25511 Budde Rd., Caroline Bldg. 1002
Spring/The Woodlands, TX 77380
Phone: 281-719-5539/ 281-748-0233
Email: fyi1@sbcglobal.net
http://familyandyouthinstitute.com

CLIENT NAME:_________________________: DOB: _______________APPT. DATE: ____________ TIME:________________
THERAPIST NAME:________________________________ THERAPIST SIGNATURE:______________________________

FAMILY & YOUTH INSTITUTE

Counseling and Psychotherapy - Client Services Agreement & Disclosure

Welcome to the practice of Family & Youth Institute. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information. We can discuss any questions you have. *When you sign this document, it will also represent an agreement between us.* You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claim made under your policy; or if you have not satisfied any financial obligations you have incurred. _________ **(*Initial and date)***

Counseling and Psychotherapy Services

The decision to begin counseling is one, which may have important consequences for the rest of your life. Research has shown that when individuals enter this type of treatment with a good understanding of what they are about to undertake, they are likely to achieve good results. The therapy process calls for a very active effort on your part during and in between sessions in order for it to be successful.

Psychotherapy varies depending on the personalities of the counselor, you the client, and the particular challenges you are experiencing. It can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience a variety of uncomfortable feelings. The benefits from therapy often lead to better relationships, solutions to specific challenges, and significant reductions in feelings of distress. There are no guarantees of what you will experience or the subsequent outcome. Your input and comfort level are important in deciding whether you wish to continue in therapy. Therapy involves a large commitment of time, money, and energy, so it is helpful to be careful and deliberate about choosing a therapist. If you have questions about procedures, it should be discussed whenever they arise. If your doubts persist, we will be happy to discuss it and/or refer to another mental health professional for a second opinion. ______________ **(*Initial and Date)***

1. **Confidentiality** – The law protects the privacy of all communications between a client and a counselor. In most situations, information about your treatment can only be released to others if you sign a written authorization form that meets HIPAA regulations. It is very important that those seeking counseling carefully read and understand the following limits of confidentiality. What you reveal in our office is kept strictly confidential with the following exceptions:
   a. State law requires reporting any known or suspected cases of child, elder abuse or neglect, including sexual abuse to the Texas Department of Human Resources. To protect others from harm I may have to reveal information about a client's treatment.
   b. State law requires reporting any known or suspected cases of child, elder abuse or neglect, including sexual abuse to the Texas Department of Human Resources. To protect others from harm I may have to reveal information about a client's treatment. Once such a report is filed, I may be required to provide additional information.
   c. If I determine the probability a client will inflict imminent physical harm on him/herself or another, I am required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization for the client in this instance.

d. Professional misconduct by a healthcare professional must be reported. In cases in which a professional or legal disciplinary meeting is being held regarding the healthcare professional's actions, related records may be released to substantiate disciplinary concerns. Insurance companies require certain information before they will pay either your therapist or the insured. This information usually includes but is not limited to: diagnosis, prognosis, and an estimate of the amount of time your therapist expects to treat you.

e. In the event that a client fails to honor, after reasonable efforts to collect his/her debt, Family & Youth Institute, LLC may place the account in the hands of an agency or attorney for collection or legal action. This will necessitate the release of pertinent demographic and accounting information. NO THERAPEUTIC INFORMATION WILL BE RELEASED.

f. During the process of this business there will be times when we will share your information with the professional staff for clinical and administrative purposes. All of the staff members have been trained about protecting your privacy. They are under legal obligation to abide by this confidentiality and have agreed not to release any information outside of the practice without formal permission. _______**(Initial and date)**

g. Although you will probably meet with only one counselor, you are receiving services from the office of FYI. Consequently, you will have a file in our office to which all therapists and staff will have necessary access. We utilize Dropbox, an online data storage service to store client records. You may view their security overview and privacy policy here https://www.dropbox.com/security. Therapists who access Dropbox from their personal computers are required to have their access password protected. FYI counselors and staff consult with each other about our work. In most cases, we need to share protected information within FYI for both clinical and administrative purposes, such as scheduling, records management, and quality assurance. _______**(Initial and date)**

h. The situations below require a written consent or authorization before I am permitted to disclose your information.

   i. The counselor-client privilege law protects your client information. Please consult your attorney or determine whether the court would be likely to order me to disclose information. I cannot provide your information without your or a legal representative's written authorization. However, if the Court subpoenas your records, I am legally bound to deliver them without your consent.

   ii. I may need to consult with another professional (i.e. your physician) about your evaluation or treatment. If any of these situations arise, I will make every effort to fully discuss it with you before taking action, and I will limit my disclosure to what is necessary.

