Person Completing Form: _____ Relationship to child: _____ Date: _____

SAGE HILL COUNSELING

CHILD/ADOLESCENT INTAKE FORM

Child Information

Child's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Message: ☐ Yes ☐ No Cell Phone: _____ Message: ☐ Yes ☐ No

Primary Email: _____ Message: ☐ Yes ☐ No

School: _____ Teacher: _____ Grade: _____

Family Information

Mother's Name: _____ Date of Birth: _____

Mother's Occupation: _____ Work hours: _____

Primary Phone: _____ Message: ☐ Yes ☐ No Secondary Phone: _____ Message: ☐ Yes ☐ No

Primary Email: _____ Message: ☐ Yes ☐ No

Father's Name: _____ Date of Birth: _____

Father's Occupation: _____ Work hours: _____

Primary Phone: _____ Message: ☐ Yes ☐ No Secondary Phone: _____ Message: ☐ Yes ☐ No

Primary Email: _____ Message: ☐ Yes ☐ No

Who has legal custody of the child? ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

List members of your family and/or all others living in your child's home:

Name	Gender	Age	Relationship to the child	School/Occupation

List other persons closely involved with your child but not living at home: _____

_____

_____

Child's Health Information

Briefly describe the reason you brought your child to counseling: _____

_____

_____

Briefly describe any stressful or traumatic events your child has experienced: _____

_____

_____

Briefly describe how your child is functioning at school (academically, socially, behaviorally): _____

_____

_____

Has your child received psychiatric or psychological treatment or counseling before? ☐ Yes ☐ No

If yes, please give name(s) of provider(s), location(s), treatment dates, diagnosis: _____

_____

When was your child last examined by a physician? _____

List any major health problems for which your child currently receives treatment: _____

_____

List all medications your child is currently taking: _____

_____

Please check and describe all concerns about your family:

- ☐ Health Concerns: _____
- ☐ Mental Illness: _____
- ☐ Alcoholism/Drug Addiction: _____
- ☐ Death in Family: _____
- ☐ Job Loss: _____
- ☐ Marital Difficulties: _____
- ☐ Physical/Sexual/Emotional Abuse: _____
- ☐ Other: _____

Anything else you would like us to know: _____

_____

Child's Developmental History

Describe any difficulties mother experienced during pregnancy (e.g. excessive nausea, serious illness, drug or alcohol use): _____

_____

Describe any difficulties during labor or delivery: _____

_____

_____

Were child's developmental milestones met on time (e.g. spoke first words, toilet trained, etc.)? _____

_____

_____

Has your child ever been placed or boarded away from home? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Briefly describe your relationship with your child: _____

_____

_____

Briefly describe how your child gets along with other family members: _____

_____

_____

How is your child disciplined and by whom? _____

_____

_____

What are your child's strengths and interests? _____

_____

_____

Please check and circle the frequency of all symptoms your child is experiencing:

- ☐ Difficulty sleeping (Occasionally or Often)
- ☐ Startles easily, very jumpy (Occasionally or Often)
- ☐ Unusually clingy (Occasionally or Often)
- ☐ Avoids certain people, places, things (Occasionally or Often)
- ☐ Stomachaches, headaches (Occasionally or Often)
- ☐ Cries a lot (Occasionally or Often)
- ☐ Hurts self on purpose (Occasionally or Often)
- ☐ Frequent tantrums or irritability (Occasionally or Often)
- ☐ Hurts animals on purpose (Occasionally or Often)
- ☐ Hides food (Occasionally or Often)
- ☐ Refuses to go to the bathroom (Occasionally or Often)
- ☐ Washes self excessively (Occasionally or Often)
- ☐ Touches others inappropriately (Occasionally or Often)
- ☐ Abuses alcohol/drugs (Occasionally or Often)
- ☐ Has unusual tics or mannerisms (Occasionally or Often)
- ☐ Poor peer relationships (Occasionally or Often)
- ☐ Nightmares (Occasionally or Often)
- ☐ Shows little or no emotion (Occasionally or Often)
- ☐ Afraid to be alone (Occasionally or Often)
- ☐ Difficulty concentrating/focusing (Occasionally or Often)
- ☐ Little sense of joy or happiness (Occasionally or Often)
- ☐ Talks about or has attempted suicide (Occasionally or Often)
- ☐ Change in eating habits (Occasionally or Often)
- ☐ Increased aggression (Occasionally or Often)
- ☐ Fascinated with fires or sets fires (Occasionally or Often)
- ☐ Wets bed or soils self (Occasionally or Often)
- ☐ Urinates in places other than bathroom (Occasionally or Often)
- ☐ Masturbates excessively (Occasionally or Often)
- ☐ Engages in risky behaviors (Occasionally or Often)
- ☐ Lies/steals (Occasionally or Often)
- ☐ Doesn't trust others (Occasionally or Often)
- ☐ Says doesn't like self or body (Occasionally or Often)
- ☐ Other: _____

