Jennifer A. Convissor, LCSW

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INFINITY WELLNESS INTAKE PACKET: Children & Adolescents

Please complete the following packet and give it to your therapist during your first session.

Pages 2-3 are solely for the caregiver and 4-5 is for the adolescent to complete.

The packet includes these documents:

- □ Contact Information and Client History (pgs. 2-3) - CAREGIVER
- □ Adolescent Treatment Survey (p. 4-5) – ADOLESCENT
- □ Confidentiality, Policies and Facility Information (pgs. 6-7)
- □ Payment Agreement (pgs. 8-9)
- □ Life & Wellness Contract (p. 10)
- □ HIPA Acknowledgment and Consent form (p. 11)

CONTACT & TREATMENT INFORMATION:

Client Name: _____ DOB: _____

Address: _____

Parent Name(s): _____

Parent Address (if different from client's): _____

Parent(s) phone(s): _____ Email: _____

School name and location: _____ Grade: _____

Family Doctor: _____ Phone: _____

Psychiatrist (if applicable) _____ Phone: _____

Length of time under care: _____ Medications (name and dosage): _____

Sibling(s) (gender, age): _____

While child was in utero, were there any health difficulties, for mother or child?:

_____

_____

Please describe significant current or past medical and/or mental health issues for child or family (continue on back if needed):

_____

_____

To your knowledge, has your child experienced any trauma or abuse? Please explain:

_____

_____

Did child meet developmental milestones on time? If not, please elaborate

_____

_____

How would you describe your child's current issues?:

When did these issues begin?

If applicable, what attempts have been made to address these issues already?

Were any of these strategies effective? Please explain:

Which attempts proved ineffective? Please explain:

What are your treatment goals?

Where did you hear about Infinity Wellness?

ADOLESCENT TREATMENT SURVEY

Please check all that apply to you and may be a focus of treatment:

- ☐ Anxiety
- ☐ Depression
- ☐ Relationships and Boundary Issues
- ☐ Lying/Manipulation
- ☐ Academic Problems
- ☐ Behavioral Problems
- ☐ Dealing with Divorce
- ☐ Concerns with Parents
- ☐ Risk of harming yourself or others
- ☐ Anger Issues
- ☐ Developmental Problems
- ☐ Sleep Problems
- ☐ Confidence/Self-Esteem Issues
- ☐ Feeling Isolated From Others
- ☐ Afraid or Suspicious
- ☐ Losing Track of Time
- ☐ Nightmares
- ☐ Intrusive Memories
- ☐ Sexual Issues
- ☐ Stress Management
- ☐ Traumatic Experiences
- ☐ Sexual Abuse
- ☐ Physical Abuse (Including Domestic Violence)
- ☐ Emotional/Mental Abuse
- ☐ Loss of Control
- ☐ Destructive Life Patterns
- ☐ Substance Abuse (Past and/or Present)
- ☐ General Family of Origin Issues
- ☐ Financial Anxiety
- ☐ Specific Fears or Panic
- ☐ Memory Problems
- ☐ Other:_____

What brings you in to therapy today?

What are you hoping for in your therapy experience?

What are some of your goals?

What, if any, are your concerns about therapy?

Have you ever been in therapy before?

If yes, was your experience positive or negative and why?

CONFIDENTIALITY, POLICIES & FACILITY INFORMATION

CONFIDENTIALITY

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Infinity Wellness will not inform others that you are in therapy and the content of sessions will remain confidential. The only time this confidentiality may be broken is if one or more of the following exceptions/conditions apply:

- If you pose physical danger to yourself or others
- If you disclose that you or another person has physically or sexually abused a child, an incompetent or a disabled person, or an elderly person.
- If you disclose that a child, an incompetent or a disabled person, or an elderly person is suffering due to neglect.

If any of the above are disclosed in session, we are mandated by law to report such information to the appropriate State agency.

Your therapist may be under supervision, which means your information may be disclosed to a supervisor outside Infinity Wellness. By your signature you authorize your therapist to release pertinent session information to his or her supervisor. If you have any questions, please ask your therapist.

It is possible that you and your therapist may run into each other in a public place. Should this occur, the therapist must protect confidentiality by not acknowledging you unless you first acknowledge your therapist. If you approach your therapist, contact should be brief and no therapy material should be discussed so confidentiality can be maintained.

RISKS AND BENEFITS

It is important for you to know that therapy can be beneficial but there are also some risks. Often when processing difficult emotions, you may feel sad, angry, tired, and experience some emotional and even physical strain as a result of the intensity of the therapy process. You should let your therapist know how you are feeling and work with your therapist to contain feelings in between sessions.

TECHNOLOGY

By your signature below, you authorize Infinity Wellness to contact you by phone using the number you provide at intake. If this is not a safe number to leave messages at, please let your counselor know in writing or note this on the intake packet itself. Your therapist may call you using a VOIP (internet based voice over IP phone) or a cell phone both of which may not be completely confidential because of potential technology issues.

Email is not the most confidential mode of communication. If you choose to use email to send information to your therapist, you do so knowing that this information is at risk, and that your therapist may respond via email.

Text messaging is a popular form of communication. If you choose to text your therapist, this information is at risk as this is not a confidential mode of communication. Please clarify how you would like to communicate with your therapist and if you do choose to text, please keep it to a minimum and use it only for scheduling/logistic purposes.

SESSIONS
Sessions are normally from 50 minutes in length though this may vary based on your individual treatment plan with your therapist. Please arrive promptly for sessions. Sessions will end at the designated time regardless of when it was started.

