Pinnacle Counseling
feel better, live better

5500 W Pinnacle Point Drive, Suite 203/204 Rogers, Arkansas 72758
Phone: 479-268-4142 Fax: 888-732-7108

CLIENT CONSENT FORM / PRIVACY NOTICE

The Department of Health and Human Services has established a “Privacy Rule” (HIPAA) to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient’s/client’s consent for uses and disclosures of health information about the client to carry out treatment, payment, or health care operations.

As our client, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. Exceptions to privacy include our concern that you may seriously harm yourself or others, or abuse or neglect of children or elderly. Also, upon your completion of a Release of Information form, we will forward records with your consent.

We also want you to know that we support your full access to your personal medical records. We will also furnish the required Personal Health Information to your insurance company in order to acquire payment reimbursement for services to you.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any questions or objections to this form, please ask to speak with our HIPAA Compliance Officer.

Child’s Name: _____
(Please Print)

Parent/Guardian_____ Date_____

Pinnacle Counseling

feel better, live better

FINANCIAL AGREEMENT

We will be glad to check your insurance benefits and file claims as a courtesy to you. It is your responsibility to provide us with accurate insurance coverage information, including any changes to the policy coverage.

By signing below, you are assigning insurance payments to Pinnacle Counseling. Also, you agree to be ultimately responsible for the amount due for services rendered, in the event that insurance denies your claims for any reason.

All payments are due at the time of service. We will provide you with an estimate of your expected charges such as co-pay, or the amount due towards deductible. Your portion is due in full at each visit. We accept cash, credit cards and checks.

As a valued client, we will hold a scheduled appointment time for you. **We reserve the right to charge for appointments not cancelled in advance**. In the event that you need to cancel an appointment, please do so with at least **24 hours' notice**, so that the spot may be released to others. Emergency situations will be considered.

Please be advised:
Most insurance policies do pay for counseling for anxiety and depression or adjustment disorders. By indicating your participation with insurance benefits, you are agreeing to the medical necessity and that you are being treated for concerns affecting your mental health.

This consent becomes effective on _____.

Client Signature_____ Date_____

Parent/Guardian_____ Date_____

Pinnacle Counseling

feel better, live better

CHILD QUESTIONNAIRE

Date: _____ Completed By:_____ Relationship:_____

Child's Name: _____ Preferred Name:_____
First Middle Last

Sex (M) ____ (F) ____ DOB _____/_____/_____

Address _____

Mother's Name: _____ Phone # _____

Mother's Address:_____

Mother's Place of Employment _____

Father's Name: _____ Phone # _____

Father's Address: _____

Father's Place of Employment _____

Who Lives in the Home_____

Your Reasons For Seeking Help?

What are your main concerns at the present time? _____

_____

_____

Please discuss your ideas about the current problem. Did a specific event lead to your wanting help now? ____ Yes ____ No If yes, what and when? _____

_____

_____

Childhood

Stressors when growing up?_____

Strong fears growing up? ____ Yes ____ No

If yes, please explain: _____

Please list child's hobbies, recreational activities and interests: _____

_____

_____

Please list any complications in pregnancy or delivery with this child:

_____

_____

Please list any problems this child had during the first weeks after he/she was born:

_____

_____

Please list any developmental delays this child has (i.e. walking, talking, language, toilet training, etc.)

_____

_____

What type(s) of discipline do you use most frequently with your child? _____

_____

How does this child relate to his/her peers? _____

_____

Learning Assessment:

Is there a history of learning disabilities? ____ Yes ____ No

Any special education or therapy provided at school?_____

Educational testing or assessments completed?_____

Grade in school?_____

Does this child have any problems in school? _____

_____

Spiritual Assessment:

Are there cultural and/or religious concerns that you want considered in treatment? ___ Yes ___ No

Please explain:_____

Child's Medical History:

Family Physician: _____

Name of Clinic:_____

Other Physicians: _____

List frequent minor childhood illnesses: _____

___YES ___NO Any other medical problems? _____

_____

___YES ___NO Has your child ever been hospitalized? If yes, where and for what problem(s)?

_____

When did the child last see your family physician?_____

What was the reason for that visit? _____

When did child last have a complete physical exam?_____

Child's Weight _____ Recent weight loss or gain _____ How much? _____

Child's sleeping Pattern:

Average number of hours per night? _____ Is child receiving enough sleep? _____

Reports nightmares?_____ Does the child have problems with bed wetting or soiling?_____

Medications Currently Being Taken By Child:

Brand Name	**Dosage**	**How often taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Nutritional Needs:

Does child use any of the following? Please indicate the amount of his/her present use:

____ Coffee ____ Tea ____ Nicotine ____ Soft drinks with caffeine ____ Alcohol

Child's Legal Issues:

To your knowledge, has child been a victim of a crime, abuse or neglect? ____ Yes ____ No

Has child been involved in any legal issues? ____ Yes ____ No

If yes, please explain:_____

_____

Psychiatry History:

Is your child currently or recently been seeing a psychologist, social worker, psychiatrist, counselor or family doctor for emotional reasons?_____

Has your child been hospitalized for psychiatric or emotional reasons? _____

If yes, where and when? _____

Family history of mental illness? _____

Please list therapeutic resources (community mental health centers, counseling clinics, therapeutic day treatment programs) that this child has used: (including dates)

_____

_____

If this child is effected by the use of substances (drugs or alcohol), either by self or family members(s), please describe. _____

_____

_____

Is there anything significant this form did not ask which you would like to share?

_____

_____

_____

_____

_____

_____

_____

How did you learn about us?_____

COMMUNICATION:

	Adult	Child
Voice Mail #	_____	_____
Text Message #	_____	_____
Email Address	_____	_____

Emergency Contact_____

Name **Relationship** **Phone #**

Pinnacle Counseling uses a variety of methods to reach clients including voice, phone message, text, and email.

Please be specific in writing if any method is unacceptable to you.

REVIEW OF OUR SERVICES:

We strive to provide the highest quality of services. We may periodically follow up in one of the above methods to get your feedback.

SOCIAL NETWORKS:

We feel it is important for counselors and clients to connect. As an agency, we are active on Facebook. We also publish a blog accessible via our website: www.pinnaclecounselingNWA.com. The blog contains useful information on mental health, family wellness, and personal change.

www.facebook.com/PinnacleCounseling

Client Signature_____ Date_____

Parent/Guardian_____ Date_____