SAGE HILL
COUNSELING

PATIENT'S RIGHTS IN PSYCHOTHERAPY

Right to privacy and confidentiality

There is a legal privilege in protecting the confidentiality of the information that you share with your therapist and exceptions to that protection. There are some situations when your therapist is permitted or required by law to disclose information without your consent or authorization. These situations are unusual in psychotherapy. If one of these situations arises, your therapist will make every effort to fully discuss it with you before taking any action and your therapist will try to limit the disclosure to what is necessary. These exceptions include:

Authorization

You give your therapist permission to share confidential information.

Safety

If you are to harm yourself, your therapist may be obligated to seek appropriate help for you, contact family members or others who can help provide protection, or notify other appropriate authorities. Also, if your therapist knows or suspects that a child, elderly person, or disabled person has been abused or neglected, the law requires that a report be filed with the appropriate government agency.

Legal proceedings

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by law. Your therapist cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information. However, if a patient files a complaint or lawsuit against their therapist, the therapist may disclose relevant information regarding that patient in order to defend themself.

Right to choose a therapist

You have the right to choose a therapist who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time. You also have a right to know the professional training and credentials of your therapist.

Right to raise questions about therapy

You have the right to ask questions about your treatment at anytime. Your feelings and feedback about the therapeutic process are always a primary concern and their discussion is often beneficial to therapy. Following are some examples of questions you may want to ask:

What are the benefits and risks of my treatment?
Are there alternative treatments?
How likely is my treatment to be successful?
If I am unhappy with my therapy or with you, what do I do about it?

Right to terminate therapy.

You can end therapy at any time. While psychotherapy can be extremely helpful, not everyone finds therapy successful, and on rare occasions, due to the nature of therapy, some problems are made worse.

SAGE HILL
COUNSELING

PATIENT'S PROTECTED HEALTH INFORMATION

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. If you have any questions about the information contained in this Notice, please contact your therapist.

Your therapist is required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with notice of their legal duties and privacy practices with respect to your health information. Your therapist is also required to abide by the terms of this Notice so long as it remains in effect. Your therapist reserves the right to change the terms of the Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by them. You may receive a copy of any revised notices from your therapist or a copy may be obtained online at sagehillcounseling.com.

Uses and Disclosures of Protected Health Information (PHI):

For Treatment

Your PHI may be used and disclosed by those involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. Your therapist will ask you to sign a Release of Information form before they consult with other health care professionals. They cannot disclose PHI to any other health care professional without your authorization.

For Payment

Your therapist may use and disclose PHI so they can receive payment for treatment and services provided to you. This will be done only with your written authorization. This includes filing for insurance benefits and processing claims. If it becomes necessary to use collection processes due to lack of payment, your therapist will disclose only the minimum amount of PHI necessary for purposes of collection.

For Health Care Options

Your therapist may use or disclose your PHI to support their business activities including, but not limited to, quality assessment activities, licensing, and credentialing. Your therapist may share your PHI with third parties that perform various business activities (i.e. accounting to billing services) provided they have a written contract with the business that requires it to safeguard the privacy of your PHI.

Required by Law

Under the law, your therapist must disclose your PHI to you upon request. In addition, they must disclose to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with requirements of the Privacy Rule.

