

# The Barrington Center for Counseling and Psychotherapy

## CHILD & ADOLESCENT INTAKE

Therapist: \_\_\_\_\_

### Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

(Patient's Cell  or Parent/Guardian's )

Alternate Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Responsible Party Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

### Insurance Information *(please attach Insurance card to clipboard for verification)*

Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group / Plan Number: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_

**FOR OFFICE USE ONLY: DX: \_\_\_\_\_ Session Fee: \_\_\_\_\_**

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## Emergency Contact for Patient:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

## General Information

The primary reason you have come to the Barrington Center:

\_\_\_\_\_

How were you referred to our practice? \_\_\_\_\_

\_\_\_\_\_

People living in the household (names, ages and relation to patient):

\_\_\_\_\_

\_\_\_\_\_

Who has legal custody of the child? \_\_\_\_\_

Are there any custody issues or considerations the therapist should be aware of? Yes  No

If yes, please *explain*: \_\_\_\_\_

\_\_\_\_\_

Who has decision making authority for the child's medical health care? \_\_\_\_\_

*\*(A copy of the custody agreement may be required by your therapist for the child's file)*

## Education Information

School Name: \_\_\_\_\_ City: \_\_\_\_\_

Current Grade: \_\_\_\_\_

List any special services, classes or accommodations received (e.g. IEP or 504 Plan): \_\_\_\_\_

\_\_\_\_\_

List any school support staff that you meet with regularly and purpose (e.g. social worker): \_\_\_\_\_

\_\_\_\_\_

What extra-curricular activities are you involved in? \_\_\_\_\_

\_\_\_\_\_

Would you like your therapist to be in contact with your school? Yes  No

*(If Yes, a consent to exchange information will be completed by your therapist)*

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## Medical / Health Information

Current Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Office / Hospital Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

List all significant medical conditions that may be relevant to your current wellbeing and treatment:

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Have you ever been hospitalized for emotional / behavioral health reasons? Yes  No

If yes, please list hospital(s) and date(s) (month / year): \_\_\_\_\_

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## Current Medications

List all medications taken regularly and the dosage, frequency, condition or symptoms for which the medication is taken (include over-the-counter and supplements): \_\_\_\_\_

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Name of prescribing doctor (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_

Would you like your therapist to be in contact with your primary / prescribing doctor? Yes  No   
(If Yes, a consent to exchange information will be completed by your therapist)

## Health Habits

Do you have a daily routine/schedule? Yes  No

Do you have regular hygiene practices? Yes  No

Do you regularly engage in physical activity? Yes  No

Do you usually eat healthy? Yes  No

Do you smoke? Yes  No  Do you drink alcohol? Yes  No

Do you use substances (including prescriptions not prescribed to you)? Yes  No

## Prior Treatment

Have you received counseling / therapy in the past? Yes  No

If yes, when did you receive counseling / therapy, where, and for what purpose? \_\_\_\_\_

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What did you like most and least about your previous counseling / therapy? \_\_\_\_\_

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## **Mental / Physical Information** *(please have the child complete if able)*

Are you currently, or in the recent past, having trouble with any of the following (please check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Depressed / Low Mood or Mood Swings                 | <input type="checkbox"/> Irritability / Easily Annoyed   |
| <input type="checkbox"/> Lack of Motivation                                  | <input type="checkbox"/> Decreased Energy or Fatigue     |
| <input type="checkbox"/> Difficulty Thinking or Making Decisions             | <input type="checkbox"/> Sleep                           |
| <input type="checkbox"/> Worthlessness                                       | <input type="checkbox"/> Hopelessness                    |
| <input type="checkbox"/> Thoughts of Death or Suicide                        | <input type="checkbox"/> Grief / Loss                    |
| <input type="checkbox"/> Family Relationships                                | <input type="checkbox"/> Social Relationships            |
| <input type="checkbox"/> Significant Increase / Decrease in Eating or Weight | <input type="checkbox"/> Body Image                      |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Excessive Worry or Fears        |
| <input type="checkbox"/> Panic Attacks                                       | <input type="checkbox"/> Obsessions / Compulsions        |
| <input type="checkbox"/> Frequent Headaches, Stomachaches or Illnesses       | <input type="checkbox"/> Hyperactivity                   |
| <input type="checkbox"/> Attention / Concentration                           | <input type="checkbox"/> Behavior                        |
| <input type="checkbox"/> Problems Related to Divorce or Separation           | <input type="checkbox"/> Trauma or Significant Stressors |
| <input type="checkbox"/> Gender or Sexuality                                 | <input type="checkbox"/> Self- Injury                    |
| <input type="checkbox"/> Alcohol, Drugs, or Prescription Medications         | <input type="checkbox"/> School Attendance / Academics   |
| <input type="checkbox"/> Bullying  | <input type="checkbox"/> Temper / Anger                  |
| <input type="checkbox"/> Other (please provide a brief explanation): _____   |  |
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## Support

Using the scale below, please rate how much support or help you receive from others in dealing with the difficulties you checked on page 4 (0 = No support or help / 10 = A lot of support or help):

**NONE-**  0  1  2  3  4  5  6  7  8  9  10 **-A lot**

## Spiritual

Are you religious / spiritual? Yes  No

If yes, how do you express your religious / spiritual side? \_\_\_\_\_

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## Leisure

What do you enjoy doing during your free time?

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## Child & Adolescent Therapy Information & Agreement

Prior to beginning therapy services for a minor child, it is important to inform you about our approach and procedures for providing therapy. The following information also includes our legal and ethical responsibilities as clinical therapists as determined by HIPAA, IL Mental Health Codes, and the Ethical Codes of our profession.

### Psychotherapy

Psychotherapy may have both risks and benefits. During the therapy process, there may be discussions of personal difficulties that can evoke feelings such as sadness, irritability, frustration and anxiety. There may be disagreements between parents or about treatment recommendations or services for the child. It is often necessary to work through these personal difficulties, uncomfortable feelings or disagreements to achieve the benefits of therapy. Benefits may include, for example, improved wellbeing, better relationships, and improved academic performance. However, there is no guarantee of these benefits.

### Confidentiality

In maintaining legal and ethical standards for therapy, all services provided by The Barrington Center therapists are kept confidential unless written consent to release information is given by the parent/legal guardian *and* child, if the child is age 12 to 17 years old (excluding Exceptions to Confidentiality as noted in the accompanying *Privacy Practices*). Therapists within the practice may consult, when clinically necessary, to provide the assistance your child may need. Confidentiality cannot be guaranteed if you, or your child, choose to exchange communications with his/her therapist via electronic means (e.g. email, text messages).

### Privacy

Therapy is most beneficial when there is a trusting relationship between the child and their therapist. Privacy is especially important in building and maintaining trust. One goal of therapy is to help your child build healthy and supportive relationships with family members. To do this, it is often necessary for children, particularly adolescents, to create a “zone of privacy” so they feel comfortable discussing personal difficulties more freely with their therapist. Therefore, it is important to understand that your child’s therapist can provide general information about treatment status but not specific details about your child’s therapy session unless your child has given consent to do so. Additionally, we ask for your help by supporting your child’s choice to voluntarily share, or not share, with you what he/she discussed during their session. If your child’s therapist has reason to believe your child is at serious risk of harm to him/herself or another, your therapist will inform you, your emergency contact and /or the appropriate resources to help keep your child or another safe. You will also be informed if your child did not attend their scheduled therapy appointment. *Our standard fee for any late cancelled appointment (without 24 hr prior notice) or no-show appointment will apply for all appointments your child did not keep and are as follows: \$50 for the first missed appointment and \$100 thereafter for each missed appointment.*

### Court or Legal Involvement

When providing therapy services for a child, there is the potential to become involved in conflict between parents. Doing so can negatively affect the therapeutic relationship between the child and therapist. Any involvement will be strictly limited to that which will benefit your child. We request that anything discussed or disclosed in a therapy session will be kept confidential and not used for personal or legal gain. Additionally, it is a policy of The Barrington Center to not become involved in any court or legal process involving your child. This includes, but is not limited to, custody agreements, visitation recommendations, allegations of abuse, court testimony and litigation cases. You also agree to instruct your attorney to not subpoena your child’s therapist. If

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your child's therapist is demanded by judge to appear or testify for court, the party responsible for their participation agrees to pay **\$500.00 per hour, paid in advance**, for time spent preparing reports, traveling, testifying, being in attendance, and any other case-related costs. *These fees are not refundable.*

## **Collaborative & Accompanying Services**

Requests for your child's therapist to collaborate with those involved in your child's care or provide accompanying services will be left to the discretion of the therapist. Examples of collaborative care and accompanying services include phone calls with parent/guardian, professionals and school staff, attending school meetings, and writing letters, reports, or treatment summaries. Your insurance cannot be billed for the therapist's time for these services; therefore, the fee to provide Collaborative and Accompanying Services becomes the responsibility of the parent/guardian and are as follows:

- Phone Consultations over 10 minutes will be charged \$25 for each 15 minutes (unless a teletherapy session is scheduled, and then we will bill insurance accordingly).
- Letters, Reports, Treatment Summaries, and Documentation: \$75 per half hour (includes preparation)
- School Staffing or requests for On-Site Services/Attendance: \$125 per hour (including preparation and travel)

*These fees are not refundable.*

**Your signature below confirms that you have read, understand, and agree to the information stated above:**

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Patient Signature (required for patients 12-17 yrs. old):

Date:

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Parent/Guardian Signature:

Date:

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Therapist Signature:

Date:

## **THERAPY CONSENT & AGREEMENT**

Welcome to The Barrington Center for Counseling and Psychotherapy. This document contains important information about our services, fees and business policies. Please read it carefully. Your therapist can discuss any questions you may have about it.

### **Professional Fees:**

I understand that if I choose to use health insurance, BCCP will contact my insurance provider to inquire about available mental health benefits and will share that information with me as a courtesy and not a guarantee of payment. My signature gives BCCP permission to release necessary information to my insurance provider related to treatment on my, or my dependent's, behalf in order to obtain reimbursement for services rendered. The remaining balance not covered by insurance (including deductible, co-payment, co-insurance, and services not covered) is my responsibility or the responsible party for dependents. If I do not have insurance, or choose to do self-pay, I understand that I will be responsible for the total fee at the time of service.

I understand that it is my responsibility to promptly notify BCCP if my insurance provider changes. I agree to contact my insurance provider to expedite payment to BCCP for services not reimbursed within 30 days. I also agree to promptly remit insurance payments to BCCP in the event that I receive payment directly from my insurance provider.

Clinical services will be charged based upon the following Fee Schedule. Session length is determined by the therapist's discretion and the guidelines set by your insurance provider, if applicable.

#### Psychologists:

Initial Consultation / Diagnostic Interview	CPT code 90791	\$200
Individual Psychotherapy 53+ minutes	CPT code 90837	\$175
Individual Psychotherapy 38-52 minutes	CPT code 90834	\$150
Individual Psychotherapy 16-37 minutes	CPT code 90832	\$ 90
Family Therapy 26+ minutes	CPT code 90846/90847	\$175
Psychological Testing 55-60 minutes	various CPT codes	\$200

#### Licensed Clinical Social Worker (LCSW) or Licensed Clinical Professional Counselor (LCPC):

Initial Consultation / Diagnostic Interview	CPT code 90791	\$175
Individual Psychotherapy 53+ minutes	CPT code 90837	\$155
Individual Psychotherapy 38-52 minutes	CPT code 90834	\$135
Individual Psychotherapy 16-37 minutes	CPT code 90832	\$ 80
Family Therapy 26+ minutes	CPT code 90846/90847	\$155



**The Barrington Center for Counseling and Psychotherapy**  
**901 Fox Glen Court, Barrington, IL 60010 • 847.304.0780**

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**Fees Not Covered by Insurance:**

Requests for the therapist's time beyond sessions will be at the therapist's discretion and cannot be billed to insurance. Therefore, the following fee(s) to provide additional services becomes my responsibility:

- Phone Consultations over 10 minutes will be charged \$25 for each 15 minutes (unless a teletherapy session is scheduled, and then we will bill insurance accordingly).
- Court Related Services: \$500 per hour paid in advance (including preparation and travel)
- Letters, Reports, Treatment Summaries, and Documentation: \$75 per half hour (includes preparation)
- School Staffing or requests for On-Site Services/Attendance: \$125 per hour (including preparation and travel)

**Appointments:**

I agree to give 24-hours prior notice if unable to keep an appointment. Missed appointments, or appointments cancelled without 24-hours prior notice, will be charged **\$50** for the first occurrence and **\$100** thereafter for each missed appointment. Insurance cannot be billed for these appointments, and without sufficient notice the time is unavailable to others. Therefore, this fee becomes my responsibility. This fee also applies to late cancelled/no show appointments scheduled for my dependents.

**Credit Card on File:**

BCCP requires a credit/debit card be kept on file to assist in the timely collection of outstanding balances. I understand my credit/debit card will be automatically charged at the end of each month for any balance remaining on my account, and I am responsible for maintaining a valid card on file throughout my time in services. If BCCP is unable to collect payment, or a balance remains after 30 days, I understand my account may be referred to an outside firm for collection, and I will be responsible for all collection costs including any reasonable attorney fees.

*Prior to starting services, your therapist or The Barrington Center office will collect your credit card information to be retained in our HIPAA compliant/secure electronic records system. For security reasons, we advise against sending this information by email, text, etc. Thank you.*

**My signature below confirms that I have read and agree to the information stated within The Therapy Consent and Agreement.**

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Patient Signature (including patients 12 -17 yrs. old)

Date:

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Therapist/Witness Signature:

Date:

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Parent/Guardian Signature:

Date:

**The Barrington Center for Counseling and Psychotherapy**  
**901 Fox Glen Court**  
**Barrington, IL 60010**  
**(847) 304-0770**

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## **Notice of Privacy Practices**

As required by the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, this notice describes how health information about you may be used and disclosed and how you can access this information.

## **Understanding Your Health Information and Health Record**

Each time you visit your psychotherapist at the Barrington Center for Counseling and Psychotherapy (throughout this document referred to as the "Center"); we document information about you and your visit. Typically, this record is referred to as your Behavioral Health Record and contains your name, symptoms, history, diagnoses, treatment given and a plan for future care or treatment. This record is used to document and plan your care and treatment and be a source of your health information.

## **Use and Disclosure of Your Health Information**

The Center will use and disclose your health information contained within the behavioral health record to give you treatment, obtain payment for your treatment, and operate our psychotherapy business.

Some examples of how your health information may be used or disclosed include the following:

1. Your therapist will collect and document information about you in your record. We may disclose information to a physician or other health care provider who will be assisting or consulting regarding your care. This information will be used to evaluate or choose the treatment we believe is best for you. This treatment will always be coordinated with you. We will document in your record the suggestions and observations made of you.
2. We will send a bill that includes some of your health information to you, to the person responsible for the bill, and your third party payer (such as your Health Insurance Company or Medicare). In some instances, we may need to send part of your record to your third party payer. The type of health information we might send includes your name, other identifying information, diagnosis, treatment, and possibly a summary of your progress.
3. We will use and/or disclose your health information to those persons or companies for which you give us written authorization or permission to do so. If you authorize us to use or disclose your information, you must complete our Release of Health Information Form. You may revoke your authorization in writing at any time to the extent that we may have already used or disclosed your health information as previously authorized.

The Center may without your written permission release your health information for the purposes described below.

- **Business Associates:**

We provide some services through other persons or companies that need access to your name or

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health information to carry out these services. The law refers to these persons or companies as Business Associates. Our 24 hour answering service would be an example of such an associate. Billing or collection service would be an additional example.

- **Law Enforcement Officials:**

We may disclose your health information to the police, other law enforcement officials, and to the courts or administrative proceedings as allowed or required by law, or required by a court order or other legal process. We also must report known, or suspected, incidents of child abuse or neglect or elder abuse or neglect.

- **Notification and Other Communications with your Relatives, Close Friends, or Caregivers:**

You or your legal representative must tell your therapist which of your relatives or other persons may receive information about you. After learning who these persons are, we may, in our best judgment, use and disclose your health information, to notify these person(s) of what they need to know to care for you. In an emergency or other situation where you are not able to identify your chosen person(s) to receive communications about you, we may exercise our professional judgment to determine whether such a disclosure is in your best interest, who is the appropriate person(s) and what health information is relevant to their involvement with your healthcare or safety.

## Patient's Rights

Your behavioral Health Record is the physical property of the Center; however the information within the record belongs to you. Federal and Illinois Laws provide you with the following rights regarding your health information that is contained in the record that the Center keeps about you.

- Right to obtain a copy of this Notice of Privacy Practices
- Right to request certain restrictions on the uses and disclosures of your health information
- Right to inspect or receive a copy of your health record
- Right to request an amendment to your health record if you believe it contains an error
- Right to obtain a list of all the people and companies which the Center has released your health information (an "accounting" of disclosures)
- Right to request that we communicate with you about your health care at a confidential phone number or address
- Right to revoke your written consent / authorization to use or disclose your health information except when the use or disclosure has already happened.

Federal and Illinois Laws also provide you with the right to be informed about and give your written authorization before any health information, is disclosed, unless such disclosure is allowed or required by law.

## The Center's Responsibilities

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

## The Barrington Center for Counseling and Psychotherapy

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- Do what is required by this Notice or a Notice that is in effect at the time The Center uses or discloses your health information
- Notify you if we are unable to agree to your requested restriction on disclosure if your health information
- Agree to reasonable requests to communicate your health information by an alternative method or at an alternative location

### Complaints

If you would like to report a Privacy Problem, want further information, or believe your privacy rights have been violated, you may file a report with Dr. Cheryl Borst at the Center at (847)304-0770 ext 1, or you may send a written complaint to the Secretary of the US Department of Health and Human Services, or to the office of Civil Rights (OCR). We will not retaliate against you if you file a complaint with us or with the Directors of OCR or HHS.

### Effective Date, Restrictions, and Changes to Privacy Policy

This notice is to into effect on April 13, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all records that we maintain. We will provide you copies of any revised notice.

**Acknowledgement:** I/we have received a copy of the "Notice of Privacy Practices."

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Patient (including patient's 12-17 yrs. old)	Date
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Witness/Therapist	Date
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Parent/Guardian	Date
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## The Barrington Center for Counseling and Psychotherapy

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We appreciate the confidence you have placed in us by making this initial appointment. Please read this contract carefully and discuss any questions or concerns you might have with your counselor.

I agree to engage BCCP and its practioners to render consulting and psychological services to:

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(Patient's name)

I understand that if I choose to use insurance, BCCP will contact my insurance company to inquire about available mental health benefits, and will share that information with me as a courtesy only, and not as a guarantee of payment.

I understand that if my insurance is a "managed care" type of benefit, my BCCP doctor/counselor is required to submit a "treatment plan" to the managed care contractor. This usually includes diagnosis, description of the problem, personal background information, treatment goals and therapy methods. My signature gives BCCP the permission to submit this information on behalf of myself (or my minor) if I choose to utilize my insurance benefit.

I understand that payment is due at the time of service. If benefits have been verified, I am responsible for the co-pay portion at each session. Otherwise, I will pay in full.

If my insurance carrier changes, I agree to contact BCCP with that information and readjust my co-pay accordingly if necessary.

I agree to contact my insurance company to expedite payment to BCCP if payments are not made promptly (over 30 days). I also agree that in the event that I receive insurance payments directly from my carrier, I will promptly remit that amount of payment to BCCP.

I understand and agree to give 24 hours prior notice if unable to keep an appointment. Since insurance companies cannot be billed for missed appointments, I understand that it is my sole fiscal responsibility.

I understand that my doctor or counselor may be required by law to release information without my approval to specific professional and others if:

- There is a clear and serious danger of harm to anyone
- A judge required specific information in a court case
- It is suspect that a criminal offense of child abuse has occurred.

I understand that this consent can be revoked at any time by submitting a written notice to BCCP.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

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Patient (including patient's 12-17 yrs. old)

Date

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Witness/Therapist

Date

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Parent/Guardian

Date