

Kirkland Clinical Associates, LLC
331 Melrose Suite 130
Richardson, Texas 75080
Office: (972) 231-2555
Fax: (972) 231-2293

CLIENT INTAKE INFORMATION FOR MINORS

About the Client: (Child)

Child's Name: _____ Birth Date: _____ Age: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Male ___ Female ___ Social Security #: _____

Referred by: _____

Father's Work #: _____ Father's Cell #: _____ Father's Email: _____

Mother's Work #: _____ Mother's Cell #: _____ Mother's Email: _____

If there is emergency at the office and we must cancel the appointment, where should we call: _____

Your emergency contact person: Name: _____ Relationship: _____
Their Work # _____ Their Home # _____ Their Cell Number _____

Who is responsible for this account?

Name: _____ Relationship to Client: _____ Birth Date: _____

Social Security Number: _____ Address: _____

City: _____ State: _____ Zip: _____

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Kirkland Clinical Associates, LLC, the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him for services rendered and/or for cancelled or missed appointments.

X _____
Signature of Legal Guardian _____ Date _____

About Your Child's Education

Current Grade: _____ Failure or Held Back? _____

What do school personnel tell you about your child? _____

Grade	School	City	State	Average Grades
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

About Your Child's Family

Relatives	Name	Age/Grade	Does Child Get Along Well with this Person?	Occupation
Father				
Mother				
Sister(s)				
Brother(s)				
Step-Father				
Step-Mother				
Step Sister(s)				
Step Brother(s)				
List all people who live in the home with this child:				

About Your Child's Routine

What kinds of physical exercise does your child get? _____

Bedtime: _____ Wake-up Time: _____ Hours of sleep on an average night: _____

Activities Involved In: _____

About Your Child's Health

Who is your child's pediatrician? _____ When was the last visit? _____

Any Concerns shared by the doctor? _____

Starting with birth and proceeding to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

Describe any allergies your child has: _____

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please _____

List all prior counselors/dates/reasons: _____

Agreement for Therapy with a Minor:

I, _____, the parent/legal guardian of the minor, _____,

- Give my permission for this minor to receive therapeutic services provided through Kirkland Clinical Associates.
- I have read, understood, and signed the informed consent related to my child's therapist and I understand the risks and benefits of receiving these services and the risks and benefits of *not* receiving these services, for both this minor and his or her family.
- Furthermore, I understand that I am expected to participate in this process by meeting with the therapist at least once per month while my child is in therapy.

My signature below means that I understand and agree with all of the points above.

 Signature of parent/guardian

 Date

About Your Child's Symptoms

Please mark all of the items that characteristically apply to your child. Feel free to add any others at the end under "Any other characteristics."

- | | | |
|---|---|--|
| <input type="checkbox"/> Accident-prone | <input type="checkbox"/> Immature | <input type="checkbox"/> Provokes others |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Inappropriate sexual behaviors | <input type="checkbox"/> Rages |
| <input type="checkbox"/> Argues | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Recent move |
| <input type="checkbox"/> Assaults | <input type="checkbox"/> Independent | <input type="checkbox"/> Refuses |
| <input type="checkbox"/> Bathroom language | <input type="checkbox"/> Inflicts pain on others | <input type="checkbox"/> Resists |
| <input type="checkbox"/> Bossy to others | <input type="checkbox"/> Insults others | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Breaks rules | <input type="checkbox"/> Interrupts | <input type="checkbox"/> Rocking or other repetitive movements |
| <input type="checkbox"/> Breaks the law | <input type="checkbox"/> Intimidated by others | <input type="checkbox"/> Runs away |
| <input type="checkbox"/> Bullied by others | <input type="checkbox"/> Intimidates others | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Bullies others | <input type="checkbox"/> Intolerant | <input type="checkbox"/> School avoiding |
| <input type="checkbox"/> Cheats | <input type="checkbox"/> Irritability | <input type="checkbox"/> Self-harming behaviors |
| <input type="checkbox"/> Clowns around | <input type="checkbox"/> Isolates | <input type="checkbox"/> Sexual preoccupation |
| <input type="checkbox"/> Competition | <input type="checkbox"/> Lacks organization | <input type="checkbox"/> Sexually active |
| <input type="checkbox"/> Complains | <input type="checkbox"/> Lacks respect for authority | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Conflicts at school | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Slow-moving |
| <input type="checkbox"/> Conflicts at home | <input type="checkbox"/> Legal difficulties | <input type="checkbox"/> Slow-responding |
| <input type="checkbox"/> Conflicts with friends | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Smart-alecky |
| <input type="checkbox"/> Conflicts with police | <input type="checkbox"/> Likes to be alone | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Loitering | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Cruel to animals | <input type="checkbox"/> Loss of friends | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Dawdles | <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Lying | <input type="checkbox"/> Suicide talk or attempt |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Manipulates | <input type="checkbox"/> Swearing |
| <input type="checkbox"/> Dependent | <input type="checkbox"/> Masturbation | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Talks out |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Moody | <input type="checkbox"/> Teased |
| <input type="checkbox"/> Difficulties with parent's partner | <input type="checkbox"/> Mute, refuses to speak | <input type="checkbox"/> Teases others |
| <input type="checkbox"/> Disobedient | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Disrupts family activities | <input type="checkbox"/> Name calling | <input type="checkbox"/> Threatens |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Needs for high degree of supervision | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Negativism | <input type="checkbox"/> Tics-movements or noises |
| <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Nervous | <input type="checkbox"/> Timid |
| <input type="checkbox"/> Failure in school | <input type="checkbox"/> New school | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Fantasy life | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Uncooperative |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Noisy | <input type="checkbox"/> Uncoordinated |
| <input type="checkbox"/> Feelings are easily hurt | <input type="checkbox"/> Noncompliant | <input type="checkbox"/> Under-active |
| <input type="checkbox"/> Fidgety | <input type="checkbox"/> Obesity | <input type="checkbox"/> Unhappy |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Only younger playmates | <input type="checkbox"/> Unprepared |
| <input type="checkbox"/> Finger sucking | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Vandalism |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Out-of-seat behaviors | <input type="checkbox"/> Violent |
| <input type="checkbox"/> Hair chewing | <input type="checkbox"/> Overactive | <input type="checkbox"/> Wastes time |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Picks on others | <input type="checkbox"/> Wetting/soiling of bed/clothes |
| <input type="checkbox"/> Hitting | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Withdraws |
| <input type="checkbox"/> Hostile | <input type="checkbox"/> Pouts | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Prejudiced | <input type="checkbox"/> Yells |
| <input type="checkbox"/> Hypochondriac | <input type="checkbox"/> Procrastinates | |
| <input type="checkbox"/> Imaginary playmates | | |

