Connections Counseling, L.L.C.

New Client's Personal Information – Child/Adolescent

Name: DOB/Age:

SS#:

For each of the questions below, please answer for all parents/step-parents/guardians, and specify which information is for whom.

Parent(s)' Name(s)': DOB(s):

Who has custody? Please specify if the custody is joint/sole/with visitation:

Are there any court orders? Court orders must be provided.

Home Address(es):

How were you referred?

Home Phone(s): May we call you or leave a message at this number? Yes No

Work Phone(s): May we call you or leave a message at this number? Yes No

Cell Phone(s): May we call you or leave a message at this number? Yes No

May we text message you on your cell phone? Yes No

E-Mail Address(es): May we E-Mail you? Yes No

Occupation(s):

Employers Name(s) and Address(es): (will not be contacted)

School/Grade of child:

Current Primary/Health Care Provider:
Address and Phone:

Current Medications:

Current Psychiatrist:
Address and Phone:

Are there firearms in the home? Yes No Do you (the child) have access to firearms? Yes No
Reason(s) for seeking counseling:

Client's Signature (if 14 or older): Date:
Parent/Guardian's Signature: Date:
Parent/Guardian's Signature: Date:
Counselor's Signature: Date:
Supervisor's Signature: Date:

Connections Counseling, LLC
Informed Consent and Confidentiality for Mental Health Counseling

Prior to receiving mental health treatment and/or counseling you, as the Client and or Client's guardian, have the following rights to be fully informed as to:

1. the nature of the proposed treatment and any reasonable treatment alternatives
2. the training, credentials, and licensure of your Counselor
3. truthful disclosure of reasonably foreseeable benefits, risks, and hazards of the proposed treatment, alternative treatments and of not doing anything
4. the right to fully withdraw consent for treatment at any time

You also have the right to the confidential treatment of information about you and/or minor child. Information maintained in your Client record will not be released to anyone outside the direct therapeutic relationship (and the specified supervisor of the counselor named in the informed consent) without your approval under the Federal HIPPA guidelines unless required by law such as the mandatory reporting of suspected child/elderly abuse or neglect, duty to warn to prevent harm to others, and in the event of dangerousness to self, others or property due to a mental disorder etc., in the event of legal proceedings against the Counselor/Practitioner, disclosure as mandated by Third Party payment requirements (i.e. insurance billings or collections procedures), or, under specific circumstances, a court subpoena.

In this case, your child/adolescent is seeking counseling. As a matter of privacy, the Counselor will only discuss the counseling content with the parent/guardian when there is a necessary harm or threat, or when the Counselor determines it is otherwise therapeutically appropriate.

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By providing your signature to this document, you attest that you, as the Client and/or Client's legal guardian:

-Have discussed these issues with your Counselor and without reservation provide your consent for treatment.
-Understand that you have the legal right to provide consent for mental health treatment and are competent to make decisions regarding the course and/or discontinuation of treatment.
-Understand that the Counselor may discuss your case with a supervisor as a matter of proper client care.
-Have received a copy of the Mental Health Bill of Rights.
-Agreed to the policy that 24 hours cancellation notice prior to a scheduled appointment is required or you will be held responsible for the full fee. Further, if a balance is due on your account, you understand that your basic billing information will be sent to a Third Party Bill Collector.

_____	_____	_____
Client's Name	Client's Signature (if 14 or older)	Date
_____	_____	_____
Parent/Guardian's Name(s)	Parent/Guardian's Signature(s)	Date
_____	_____	_____
Counselor's Name	Counselor's Signature	Date
_____	_____	_____
Supervisor's Name	Supervisor's Signature	Date

Connections Counseling, LLC
Risks and Benefits of Counseling

The practice of Counseling is defined as follows:

The application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.

Adopted by ACA Governing Counsel, October 1997 / Adopted by NBCC Board of Directors, November 1997

Benefits of Counseling: Research indicates that most people who engage in counseling benefit from the experience. Counseling provides the person with the opportunity to talk and learn about themselves and their problems in a safe, non-judgmental, caring environment. Counseling can impact and improve relationships with significant others. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, goals; an increase in productivity in work, school, and relationships; and an improved ability to deal with everyday stresses. Counseling may help relieve the stress and impaired functioning associated with trauma, grief and mental disorders.

Risks of Counseling: The risks associated with the counseling process may include remembering unpleasant events and may arouse strong feelings, and as an outcome, may result in ill-advised or risk taking choices/behaviors. The risks also include continuation of presenting problems, increased feelings of loneliness, sadness, depression, anxiety, feelings of hopelessness or suicide. Counseling for relational issues may result in the growth of only one partner and/or the decision to end the relationship. There may be other risks as well.

Counseling is a relationship and you have the right to discuss your concerns about the risks associated with the progress of counseling with your counselor at any time.

Signing this agreement implies that the under-signed have read and agreed to the intent of this policy and have discussed any concerns with the counselor prior to the beginning of the counseling relationship.

_____	_____	_____
Client's Name	Client's Signature (if 14 or older)	Date
_____	_____	_____
Parent/Guardian's Name(s)	Parent/Guardian's Signature(s)	Date
_____	_____	_____
Counselor's Name	Counselor's Signature	Date
_____	_____	_____
Supervisor's Name	Supervisor's Signature	Date

Connections Counseling, LLC
Client Rights

The client has the right:

A) To be treated with dignity, consideration and respect at all times;

B) To expect quality service provided by concerned, trained, professional and competent staff;

C) To expect complete confidentiality within the limits of the law, and to be informed about the legal exceptions to confidentiality;

D) To a clear working contract in which business items, such as time of sessions, payment plans/fees, absences, access, emergency procedures, and third-party reimbursement procedures are discussed;

E) To a clear statement of the purposes, goals, techniques, rules of procedure and limitations, as well as the potential dangers of the services to be performed, and all other information related to or likely to affect the ongoing mental health counseling relationship;

F) To appropriate information regarding the mental health counselor's education, training, skills, license and practice limitations and to request and receive referrals to other clinicians when appropriate;

G) To full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible;

H) To obtain information about their case record and to have this information explained clearly and directly;

I) To request information and/or consultation regarding the conduct and progress of their therapy;

J) To refuse any recommended services and to be advised of the consequences of this action;

K) To a safe environment free of emotional, physical and sexual abuse;

L) To a client grievance procedure, including requests for consultation and/or mediation; and to file a complaint with the mental health counselor's supervisor, and/or the appropriate credentialing body; and

M) To a clearly defined ending process, and to discontinue therapy at any time.

The under-signed have read and agreed to the intent of this policy and have discussed any concerns with the counselor prior to the beginning of the counseling relationship.

_____	_____	_____
Client's Name	Client's Signature (if 14 or older)	Date
_____	_____	_____
Parent/Guardian's Name(s)	Parent/Guardian's Signature(s)	Date
_____	_____	_____
Counselor's Name	Counselor's Signature	Date
_____	_____	_____
Supervisor's Name	Supervisor's Signature	Date