____ ***(sign and date) I/We have read and fully understand the limits of my/our confidentiality. I/We have had a chance to ask my/our counselor for clarification regarding the limits of confidentiality.***

2. The Therapeutic Relationship -- It is important that you understand that it is a professional relationship. Dual relationships are not allowed and may be harmful to clients as they may prevent therapeutic objectivity. While I appreciate your consideration, my professional duty to you precludes my ability to attend any of your personal events or accept any gifts. Your decision to retain me for services or to refer others to me for services is sufficient appreciation for the work that I do. Sexual contact between a client and a counselor is not part of any recognized therapy and is *illegal* in Texas. _________ **(*Initial and date*)**

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3. **Client Rights** - HIPAA provides you with rights regarding your records and the ability to disclose the information. These rights include requesting that I amend your record, putting restrictions on information from your professional record disclosed to others; requesting an accounting of most disclosures of protected health information you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this agreement with privacy policies and procedures. HIPAA also affords you the right that I keep health information about you protected. This is your clinical record which includes information about your reasons for seeking therapy, a description of issue(s) which impact your life, a diagnosis, goals set for treatment and progress, medical social treatment history, any past treatment record I receive from other providers, reports of any professional consultations, your billing records, and any reports sent to anyone, including your insurance carrier. __________***(Initial and date)***

4. **Professional Fees** – Fees charged for service at FYI may vary based on therapist credentialing level (full licensure versus intern licensure) and CPT service code (length and type of appointment). A schedule of fees is available for review upon request. **Generally, billing rates for fully licensed therapists (LMFTs, LPCs, LCDCs, and LCSWs) will be higher than those for licensed interns (LPC-Interns, LCSW-Interns, LMT-Associates, and LCDC-Interns).** Because it is our mission to make counseling services affordable for everyone, Our LPC Interns & LMFT Associates may provide private pay services at a reduced rate. Student interns may offer pro-bono sessions for qualified clients. Most licensed therapists and interns may accept sliding scale pay for qualified clients with **$35 to $60 per 45 minutes** being the minimum payment accepted. Each therapist sets his/her sliding scale minimum. Interns do not accept insurance but may accept sliding scale. Licensed therapists accept some private insurance and some Medicaid. Other services, including non-emergency phone calls over ten (10) minutes, generating reports, written **communication** requested by clients, consulting with other agencies and professionals at your request, and the time spent performing any other services you may request may be charged to you.

   Late Cancellation Fees - Fees may be collected when services are rendered. Appointment **cancellation with less than a 24 hour notice may result** in a fee equal to $80 and may be collected at your next appointment or may be charged to the credit card or debit card using information on file. . After two no-shows/late cancellations, client may be asked to pre-pay before services are rendered. Clients who have prepaid agree to have the entire fee deducted from their pre-payment in cases of no shows and late cancellations. ________ **(*Initial /date)***

5. **Insurance-** Clients utilizing insurance will be expected to submit co-pays the day of the visit. We also work with out-of-network clients who are covered by an insurance we do not accept. **These clients pay us at the time of the visit. Their fee will be the full cash pay cost of our services unless they meet qualifications for sliding scale AND they are working with a therapist who accepts payment on a sliding scale. We will either provide a receipt for services so the client can file with the insurance company for reimbursement, or we may, in some cases, file for clients. *Interns are not credentialed to accept insurance***. Therefore, we do not file insurance for their personal clients. Unless specifically disallowed by the insurance company, insurance may be filed for intern services when interns assist a credentialed therapist by seeing clients in conjunction with and directly under the supervision of the credentialed therapist who is their licensed supervisor. Note: Some mental health conditions and diagnoses are not reimbursable through insurance. Likewise, most insurance companies do not cover marriage or family counseling. Clients are expected to cover these costs personally. ___________ ***(Initial and date)***