Any Other Characteristics: _____

Important Information for you to Know:

Please Initial Each Box:

- I understand that the therapists at Kirkland Clinical Associate, LLC are licensed through the Texas State Board of Examiners of Licensed Professional Counselors and hold advanced degrees from accredited universities.
- I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.
- I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.
- I understand that if I am concerned about slow progress or lack of progress I have the right to speak to my therapist about this.
- I understand that my therapist does not perform formal testing but refers individuals to those who do.
- I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Kirkland Clinical Associate, LLC, or one of it's associates to tell someone else in writing or verbally, b) My therapist determines that I may pose a threat to myself or others, c) If KCA or one of it's associates is ordered by a court to disclose information, or d) that child abuse is alleged, at which time authorities will be notified.
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that if I have a complaint I cannot resolve with KCA or one of its associates and I wish to file a formal complaint I may contact the Texas Sate Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.
- I understand that there is a returned check fee of \$35.00 and that if a returned check is not cleared up in 30 days KCA will file a suit with the Dallas County District Attorney's Office.
- I understand that all co-pays are due at the time of service.
- I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to KCA.
- I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of \$60.00 that must be paid at my next scheduled appointment.
- I understand that the rate for each session is \$125.00. These fees are for 45-minute sessions.
- I understand that no associate at KCA can recommend or prescribe medications but can encourage clients to see an M.D. for a medication evaluation.

By signing below I confirm that I have read, agree to and received a copy the above information:

Signed by Legal Guardian

Date

(This copy is for you to read, understand, sign, and leave with your therapist)

This copy is for you to read, understand, and keep

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Notice of Privacy Practices

**Kirkland Clinical Associates, LLC
Richardson, Texas**

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.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by it's terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services. You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of April 14, 2003

THIS IS YOUR COPY TO KEEP

Acknowledgement of Receipt Of Notice of Privacy Practices
For
Kirkland Clinical Associates, LLC

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

Patient: _____ Date: _____
(If patient is a minor, Parent or guardian must sign)

Consent For use and Disclosure of Health Information

I hereby permit Kirkland Clinical Associates to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

Patient Signature: _____ **Date Signed:** _____

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Kirkland Clinical Associates
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Insurance Verification Information

(Please Print)

About the Client:

Client's Name: _____ Client's Birth Date: _____ Client's SS #: _____

Client's Address: _____ City, State, Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

About the Insurance Holder:

Name: _____ Birth Date: _____ SS #: _____

Relationship to Client: _____ Employer: _____

About Your Insurance: (We will get your EAP info when we call the insurance company. This is not EAP Information)

Insurance Company: _____ Mental Health Phone #: _____
 Group #: _____ Subscriber #: _____;
 Is there an Employee Assistance Program (EAP) where you work? Yes / No / Don't Know

OFFICE PERSONNEL WILL COMPLETE ALL INFORMATION BELOW. PLEASE LEAVE BLANK

Date Verified: _____ Info from: Ins.Co. & Name: _____ Elect. Claims ID # _____

Therapist is: In net ___ Out net ___ # of Sessions Allowed/Year _____; Per Lifetime: _____;

This contract covers: **# of Sessions** **Authorization #** **Auth Effective These Dates**

90801	Diagnostic Evaluation	_____	_____	_____
90806	Individual Treatment	_____	_____	_____
90808	Extended Session	_____	_____	_____
90846	Family without Patient	_____	_____	_____
90847	Family with Patient	_____	_____	_____
90853	Group Therapy	_____	_____	_____

EAP Coverage **# of Sessions** **Authorization #** **Auth Effective These Dates**

EAP Sessions _____ _____ _____

Mental Health Claims

address: _____

- Co-Pay: \$ _____; or _____ % of allowed amount;
- Deductible: Balance is \$ _____ as of date verified.
- Annual Deductible is \$ _____ and starts over on: _____
- Other: _____

**PLEASE FAX THIS PAGE TO OUR OFFICE AS SOON AS POSSIBLE SO WE MAY
 VERIFY YOUR BENEFITS PRIOR TO YOUR APPOINTMENT**