Without Authorization

Applicable law and ethical standards permit disclosure of information about you without your authorization in a limited number of other situations. Types of uses and disclosures that may be made without your authorization are as follows:

- Required by Law or mandatory Government Agency audits or investigations
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Minors

If you are a minor, information regarding illegal or harmful acts may be disclosed to a parent or guardian.

Verbal Permission

Your therapist may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization

Uses and disclosures that are not specifically permitted by applicable law will be made only with your written authorization. You have the right to revoke your authorization any time by writing your therapist with your request.

Your Rights Regarding Your Protected Health Information (PHI):

You have the following rights regarding PHI. To exercise any of these rights, please submit your request in writing to your therapist.

Right of Access to Inspect and Copy

You have the right, which may be restricted only in exceptional circumstance, to inspect and copy PHI that may be used to make decisions about your care. Restrictions apply only in those situations where compelling evidence indicates that access would cause serious harm to you. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's record will not be accessible to you. Your therapist may share a reasonable, cost-based fee for copies.

Right to Amend

If you feel the PHI your thearpist has about you is incorrect or incomplete, you may ask your therapist to amend the information although they are not required to agree to the amendment.

Right to an Accounting of Disclosures

You may obtain an accounting of certain disclosures of PHI made by your therapist after June 16, 2014. This right applies to disclosures other than those already mentioned.

Right to Request Restrictions

You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. Your therapist is not required to agree to any restriction you request.

Right to Request Accounting of Disclosures

You have the right to request that your therapist communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of the Notice

You have the right to a paper copy of this Notice.

Questions and Complaints

If you desire further information about your privacy rights, or are concerned that your therapist has violated your privacy rights, you may contact them. You may also file written complaints with the Director, Office for Civil Rights or the U.S. Department of Health and Human Services. Your therapist will not retaliate against you if you file a complaint with the Director or your therapist.

Effective Date and Changes to this Notice

This Notice is effective January 1, 2015. Your therapist may change the terms of this Notice at any time. If your therapist changes this Notice, they will post the revised Notice on the website www.sagehillcounseling.com. You may also obtain any revised notice by contacting your therapist.

SAGE HILL
COUNSELING

PATIENT POLICIES

Location

6363 Poplar, Suite 404, Memphis, TN 38119

Scheduling

Appointments are generally made on a weekly basis. While we try to establish regular times for our patients, appointments are not automatically held open from week to week. It is your responsibility to reschedule with your therapist at the end of a session.

Missed Appointments/Cancellations

You will be charged for a missed appointment if you have failed to notify your therapist within 24 hours of your scheduled time (emergencies and illness accepted at your therapists discretion).

Payments

Unless other arrangements have been made, payments are to be made at each session. The fee is based on a clinical hour of 50 min. Checks are to be made payable to “Sage Hill Counseling.” If you choose to pay via credit/debit card there will be an additional $5.00 convenience fee. We do not accept cash. Fees may increase periodically, and thus the fees are subject to change with one week’s prior notification

Insurance/Third Party Billing

WE DO NOT file insurance claims. We are NOT paneled by any insurers. If your insurance provider or another third party will be covering the cost of your counseling, then you need to make arrangements with them to reimburse you directly. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to the insurance company. We are willing to fill out any part of the form that is necessary. (This may include additional fees and does not insure that they will reimburse you.)

Communication

You may leave a brief voice message regarding appointment and scheduling on your therapist’s confidential voicemail extension by calling 901-302-9575 or e-mail. Messages are checked on a regular basis and will be returned in a timely manner. Please limit your messages to appointments and scheduling. If you are in an emergency and cannot reach your therapist, please call one of the following numbers for help; General Emergencies, 911; or Crisis Hotline: 901-274-7477.

SAGE HILL
COUNSELING

PARENTAL/GUARDIAN MINOR CONSENT

Collaborative Approach

The involvement of children and adolescents in therapy can be highly beneficial to their overall personal development. Sometimes, it is best to see children with parents/guardians and other appropriate family members. Other times, it is best to see children alone. Often a mixture of the two is required for the child to receive the full benefits of the therapy. Together, parents/guardian, the child, and the therapist, assess which approach is in the best interest for the child. This can change throughout the course of therapy.