6. **Payment of all services rendered regardless of whether insurance pays or not.** For your convenience, we accept cash, checks, and credit cards. If payment is not made prior to the third session, your session may be

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cancelled and may not be rescheduled until payment is received. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. A $25 monthly billing charge will apply to unpaid accounts. A $45.00 fee will be charged for returned checks. _________***(Initial and date)***

7. **Your insurance company does not guarantee payment of benefits.** They usually require clients to pay a standard amount before reimbursement is allowed (a deductible), and then they pay a percentage of the fee. We advise you to contact your insurance company to determine what your deductible is and what percentage of the fee they pay. The client remains responsible for *payment in full*, including any portion not reimbursed by insurance. Though FYI does typically check insurance benefits and acquire preauthorization for covered sessions, the client remains the person primarily responsible for verifying insurance coverage benefits and acquiring authorization for coverage. By signing this Agreement, you agree FYI can provide requested information to your carrier. *Please be aware we have no control over the confidentiality procedure of third parties once the clinical information leaves our office.* Typically, third-party payers generate computer records with this information. _____***(Initial/date)***

8. **Cancellation of Sessions- In consideration of all parties involved. WE REQUIRE AT LEAST 24 HOURS ADVANCED NOTICE FOR CANCELLED APPOINTMENTS.** This gives us time to contact other clients who wish to be seen. If you are able to cancel 24 hours in advance **and** reschedule a new appointment during the same week, you will not be charged for the appointment not kept. **In the event you cannot reschedule within that same week you will be financially responsible for the cancelled appointment. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. NOTE: A FEE OF $80 MAY BE CHARGED TO YOUR CREDIT/DEBIT CARD ON FILE WITH US FOR ANY MISSED APPOINTMENTS THAT ARE NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME. If FYI does not have said information on file, payment will be collected at the time of your next visit. _________ (*Initial and date*)**

9. **Court Proceedings** – If you ever become involved in a divorce or custody dispute or other legal proceedings, you need to understand and agree that I ***do not*** provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on three reasons: (1) My statements may be seen as biased in your favor because we have a therapy relationship; (2) the testimony may affect our therapeutic relationship, and (3) FYI therapists may not be trained as forensic experts. In the event, that I am required to appear in court for any reason, there will be a charge of $1,000.00 per day, a minimum of $600 for a half day or less. This fee must be paid before the court date by cash, credit card or debit card. This fee will be applicable in the event of court date postponements, regardless of negotiated settlements in or out of court. Court Preparation time is $125.00 per hour. ______________***(Initial & date)***

10. **Emergencies** -- Our telephones are answered by confidential voice mail or our scheduling clerk when we are in session or out of the office**. In some cases, therapists have calls forwarded to their private numbers.** We will make every effort to return calls on the day received, with the exception of weekends and holidays. If you are unable to reach us and feel you cannot wait for the return call, contact your family physician or go to the nearest emergency room. If we are unavailable for an extended time, we will provide the name of a colleague _______***(Initial & date)***

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11. **Technology Use** -- FYI may use text and/or computer automated systems to remind clients of appointments. FYI makes every effort to ensure client PHI (protected health information) and PI (personal information) are not revealed when using technology. Email messages from FYI therapist contractors are to be encrypted. Texts should have no client identifying information in them. This includes, but is not limited to, client name, address, phone number, FYI client account number, information alluding to a client and therapist relationship, and/or any other information that may identify the client or the nature of the client's business with FYI. FYI policies prohibit therapist contractors from using email and text as a form of therapeutic intervention and or conversation. FYI also maintains a policy that personal phones used for client business have a screen lock to prevent unauthorized viewing of client content on the phone. When client phone numbers are stored in personal phones, information (including but not limited to client names and FYI account numbers) that may allow unauthorized persons to identify the client should not be linked to the client's contact information. Other persons (including but not limited to, children, family members, acquaintances, and/or friends) should not have access to use of the phone that contains any PHI, PI, or any HIPPA covered information on it. On a limited basis and strict compliance with HIPPA guidelines, FYI may offer the option for phone sessions and/or computer video sessions for clients who are unable to schedule regular appointments in the office. FYI does require the intake session(s) to be held in person and does require face-to-face sessions in the office a minimum or each six (6) weeks. Confidentiality is maintained where possible, but clients using technology options are advised there may be occasions when outside forces may breach security systems in place. _______***(Initial & date)***

12. **Counseling VIA Technology** - Technology-assisted distance counseling for individuals, couples, and groups involves the use of the telephone or the computer. Tele counseling involves synchronous distance interaction among counselors and clients using one-to-one or conferencing features of the telephone to communicate. Video based individual Internet counseling involves synchronous distance interaction between counselor and client using what is seen and heard via video to communicate. To utilize technology for therapy, the client must meet the following guidelines:
    a. Be an established client with intake paperwork, payment information, credit or debit card information with permission to charge, and an emergency contact face sheet on file with FYI.
    b. Be prepared to definitively identify himself/herself as being the person to whom the therapist is speaking. This may include providing unique information such as social security number, predetermined code words, address, and/or other identifying information.
    c. Have a release of information for an emergency contact for a person at or with access to the location from which the client calls.
    d. Assume responsibility for securing a location that is confidential.
    e. Understand when communicating via technology, confidentiality cannot always be guaranteed.
    f. By engaging in counseling via technology, client acknowledges that risk and holds FYI harmless.
    g. Be domiciled (primary residence) in the state of Texas or be located on a US military base if out of the State of Texas to receive counseling services from FYI therapist contractors. Therapists are licensed to practice only in Texas.
    h. Agree to an alternate form of communication in case technology fails during the counseling session. If counseling cannot be resumed, client will still be charged for the session. If technology fails less than 30 minutes into a counseling session and communication cannot be reestablished, client can reschedule at no charge for the remainder of the missed session.
    i. Remember when visual cues (video) are unavailable, misunderstandings can occur.
    j. Your technology based sessions are not recorded or preserved in any way by FYI. Your counselor will take notes (as directed by law). __________ ***(Initial & date)***

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13. **Facebook and Social Media** - Social media, including but not limited to Facebook and Twitter, may be used by therapists in this practice as tools for marketing services and disseminating information about themselves and the services they offer. Social media of any kind are not secure in terms of privacy and confidentiality, so the FYI policy regarding the use of social media includes the following:
    a. We do not provide therapy via social media.
    b. Ethical codes prohibit therapists from friending, following, or otherwise interacting with clients via social media.
    c. Therapist contractors will not acknowledge or return private messages delivered via social media.
    d. Therapist contractors will not acknowledge or respond to client emergencies delivered via social media.
    e. If you have an emergency do not contact your therapist via social media. Instead call the FYI office, go to the emergency room nearest you and/or call 911.
    f. You may use social media to reveal your own identity as a client of FYI, but you may not reveal the identity of another client. Doing so would be a breach of confidentiality, and FYI would take all available steps to protect the revealed client's rights, including blocking the offending client from accessing our social media and referring the offending client to another practice. _________ ***(Initial & date)***

14. **Therapist/Supervisor Scope of Competence** – I understand FYI therapist contractors maintain and will provide upon request detailed education and licensure information. I have been informed of my therapist's scope of competence, education, and licensure. ____________***(Initial & date)***

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FAMILY & YOUTH INSTITUTE LLC

Counseling and Psychotherapy - Client Services Agreement & Disclosure

SIGNATURE PAGE

Your signature below indicates you have read and fully understate the Family & Youth Institute, LLC Counseling and Psychotherapy - Client Services Agreement & Disclosure and agree to its terms. It also serves as an acknowledgement that the HIPPA privacy notice described above was made available to you.

