CLIENT INTAKE FORM

CLIENT INFORMATION

NAME ____________________

ADDRESS ____________________ **CITY** ____________ **STATE** ______ **ZIP** ________

TELEPHONE NUMBER **Home** ____________ **Bus.** ____________ **Cell** ____________

E-MAIL ADDRESS ____________________

SOCIAL SECURITY NUMBER ____________________

BIRTHDATE ____________________ **MALE** _____ **FEMALE** _____

REFERRED BY ____________________

PRIMARY CARE PHYSICIAN (NAME, PHONE NUMBER, AND ADDRESS)

____

RESPONSIBLE PARTY (if applicable)

PARENT/GUARDIAN ____________________

ADDRESS ____________________

TELEPHONE NUMBER **Home** ____________ **Bus. or Cell** ____________

SOCIAL SECURITY NUMBER ____________________

INSURANCE INFORMATION

MARITAL STATUS **Single** ________ **Married** ________ **Divorced** ________

EMPLOYMENT STATUS **Employed** ________ **Student** ________

NAME OF INSURED ____________________

BIRTHDATE OF INSURED ____________________

INSURED ID# ____________________ **Group #** ____________

RELATION TO INSURED **Self** ________ **Spouse** ________ **Child** ________

NAME OF EMPLOYER ____________________ **PHONE #** ____________

INSURANCE COMPANY NAME ____________________ **PHONE #** ____________

INSURANCE COMPANY ADDRESS ____________________

I authorize the release of medical information necessary to process an insurance claim. I authorize payment of benefits to Clinical Counseling Associates, Inc. for services rendered. I understand that I am responsible for any charges not covered by my insurance plan. I understand that a statement of account will be sent monthly to keep me apprised of my account status and what amount I am responsible for. I understand that if I have any questions regarding my account, I may call the office for assistance.

SIGNED ____________________ **DATE** ____________________

Laura K. Probasco, LCSW
1129B W. Kansas, Liberty, Missouri 64068
Telephone Number: (816) 781-8550

Fax Number: (816) 792-3219

FEE AGREEMENT

PAYMENT POLICY

Clients should keep their appointment or call at least 24 hours in advance to cancel visits. If not, the client will be charged for the visit at 50% of the regular fee. The second time this occurs, you will be charged the full regular fee. (Insurance can not be billed for a no show charge) The usual fee for professional services is $90 for the initial visit and $80 per 50-minute session thereafter. Payment will be due at the time service is rendered. We accept cash, check, credit card or debit card. ____ Please initial

If you wish, as a courtesy we will file insurance within five business days of your visit, however, insurance coverage is not a guarantee for payment. It is the client's responsibility to check with the insurance company regarding coverage and copayments. If the client provides documentation of coverage by a managed care plan with whom we have a contract, we will accept copayment of charges. ____ Please initial

If a balance is on your account, a statement will be provided monthly. If a balance remains for more than 60 days, your account will be assessed a $10 service charge. This charge will continue each month until your account is paid in full. ______ Please initial

There will be a $30 charge for any check returned for insufficient funds, closed account, or for any other reason. ____ Please initial

A treatment plan will be provided for $25. This will not be submitted to insurance. ______ Please initial

School visits and observations are available for $75 per visit, plus mileage. We may not be able to submit this to insurance. ______ Please initial

Phone consultations with schools (teachers, administrators, counselors, etc.), doctor's office or daycare providers can be provided for a fee of $25 for every 15 minutes. This will not be submitted to insurance. _____ Please initial

Letters to schools, doctors, counselors, etc. can be provided for a fee of $25. This will not be submitted to insurance. ______ Please initial

STATEMENT OF UNDERSTANDING

I have read the above payment policy and agree to abide by these policies. I understand that I am responsible for 100% of charges for services provided. I understand I am responsible to pay full fees for services at the time of each session. I understand that I am responsible for contacting my insurance company to confirm coverage and/or copayments. I understand that I must provide documentation of insurance coverage before the provider will agree to accept copayments. ____ Please initial

I hereby authorize the release of medical information necessary to process insurance claims. I authorize payment of benefits directly to Clinical Counseling Associates, Inc. for services rendered. If my insurance company sends me checks for payment of sessions, I agree to notify Clinical Counseling Associates, Inc. and sign over any checks to CCA as payment for any outstanding charges on my account. I understand that I am responsible for any charges on my account. I understand that a statement will be sent monthly to keep me informed of my account status. I understand that if I have any questions regarding my account, I may call the office for assistance. Please date and sign. Thank you.

Date ____________________________ Signature _________________________________

CLINICAL COUNSELING ASSOCIATES, INC.
LAURA K. PROBASCO, LCSW
1129B W. Kansas St.
Liberty, Missouri 64068
Phone: (816) 781-8550
Fax: (816) 792-3219
e-mail: cca144@sbcglobal.net

Please read the following information about our office policies. If you have any questions, please do not hesitate to ask.