FACILITY
Free parking is available behind our building. From Central Avenue, it appears the driveway belongs to the blue house next door (273 Central Avenue), but we share the driveway and our parking lots are connected. Park behind the white house (267 Central Avenue – our office) and take the path in the middle of the houses, to reach the main entrance. Our office is the 2nd door on the left, on the 1st floor. There is a small kitchen area and private bathroom at the end of the hallway.

CANCELLATIONS
We understand that you may need to cancel an appointment. It is helpful for us to know if you will not be coming, so we ask that you give us 24 hours notice for any change or cancellation. Any late cancellation (less than 24 hours notice), change, or missed appointment will be charged the full agreed upon session rate.

AGREEMENT
I understand that, consistent with the HIPAA requirements, consent to treatment and consent to release will expire after twelve months and I may revoke such consent at will, although revocation is not retroactive.

I have been informed of and read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees for services rendered by my therapist.

If you have any questions or would like additional information, please feel free to ask.

ATTESTING THAT I UNDERSTAND THE ABOVE, AND AGREE TO THERAPY UNDER THE ABOVE LIST OF DISCLOSURES, I HAVE SIGNED BELOW:

_____
CLIENT SIGNATURE, DATE:

_____
SIGNATURE OF SPOUSE IF FAMILY/MARITAL COUNSELING, DATE:

_____
THERAPIST, DATE:

PAYMENT AGREEMENT

(Please initial each line item and sign below)

_____ Payment is due at the time of your appointment. Cash and check are acceptable forms of payment. Please make checks payable to **Jennifer Convissor**.

_____ The standard fee for services is $130 per 50 minute individual, couple or family session (on the phone or in the office) and $100 for full-time students who are working less than 20 hours per week.

_____ Services are offered at reduced fees based on total household income and client circumstance. Sliding scale fees are negotiated between you and your therapist and are revisited when your circumstances change or at the beginning of the new year, whichever occurs first.

_____ The agreed upon fee for your counseling services is currently $_____ per 50 minute session.

_____ A fee of $30 will be assessed for a returned check and future payments must be made in cash.

_____ Cancellations require 24 hours notice prior to the time of the appointment. You will be charged the full agreed upon fee (noted above) for cancelling appointments with less than 24 hours notice or for missing appointments without prior notice.

_____ The initial intake session will be dedicated to understanding the client's background and current situation, assessing for immediate risks, evaluating readiness for requested therapy, providing referrals if needed, and establishing treatment goals. There may be no therapeutic counseling or intervention during the initial intake session.

_____ Phone calls in excess of 15 minutes will be billed to the client's account in accordance with the standard session fee.

_____ Treatment may be interrupted or terminated; after 3 unpaid no shows, due to 3 consecutive cancellations, or after unresolved debt of 3 or more sessions.

By initialing each line item above and by signing below, I acknowledge that I understand and commit to the above and enter into this agreement willingly and voluntarily.

_____

Client Name (please print):

_____ _____

Signature of Client or Legal Guardian: Date:

_____ _____

Signature of Therapist: Date:

CREDIT CARD AUTHORIZATION

I authorize Infinity Wellness to use the credit card information below to charge my credit card using an on-line credit card system for the following purposes:

1) FOR A MISSED SESSION at the rate of my regular session if I cancel less than 24 hours in advance of my appointment.

2) IF AND WHEN MY PAYMENT BALANCE BECOMES PAST DUE. The provider will inform me about this charge.

I acknowledge that I will be receiving an e-mail with a receipt for the payment and the appropriate information needed to submit to my insurance company and/or for tax purposes if I use my credit card.

CREDIT CARD INFORMATION

Credit Card Type (circle one): MasterCard Visa

_____ Credit Card Number

_____ Credit Card Holder's Name on Card

_____ 3 digit Security Code _____ Expiration Date

_____ E-mail address for receipts

_____ _____

Signature: Date:

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LIFE & WELLNESS CONTRACT

I, _____, agree to ***not*** harm myself in any way, attempt to kill myself, or kill myself during while I am in treatment.

I agree that, for any reason, if my sessions are postponed, canceled, etc., that this agreement is still valid. In this period of time, I agree to care for myself, to eat well, and to get enough sleep each night.

For support, I agree to make weekly social/family contact with the following individuals:

_____

_____

I agree to rid my presence of all things I could use to harm or kill myself. I agree that, if I am having a rough time and come to a point where I may break any of these promises, I will call and make significant contact with any of the following individuals:

_____ at: #_____

_____ at #_____

If I cannot contact these individuals, I will immediately call the **Crisis Hotline at** #_____or call 1-800-273-8255, the U.S. 24-hour suicide prevention line.

I agree that these conditions are important, worth doing, and that this is a contract I am willing to make and keep. By my word and honor, I intend to keep this contract.

Signed_____ **Date**_____

Witnessed by_____ **Date**_____

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HIPAA Privacy Authorization Consent Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization and Collateral Consent: I authorize Jennifer Convissor and Infinity Wellness to use and disclose my protected health information described below to:

_____ (individual seeking the information).

I authorize _____ (collateral contact) to disclose my protected health information, described below, to Jennifer Convissor and Infinity Wellness.

2. Covered Dates of Treatment: This authorization for release of information covers the period of healthcare from: _____ to _____.

OR

a. □ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete mental health record.

OR

b. □ I authorize the release of my complete health record with the exception of the following information (please specify): _____

4. This information may be used by the person I authorize, to receive this information for purposes of treatment or consultation, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

7. I understand that my treatment, or payment, will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his or her relationship to patient