____
Print Client Name ***Date***

____
Client Signature ***Date***

____
Signature of parent or guardian required for clients less than 18 years old. ***Date***

*****It is requested that parent or guardian AND client Age 17 sign the documents*****

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Consent To Treat

In order for minor children to receive psychological services, it is necessary for the parent or legal guardian to grant permission for such services to occur.
Names and date of birth of child(ren) to receive psychological services:

Name____ Date of Birth____/_____/____
Name____ Date of Birth____/_____/____
Name ____ Date of Birth____/_____/____
Relationship to child(ren) of person requesting services: ___Parent ___Stepparent ___Guardian
___Grandparent ___Other: Explain:____

Are you the legal parent or custodian to above-named children? Yes____ No____

If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you will be asked to provide a copy of the court order which names you the legal custodian of the above children. We must have the entire document and must be able to verify your right to consent independently to mental health care.
I have provided/will provide proof, by court documents, that I have the legal right to request counseling or psychotherapeutic treatment for the above minor. Yes___ No___ N/A_____

If the answer to any of the above questions is "No," counseling services cannot be provided to the above named child(ren) until a copy of the court order naming you the legal custodian is provided to this office and/or a signed FYI Consent to Treat form is received from both parents.
I acknowledge that:

- *Both natural parents, even though divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).*
- *This treatment may also include referral to other appropriate State, Private, and/or County agencies for further counseling.*

I ________________________, hereby give my consent for ___________________________to receive counseling or psychotherapy by __________________________ of the Family &Youth Institute, LLC in providing counseling services to the child(ren) named above. These services may include: ( ) Clinical Services, ( ) Psychological Testing, ( ) Counseling, ( ) Psycho-education, ( ) Play Therapy and/or ( ) other services, explain:_________________.

____ Date__/___/____
Name of Client Signature
____ Date: __/___/____
Parent/Guardian Signature if client is a minor

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CLIENT NAME:________________________: DOB: ______________APPT. DATE: ____________ TIME:_______________
THERAPIST NAME:________________________________ THERAPIST SIGNATURE:______________________________

Credit/Debit Card/ Checking Account Payment Authorization

Client Name: ____
Responsible Party:__________________________________

I,_____________________________ authorize Family & Youth Institute, LLC, to charge my sessions or copayments to my credit or debit card account as referenced below:

Payment Options: (Present your card for each session you want to charge.) __ 1. Charge my account for **all** of my sessions/ co-payments as they occur.
__ 2. Charge my account **only when I do not pay by check or cash.**
__ 3. Charge my account for my **current balance due** in the amount of $____________.

NOTE: A fee of $80 WILL BE CHARGED TO YOUR CREDIT/DEBIT CARD ON FILE WITH US FOR ANY MISSED APPOINTMENTS THAT ARE NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME.

Credit Card Account Information:

Credit Card#:___________________________ Exp. Date ____/____ CVC Code:___________ Zip Code: _____
___Discover ___Master Card ___Visa ___American Express
____Date:___/____/____
Signature of Authorized Credit Card Holder

Debit Card Account Information:
Debit Card#: __________________________ Exp. Date: ____/____ CVC Code:___________ Zip Code: _____
___Visa ___MasterCard ___Discover ___American Express
____Date: ____/____/____
Signature of Authorized Card Holder

Health Savings Account Information:

HSA Card Number:______________________ Exp. Date:____/____ CVC Code:__________ Zip Code:_____
___Visa ___MasterCard ___Discover ___American Express
____Date: ____/____/____
Signature of Authorized Card Holder

In the event that I have not paid on my account within 90 days after services have been rendered, I agree to allow Family & Youth Institute, LLC to charge my account for the balance due. I also agree to allow Family & Youth Institute, LLC to charge an $80 fee for any missed appointments that do not follow cancellation guidelines provided in the FYI disclosure statement (Item 7).

____________________________________ Date: ____/_____/____
Signature of Authorized Card Holder

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CLIENT INFORMATION FORM Date Open: ___________Closed: ____________

Client Name _____________________ DOB _____/_____/_____ Sex: M / F
Client Address __________________________ City: ________________ St: _______ Zip __________
Home Phone___________________Cell ____________________ Email_________________________
Client Employer/School_____________________________Work Phone(_______)_______________
Client TEXAS DRIVER'S LICENSE NO. ________________**Client SS#:_______________________ If a client is a minor please provide parents' names, addresses, dates of birth, and phone numbers.**
Mother's Name: __________________________D.O.B.__________ Phone: (_____)______________

Address: ________________________________City:_________________State:_____Zip:________

Mother's SS#: __________________________Work Phone ___________ Mobile Phone ____________

Father's Name: ___________________________D.O.B.__________ Phone: (_____)______________

Address________________________________City:_________________State:_____Zip:________

Father's SS#: ___________________________Work Phone ___________ Mobile Phone ____________

IF OTHER THAN PARENT: Financial Guarantor Name:_________________________________
Guarantor Address ____________________________ City: _____________ St: _______ Zip _______
Guarantor Employer _______________________________________Phone(_____)________________
Guarantor TDL#: _____________SS#:________________ DOB: __________/__________/__________
Emergency Contact:

Name:___________________________Address:____
Phone: (____)___________________
Nearest Relative Not Living With You: ___________________________Relationship: _____________
Address: ____Phone: (_____)________________
Name of nearest Friend Not Living With You: ____
Address:____ Phone : (_____)______________
Person Who Referred You: _________________________________Phone: (_____) _______________
I understand and agree that I am ultimately responsible for the balance on my account for all services rendered. I have completed the above answers and certify this information is true and correct to the best of my knowledge. I agree to notify you of any changes in status for the above information.

Signature of Client ____ Date____/____/___
Signature of Parent/Guardian/Guarantor_________________________________ Date ____/____/___

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THERAPIST NAME:________________________________ THERAPIST SIGNATURE:______________________________

INSURANCE BENEFITS VERIFICATION FORM

This form must be thoroughly completed. We will be unable to file your insurance claims without this information and you will be financially responsible for the full amount of each session.

Client Name: ____________________________________ DOB: ___/___/__ Sex: ( ) M ( ) F
Client's relationship to insured: ☐Self ☐Parent ☐Child ☐Spouse ☐Other
Client's Contact: Home Phone: (_____)________________Cell Phone: (_____)___________________
Client/'Email: ______________________________________Client Fax:_________________________
Client's Employer/School __________________________________Phone: (_____)_______________
Insured's Name ____________________________________ Home Phone: (_____)________________
Insured's DOB: ______/______/______ Insured Address:_____________________________________
Insured's Employer ________________________________ Office Phone: (_____)_______________
Group#: _______________________ SS#:________________ INS. ID#: ____________________
Insurance Co. Name: _____________________ Insurance Type: ☐HMO ☐PPO ☐EAP ☐_____
Phone No. for Mental/Nervous or Member Services: (____) _________ - _____________
Secondary Carrier: ______________________________________ Phone No.: (_____)_____________
Group#___ _______________________ SS#:__________________ INS. ID#: ___________________

Complete only if you have called your insurance company for the information requested below:

Have you made the initial call to your insurance company prior to your first session to inquire about pre-authorization of benefits? Y / N

Pre-certify: ☐ yes ☐ no Phone: ________________ Authorization # ____________________
Coverager Start Date: ______________________ Expiration Date: ______________________
Deductible: _____________ Met? Y / N Remaining $: ____________Co-pay $: ______________
Total sessions per calendar year: ________________No. Sessions Remaining: _________________

I hereby authorize release of information necessary to file a claim with my insurance company to Family & Youth Institute, LLC, and ASSIGN BENEFITS OTHERWISE PAYABLE TO Family & Youth Institute. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

SIGNATURE: ____ Date:_____/_____/____

Signature of Patient or Guardian/Policy Holder

I **hereby authorize my therapist/counselor to release any information acquired in the course of my examination or treatment necessary to satisfy mental health insurance claims. I realize that my insurance carriers may require detailed personal information about my psychotherapy in order to certify and/or authorize payment for my sessions.**

Client Signature ____ Date ______/______/______
Parent/Guardian Signature__________________________________ Date ______/______/_______
Insured's Signature _______________________________________ Date ______/______/_______

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CLIENT NAME:_________________________: DOB: _______________APPT. DATE: ____________ TIME:________________
THERAPIST NAME:________________________________ THERAPIST SIGNATURE:______________________________

Certification of Sessions

You are responsible for verifying benefits, obtaining referrals from primary care physicians and pre-certifying your sessions unless we are contracted as a provider from your insurance company. Failure to contact your insurance company for pre-authorization usually results in a denial of payment. In this case we must hold you financially responsible for the full amount due for all services performed. ___________ (Initial and date)

Financial Responsibility

Ultimately, **you are responsible for the total amount due including any amount not covered by your insurance company except when covered by insurance companies with whom we are a contracted network provider.** Please understand, your insurance company does not guarantee payment of any claim we submit.

I accept full financial responsibility for my account as described above with Family & Youth Institute. I also understand and agree that charges to my account will be subjected to a late charge of 1.5% per month on any unpaid balance. I agree to pay for any $35.00 per check for returned checks.

____ Date: _____/_____/_____

Signature of Responsible Party

Filing Insurance Claims

Request to File Benefits -- It is my request that the **Family & Youth Institute** file charges with my insurance company and **I agree to pay any and all deductible and co-payments at the time services are rendered.**

____ Date: _____/_____/_____

Signature of Responsible Party

Assignment of Benefits

We will accept assignment of benefits under the following conditions: (1) deductibles and co-payments are paid at the time services are rendered or within 30 days of receiving a bill and (2) **completed and signed intake forms are provided to our office by the patient in a timely manner**. Please note that insurance companies have time limits on the amount of time we are allowed to submit a claim. ________ (Initial and date)

I agree to assign my benefits to the Family and Youth Institute.

____ Date: _____/_____/_____

Signature of Responsible Party

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CLIENT NAME:________________________: DOB: _______________APPT. DATE: ____________ TIME:_______________
THERAPIST NAME:________________________________ THERAPIST SIGNATURE:______________________________

Consent to Release of Information/Records:

I __________________________hereby authorize______________________ to release information
(Client/ Parent / Guardian's Name) (Physician/School/ Other)
to ___________________ concerning confidential information pertaining to me (or my minor child).
(Clinician at FYI)
I __________________________hereby authorize____________________ to release information to
(Client/Parent/ Guardian 's Name) (Clinician at FYI)
______________________ concerning confidential information pertaining to me (or my minor child).
(Physician/School/ Other)
In consideration of this consent, I hereby release the above parties from any legal liability the release of this information.

Confidential information concerning:

NAME: ________________________________DOB: ________________ SSN: _______________________

The release shall be limited to the following information:

☐Intake/Psychosocial ☐Psychiatric/Medical ☐Psychological
☐Progress Notes ☐Vocational ☐Educational
☐Drug/Alcohol Abuse ☐Unrestricted ☐Diagnosis
☐Other – Specify____

Release of the above information is required for the following purpose:

☐Update Psychiatric/Psychological ☐Review of Prior Treatment
☐Monitor Medical Status ☐Medication Verification
☐Use In Residential Placement ☐ Other – Specify_____________________________________

I understand that this consent is subject to revocation at any time, except to the extent that action has been taken in reliance on it. In any event, this consent shall expire one (1) year from the date signed unless revoked earlier.
________________ (initial) ____/____/___(date)

_______________________ _____________________________ ____/______/_____
Client Signature Parent/ Guardian Signature Date

TO THE PARTY RECEIVING THIS INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by state law. Where a drug and alcohol abuse client is involved, Federal law also protects the confidentiality of these records. See, 42 CFR, Part 2. In either event, information shared is subject to the applicable laws, rules, and to whom it pertains, or as otherwise permitted by the applicable laws, rules and regulations. Please note: A general authorization for the release of medical or other information is not sufficient for these purposes. Regulations prohibit you from making further disclosure of these records without the specific written consent of the person.