COUNSELING SESSIONS AND CLIENT RIGHTS AND RESPONSIBILITIES

All counseling sessions are by appointment only. Sessions last approximately 50 minutes once a week. Sometimes it is necessary to meet more often initially to handle crisis situations. The frequency of counseling sessions will gradually decrease as progress is made in counseling. This will also depend on your insurance policy.

All clients will be treated by a licensed mental health professional with respect for their individual needs, preferences, feelings, and requirements. An individual treatment plan will be developed for each client. The client has the right to participate with the therapist in treatment planning decisions. If transfer or discharge of the patient from treatment becomes necessary, clients will be given the reasons and plan, as well as reasonable advance notice.

All clients are responsible for providing the therapist with all needed information to allow them to provide appropriate care, as well as being open and honest with their therapist. Clients should ask questions so that they understand the care and instructions they are given. They should actively participate in their own treatment and carry out therapeutic homework assignments.

CONFIDENTIALITY

Matters discussed with your therapist are protected by laws insuring your right to privacy. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then, only to the extent you authorize. Your treatment record and related financial records are kept in a file cabinet in an office, or other area not accessible to the public. Records will not be copies or otherwise made available to others, except as noted below, without a signed authorization to release information.

Those cases where information may be disclosed without your consent are:
1) Information required by insurance company to process a claim or obtain further clinical visits.
2) Where child abuse is known or suspected. (Reporting is required by State Law)
3) When the abuse of an elderly or dependent person is known or suspected. (Reporting is required by State Law)

4) If there is a situation that is potentially life threatening.
5) When ordered by the Court.
6) In some cases, details of your treatment may be discussed with a clinical supervisor or another clinician for the purpose of consultation. When this is done, no identifying information will be included (i.e., the client is anonymous)

Please initial that you have read and understand these policies. _______

Clinical Counseling Associates Inc.
Laura K. Probasco
1129B W. Kansas
Liberty, Missouri 64068
(816) 781-8550
email: LauraProbasco@hotmail.com

Developmental History

Date: ______________________

Child's name: ___________________________________Birth Date: ___________________

Filled out by: ____________________________________ Relationship to child: _____________

It is very helpful for us to have information in the following areas. Please fill out this form as completely as you can.

Family members:

Name	Relationship	Birth Date
______________________	_____________________	_____________________
______________________	_____________________	_____________________
______________________	_____________________	_____________________
______________________	_____________________	_____________________
______________________	_____________________	_____________________
______________________	_____________________	_____________________
______________________	_____________________	_____________________

Has the child received counseling and/or play therapy before? Yes No If so, please list where and dates of services:

____

Pregnancy and Birth:

1. Is your child adopted? Yes No Has the child been told he/she was adopted? Yes No

2. Was the pregnancy planned? Planned Unplanned

3. How was the mother's health during pregnancy?

4. Was there anything unusual about the birth? (premature, length of labor, complications etc.)

____

____

Early Childhood:

During the first six months, did the baby or mother have any problems in the following areas? (please describe)

1. Depression:

2. Breast Feeding:

3. Formula:

4. Allergies:

5. Colic:

6. Sleeping:

After the first six months, were there any problems in the following areas? (please describe)

1. Eating difficulties:

2. Sleeping difficulties:

3. Does the child have their own bed? Yes No If not, who does he/she sleep with?

____

4. Does the child wet the bed? Yes No

5. How many hours a night does the child sleep? ____________________________

Temperament (please rate the following behaviors)

1. Activity Level: under active ___ average activity level ___ overactive ____

2. Adaptability: adapted easily to change ____ resisted change ____

3. Intensity: average ____ feelings were often intense ____

4. Mood: often happy _____ average range of moods ____ often dissatisfied or irritable ___

Physical:

1. Does the child have speech difficulties (stuttering, delays, etc.) Yes No

2. Was the child early ____ average _____ late _____ sitting?

3. Was the child early ____ average _____ late _____ standing?

4. Was the child early ____ average _____ late _____ walking?

5. Was the toilet training easy to complete? Yes No

6. Does the child still have soiling or wetting problems? Yes No

7. Any vision or hearing problems with the child? Yes No

Health:

1. Any unusual medical problems? Yes No If yes, please explain:

____

2. Has the child been hospitalized frequently? Yes No If yes, please explain:

____

3. Is the child on any medications now? Yes No If yes, please explain:

____

4. Are immunizations up to date? Yes No

5. Please list any doctors and/or professionals contacted:

____

Child Care

1. Does someone other than mother/father/guardian have more than occasional responsibility for the child? Yes No If yes, who? ________________________________

2. Is the child in day care? Yes No

3. Who disciplines the child?

4. What methods are used?

5. Do parent(s) agree on discipline method and share responsibilities?

6. How effective has this been?

Social/School

1. Does your child have many friends? None Few Many

2. What age group does the child get along with best? ___________________________

3. Has the family moved frequently? Yes No

4. Has the child had any problems in school? (please describe)

Academic (learning problems, special classes):

Behavioral:

1. Has the child had any legal or juvenile court problems? Yes No

2. Has the child ever had any problems with alcohol or drugs? Yes No

Other Concerns: