremont, and Counseling Associates of the Upper Valley. A copy of this signature is as valid as the original.

We have a standard 24-hour cancellation policy. Please notify your therapist as soon as you know you will be unable to keep an appointment ***at least*** *24 hours, preferably 48 hours, in advance of the scheduled time. The policy of this office is to charge $60 for those missed sessions not canceled with 24 hours notice.* ***Insurance companies will not pay for sessions that you miss, and it would be fraudulent for us to submit a claim for missed sessions.***

Signature: Date:

Primary Insurance Company:	Secondary Insurance Company:
ID#: Group #:	ID#: Group #:

Please provide your insurance card(s) for copying at the time of appointment or upload via our secure form on ca-mh.com.

Responsible party to whom statements will be sent if different from Client:

Name:	Relationship:
Address:	Phone #:

Coordination of Care

Coordination of care among healthcare providers improves quality of care and achievement of treatment goals. Authorizing this coordination of care with your child's primary care provider (PCP) or another professional is optional though, increasingly, insurance companies are requiring this and considering this standard of care. If you authorize coordination of care with your child's PCP, Counseling Associates will send a confirmation to your provider that we have met for this initial session. Coordination of care may also include brief periodic updates regarding treatment and other coordination communications either in writing or by phone. We are happy to answer any questions you may have about coordination of care and this authorization.

☐ I authorize coordination of care between my child's PCP and Counseling Associates.
Please sign release on following page.

☐ I decline coordination of care at this time. *Do not complete release on following page.*

☐ I have questions about coordination of care and would like to wait and speak with my child's therapist.

☐ My child has other providers or individuals for whom I would like to authorize communlcations.
Please sign release on following page and access additional forms at (website)

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the following (available on our website or in office):

- Counseling Associates Practice Information
- CA Cancellation Policy
- Notification of Privacy Policies Regarding Protected Health Information (PHI)
- Telebehavorial Health Informed Consent
- NH Mental Health Bill of Rights

I understand the information about the therapy I am considering for my child. I have had all of my questions answered to my satisfaction.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that, as with any treatment, there are some risks as well as many benefits with therapy. I am aware that I may stop my child's treatment with this therapist at any time. I understand that I will still be responsible for paying for services already received. I understand that there may be consequences to such a decision outside of my child's therapist's control. (e.g. if my child's treatment has been court-ordered. I will have to respond to the court).

My signature below indicates that I understand the information about the therapy I am considering for my child, and I have had all questions answered to my satisfaction. I agree to abide by the terms outlined throughout our professional relationship with Counseling Associates of New London, PLLC, which includes Counseling Associates of New London, Newport, Claremont, and the Upper Valley. I consent for my child to receive services from Counseling Associates and I agree to take an active role in my child's treatment.

Signature of Parent/Guardian | Date

Printed name | Relationship to client

Signature of Provider | Date

Authorization to Disclose Health Information

_____, born on this date _____
(Name of person whose information is being disclosed)

authorize **Counseling Associates of New London, Newport, Claremont, & Upper Valley** to

☐ Release ☐ Receive ☐ Exchange

Protected Health Information (PHI) about the above referenced individual to:

Name:	Phone:
Address:	

Information as described below:

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

☐ Mental Health (MH) ☐ Substance Use Disorder (SUD) ☐ Both (MH/SUD)

Type of Information / Record: Check the information / record type you wish disclosed

Check ☐ **Yes** if you request the **Entire Record** to be disclosed - *this includes, but is not limited to: assessment, treatment plans, progress notes, medication, attendance, test results, behavioral support plans, discharge reports, etc.*

Check ☐ **No** if you wish to specify which of the items below to disclose:

☐ Yes	☐ No	Attendance
☐ Yes	☐ No	Assessments/Evaluations including diagnosis, treatment recommendations
☐ Yes	☐ No	Treatment Plan/Individual Plan of Care
☐ Yes	☐ No	Progress Notes
☐ Yes	☐ No	Medications Prescribed
☐ Yes	☐ No	Agency Discharge Summary/Plan
☐ Yes	☐ No	Behavioral Support Plans
☐ Yes	☐ No	Test Results (includes lab results and urine toxicology reports)
☐ Yes	☐ No	HIV/AIDS
☐ Yes	☐ No	Other (must specify):

Date range of information to be disclosed:

The purpose of the disclosure:

Date or event upon which this authorization will expire:

I understand that if I do not note a date or event, this authorization will expire one year from the date signed below.