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THERAPIST NAME:__________________________________ THERAPIST SIGNATURE:________________________________

CLIENT NAME:___________________________: DOB: ________________APPT. DATE: _____________ TIME:_________________
THERAPIST NAME:__________________________________ THERAPIST SIGNATURE:________________________________

Adult Checklist of Concerns – FOR A CHILD CLIENT, PARENTS MARK ITEMS AS THEY RELATE TO THE CHILD. FOR AN ADULT CLIENT, THE CLIENT MARKS ITEMS AS THEY RELATE TO HIM/HER PERSONALLY. **Adult Checklist of Concerns Page 1 of 3**

Please mark all of the items below that apply, and feel free to add any others at the bottom.

- ☐ I have no problem or concern being here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, under eating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt

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CLIENT NAME:_________________________: DOB: _______________APPT. DATE: ____________ TIME:________________
THERAPIST NAME:________________________________ THERAPIST SIGNATURE:______________________________

- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns . . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating

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Any other concerns or issues____
____
____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:____
____

List any significant events that pertain to you or your child(ren)(injuries, operations, illnesses, death, divorce, moves)____
____

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THERAPIST NAME:________________________________ THERAPIST SIGNATURE:______________________________

Child/Adolescent Checklist of Characteristics Many characteristics apply to both children and adults. For a **child client**, mark all items that apply **to your child** on both this form and the "Adult Checklist of Concerns." **For an adult client, complete the Adult Checklist and then mark any items on this form that may have been descriptive of your childhood.**

- ☐ Affectionate
- ☐ Under active, slow-moving or slow-responding, lethargic, uncoordinated, accident-prone
- ☐ Argues, "talks back," smart-alecky, defiant
- ☐ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks, or provokes
- ☐ Cheats
- ☐ Cruel to animals
- ☐ Concern for others
- ☐ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- ☐ Complains
- ☐ Cries easily, feelings are easily hurt
- ☐ Dawdles, procrastinates, wastes time
- ☐ Difficulties with parent's paramour/new marriage/new family
- ☐ Dependent, immature
- ☐ Developmental delays
- ☐ Disrupts family activities
- ☐ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ☐ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ☐ Dropping out of school
- ☐ Drug or alcohol use
- ☐ Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ☐ Exercise problems
- ☐ Extracurricular activities interfere with academics
- ☐ Failure in school
- ☐ Fearful
- ☐ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ☐ Fire Setting
- ☐ Friendly, outgoing, social
- ☐ Hypochondriac, always complains of feeling sick

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CLIENT NAME:_______________________: DOB: _____________APPT. DATE: ___________ TIME:______________
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- ☐ Immature, "clowns around," has only younger playmates
- ☐ Imaginary playmates, fantasy
- ☐ Independent
- ☐ Interrupts, talks out, yells
- ☐ Lacks respect for authority, insults, dares, provokes, manipulates
- ☐ Learning disability
- ☐ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ☐ Likes to be alone, withdraws, isolates
- ☐ Lying
- ☐ Low frustration tolerance, irritability
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Nervous, Nightmares
- ☐ Need for high degree of supervision at home over play/chores/schedule
- ☐ Obedient
- ☐ Obesity
- ☐ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- ☐ Oppositional, resists, refuses, does not comply, negativism
- ☐ Prejudiced, bigoted, insulting, name calling, intolerant
- ☐ Under active, slow-moving or slow-responding, lethargic, uncoordinated, accident-prone
- ☐ Recent move, new school, loss of friends
- ☐ Relationships w/brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking
- ☐ Responsible
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad, unhappy, pouts
- ☐ Self-harming behaviors—biting or hitting self, head banging, scratching self,
  speech difficulties
- ☐ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ☐ Shy, timid
- ☐ Stubborn
- ☐ Suicide talk or attempt

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THERAPIST NAME:________________________________ THERAPIST SIGNATURE:______________________________

- ☐ Swearing, blasphemes, bathroom language, foul language
- ☐ Temper tantrums, rages /
- ☐ Thumb sucking, finger sucking, hair chewing
- ☐ Tics—involuntary rapid movements, noises, or word productions
- ☐ Teased, picked on, victimized, bullied
- ☐ Truant, school avoiding

Other Information