Therapist's Limited Role

The therapist's role is that of an advocate for the overall emotional and psychological development of the child. Because of the therapist's role as child's advocate, it is in the best interest of the child that the therapist not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist. If requested, the child's therapist can provide recommendations for these services.

Limited Confidentiality

Confidentiality is an essential part of any therapeutic process. The issues of patient confidentiality and parental/guardian collaboration are critical in treating children. When children are seen with parents/guardians, the content discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, and at the same time, that parents have access to therapeutically necessary information. This agreement must have the understanding and approval of the child and parent/guardian. The following circumstances override the general policy that children are entitled to privacy while parents/guardians have a legal right to information.

Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible. Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child.

Any evaluation, treatment, or reports ordered by or done for submission to a third party, such as an insurance provider, court, or a school, is not entirely confidential and will be shared with that entity with your specific written authorization. Please also note that the therapist does not have control over information once it is released to a third party.

Providing Consent

When a minor has parents who are divorced, a copy of the permanent parenting plan must be provided. The parenting plan allocates which parent has final decision making authority in the area of mental health care and other areas. When parents have joint decision-making rights regarding their child's mental health care, written consent from both parents for the child is required. Even in cases where one parent has final decision-making authority, it is usually in the child's best interest that consent from both parents is obtained.

SAGE HILL
COUNSELING

PARENTAL/GUARDIAN MINOR CONSENT

Now that the various aspects surrounding confidentiality and consent have been stated, the specific agreement between you and your child/children follows:

I, (parent/guardian)_____ agree that (clients name)_____ should have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist. At the same time, except under unusual circumstances, I understand that I have a legal right to obtain this information. To increase the effectiveness of the therapy, I agree to the following:

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of the sessions. If my child prefers/ children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/ children have been abused or is/ are a clear danger to self or others, the therapist will normally tell me only the following:

- Whether sessions are attended
- Whether my child is/ children are generally participating or not
- Whether progress is generally being made or not

The normal procedure for discussing issues that are in my child's/ children's therapy will be joint sessions including my child/ children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/ children present.

Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/ children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/ children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

I understand that my therapist is limited in their scope of practice and does not provide clinical opinions or commentary as to legal issues regarding a child, parent/guardian, or family.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Therapist Date

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RECEIPT OF INFORMATION

I acknowledge that my therapist has given me a copy, reviewed, and discussed with me the following information:

_____ Patients Rights in Psychotherapy

_____ Patient Protected Health Information

_____ Patient Policies

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Therapist Date

SAGE HILL
COUNSELING

CREDIT CARD AUTHORIZATION FORM

Credit Card Policy:

Sage Hill Memphis requires a credit card on file to be used only for missed appointments and late cancellation fees. In addition, you can choose to authorize your therapist to charge your card automatically for sessions that you attend. Because there is an additional banking fee associated with using a credit or debit card, a $5.00 per transaction fee will be charged should you choose this option.

Type of Credit Card: (please circle)

Visa MasterCard Discover AM EX Other _____

Name on Card: _____

Credit Card Number: _____

Billing Zip Code: _____ Expiration Date: _____ CCV Number: _____

Authorization:

_____ The undersigned card member consents and permits Sage Hill Memphis, LLC, to charge to my credit account fees for late cancellations or missed appointments.

_____ Recurring Charge Authorization: The undersigned card member consents and permits Sage Hill Memphis LLC, to charge the standard rate for counseling sessions. I understand there will be an additional $5.00 fee for this convenience. I release my therapist, as applicable, from any and all claims arising from the use of this service. I understand and agree that Sage Hill Memphis LLC, may continue to charge such amounts to my Credit Card account until receiving notification from me that I have terminated this consent and permission at which time Sage Hill Memphis, LLC, shall cease charging any such amounts to my Credit Card account.

_____ _____
Signature Date

_____ _____
Email Address Phone Number