If none is indicated the means of this disclosure may be written, verbal, or electronic.

• I understand that my substance use disorder treatment records are protected under federal regulations, 42 CFR Part 2, and cannot be discloed without my written consent, unless otherwise allowed by the regulations or required by law.

• I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization.

• For disclosures of information made to organizations outside of the State of New Hampshire, health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Standard of HIPAA.

• I understand that confidentiality of such records is also protected by State law.

• I understand that generally Counseling Associates may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied participation in the services if I do not sign an authorization form.

• I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment payment or healthcare operations.

• I also understand I will not be denied services if I refuse to authorize a disclosure for other purposes.

• I understand that I may request restrictions on the use or disclosure of information for the purposes of treatment, payment, and healthcare operations that Counseling Associates may or may not agree to the requested restrictions.

• I understand I may revoke this authorization at any time except to the extent that the practice or other agency making the disclosure has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the practice at our address.

I have read all of the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

Name of Client (please print) _____ Date _____

Signature of Parent/Guardian _____ Date _____

Verbal revocation received:_____(date) at _____(time)
Staff Member:

Written revocation: I hereby revoke this authorization on _____(date).
Do not release any further information under this authorization.
Client/Guardian Signature:

Electronic revocation received:_____(date) at _____(time)
Staff Member:

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Please Tell Us

Please describe the reason for the appointment:

What do you and your child hope to gain from therapy?

What strengths does your child have that you will bring to this work?

Has your child seen a therapist before? ☐ Yes ☐ No
If Yes, please note the name of the therapist(s) and approximate date(s):

Health & Wellness Information

Date of Birth: Age: Gender:

Height: Weight: | Immunizations up to date? ☐ Yes ☐ No

Primary Care Provider: | Date of Last Physical:

Other Providers:

Current Health: ☐ Good ☐ Fair ☐ Poor Are you concerned about your child's health? ☐ Yes ☐ No
If yes, please describe concerns:

Do you or someone else have any concerns about your child's development? ☐ Yes ☐ No
If yes, please describe concerns:

Medications

Has your child ever received medications in the past for emotional, physical, learning, or behavioral concerns?
☐ Yes ☐ No If yes, please list all below:

Medication	Dosage	Current	Taken since	Is it helping?	Side effects

Please attach additional sheet(s) as needed for additional medication information.

Over the counter, Supplements, Herbal:

Allergies or adverse reactions: ☐ No Known Drug Allergies

Educational History

Current School: Grade in School:

Do you or someone else have any concerns about your child's education? ☐ Yes ☐ No
If yes, please describe:

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Pediatric Symptom Checklist

Please mark under the heading that best fits you:	Never	Sometimes	Often
1. Complain of aches or pains	☐	☐	☐
2. Spend more time alone	☐	☐	☐
3. Tire easily, little energy	☐	☐	☐
4. Fidgety, unable to sit still	☐	☐	☐
5. Have trouble with teacher	☐	☐	☐
6. Less interested in school	☐	☐	☐
7. Act as if driven by motor	☐	☐	☐
8. Daydream too much	☐	☐	☐
9. Distract easily	☐	☐	☐
10. Are afraid of new situations	☐	☐	☐
11. Feel sad, unhappy	☐	☐	☐
12. Are irratable, angry	☐	☐	☐
13. Feel hopeless	☐	☐	☐
14. Have trouble concentrating	☐	☐	☐
15. Less interested in friends	☐	☐	☐
16. Fight with other children	☐	☐	☐
17. Absent from school	☐	☐	☐
18. School grades dropping	☐	☐	☐
19. Down on yourself	☐	☐	☐
20. Visit doctor with doctor finding nothing wrong	☐	☐	☐
21. Having trouble sleeping	☐	☐	☐
22. Worry a lot	☐	☐	☐
23. Want to be with the parent more than before	☐	☐	☐
24. Feel that you are bad	☐	☐	☐
25. Take unneccessary risks	☐	☐	☐
26. Get hurt frequently	☐	☐	☐
27. Seem to be having less fun	☐	☐	☐
28. Act younger than children your age	☐	☐	☐
29. Do not listen to rules	☐	☐	☐
30. Do not show feelings	☐	☐	☐
31. Do not understand people's feelings	☐	☐	☐
32. Tease others	☐	☐	☐
33. Blame others for your troubles	☐	☐	☐
34. Take things that do not belong to you	☐	☐	☐
35. Refuse to share	☐	☐	☐

SUBMIT