Integrated Health Center – Psychotherapy

Child Intake

Patient Information (minor)

Today's Date: _____ Grade in School:_____ Age:_____

Patient's Full Name: _____Nickname: _____ Date of Birth: _____

Address:_____

City, State, Zip:_____

Family Information

Parent Name: _____ DOB:_____

Address:_____

Cell Phone: _____ Home or Alternate Phone: _____

Email address: _____ Occupation:_____

Relationship to child:_____

Biological Step Foster Adoptive Other:_____

Parent Name: _____ DOB:_____

Address:_____

Cell Phone: _____ Home or Alternate Phone: _____

Email address: _____ Occupation:_____

Relationship to child:_____

Biological Step Foster Adoptive Other:_____

Parents Relationship status: Married Separated/Divorced Never Married

Who is the child's main caretaker?_____

Will you be filing a claim with your insurance? __Yes __No Insurance Company:_____

How were you referred to our office: _____

Are you court ordered to seek therapy? Yes or No

If yes please list agency, attorney, or probation officer's contact information:_____

_____

Patient Assessment

In filling out this form you are welcome to provide as much information as you would like. If you find a question that you desire to leave blank, you are welcome to do so for any reason. Your counselor will review this form and if they have any questions regarding your answers, she will follow up with you in session.

Presenting Problem

Briefly describe the reason(s) for seeking therapy:

_____

_____

_____

_____

Family Background

Please list all family members either living in the household or are significant in your child's life:

Name	Age	Gender	Relationship	Lives with
_____	_____	_____	_____	Y or N
_____	_____	_____	_____	Y or N
_____	_____	_____	_____	Y or N
_____	_____	_____	_____	Y or N
_____	_____	_____	_____	Y or N
_____	_____	_____	_____	Y or N

Are there cultural or religious beliefs that are important to you that your counselor should be aware of?

Yes or No If yes, please explain:_____

In what cities has your child been raised? _____

How many schools has he/she attended:_____

Has your child ever received special education services? If yes, what services have been provided? _____

_____

Has your child experienced any of the following problems at school?

Fighting	Lack of friends	Drugs/Alcohol	Detention	Suspension
Absences	incomplete work	Learning Disabilities	Poor grades	Behavior problems

Does your child exhibit any of the following behaviors that concern you?

Angry	Impulsive	Fearful	Trouble sleeping	Nightmares
Appetite	Slow to learn	Wets bed	Anxious	Risky behavior
Withdrawn	Distractible	Violent	Peer problems	Forgetful

Please circle any past, present, or impending problems/stressors in the family:

Physical / sexual abuse deaths financial/unemployment frequent relocations

divorce legal problems injuries/disabilities other:_____

Please specify details and approximate age of occurrence:

_____

_____

Who in the family does your child feel closest to? _____

Most distant from? _____ In most conflict with? _____

What are some of the things that are currently stressful to your child and his/her family: _____

_____

Health History

How is your child's current physical health? Poor Fair Good Excellent

Please list any medical problems or physical handicaps (e.g., headaches, dyslexia, diabetes, etc.):_____

_____

Please list any prescribed medications your child takes, including dosage and frequency: _____

_____

Does your child or anyone in the child's family currently (or in the past) use any type of drugs, tobacco or alcohol?
Yes or No Please describe:_____

Please list any past counseling that your child has had? What was the reason? Was it helpful? _____

_____

_____

Has anyone in the family ever been hospitalized for psychiatric reasons? Yes or No

If yes, please specify the details: _____

_____

Has your child had suicidal thoughts? Yes or No When was the most recent time? _____

Has your child ever intentionally inflicted harm upon him/herself? Yes or No

If yes, how often? _____ Nature of harm: _____

Has your child intentionally hurt someone else? Yes or No

If yes, when? _____ Nature of experience: _____

Has your child experienced any significant stressors or traumatic events? Yes or No

If yes, when? _____ Nature of experience: _____

_____

Has your child experienced legal problems? Yes or No Please list: _____

Personal Assessment

What do you hope will change because of your child participating in therapy?

_____

_____

_____

What do your child's peers/friends/teachers say about them? _____

_____

How does he/she spend their leisure time? _____

_____

What are his/her Strengths? _____

_____

_____

Permission for Treatment

In presenting my child for diagnosis and treatment, I voluntarily consent to the rendering of counseling services provided by Christina Szarka, MSW MSTL. I acknowledge no guarantees have been made to me as to the effect of treatment on his/her condition. I acknowledge I am responsible for all reasonable charges in connection with care and treatment. I have read this statement and acknowledge that I understand it.

_____ _____

Parent Name Date

_____

Parent Signature

Integrated Health Center, LLC
7286 S. Yosemite St. #150
Centennial, CO 80112
(303) 220-7319

COLORADO NOTICE FORM OF HIPAA LEGISLATION

Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your counselor may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.

• "Treatment, Payment, and Health Care Operations"

– Treatment is when your counselor provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your counselor consults with another health care provider, such as your family physician or another psychotherapist.

– Payment is when you obtain reimbursement for your healthcare. Examples are if your counselor discloses your PHI to your health insurer for reimbursement for health care.

– Health Care Operations are activities that relate to the performance and operation of your counselor's practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits, administrative services, case management, and care coordination.

• "Use" applies only to activities within your counselor's [office, clinic, practice group,etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "Disclosure" applies to activities outside of your counselor's [office, clinic, practice group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Your counselor may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your counselor is asked for information for purposes outside of treatment, payment or health care operations, your counselor will obtain an authorization from you before releasing this information. Your counselor will also need to obtain an authorization before releasing your notes. "Psychotherapy Notes" are notes your counselor has made about your conversation during a private, group, joint, or family counseling session, which your counselor has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your counselor has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Your counselor may use or disclose PHI without your consent or authorization in the following circumstances:

• Child Abuse – If your counselor has reasonable cause to know or suspect that a child has been subjected to abuse or neglect, your counselor must immediately report this to the appropriate authorities.

• Adult and Domestic Abuse – If your counselor has reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then your counselor must report this belief to the appropriate authorities.

• Health Oversight Activities – If the Grievance Board for Unlicensed Psychotherapists or an authorized professional review committee is reviewing my services, your counselor may disclose PHI to that board or committee.

• Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and your counselor will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

• Serious Threat to Health or Safety – If you communicate to your counselor a serious threat of imminent physical violence against a specific person or persons, your counselor has a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If your counselor believes that you are at imminent risk of inflicting serious harm on yourself, your counselor may disclose information necessary to protect you. In either case, your counselor may disclose information in order to initiate hospitalization.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

• Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, your counselor is not required to agree to a restriction you request.

• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing your counselor. On your request, your counselor will send your bills to another address.)

• Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in your counselor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your counselor may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your counselor will discuss with you the details of the request and denial process.

• Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your counselor may deny your request. On your request, your counselor will discuss with you the details of the amendment process.

• Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, your counselor will discuss with you the details of the accounting process.

• Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

•You are entitled to receive information from your counselor regarding the methods of therapy, the techniques used, the duration of therapy (if known), and fee structure.

•You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

Psychotherapist's Duties:

• Your counselor is required by law to maintain the privacy of PHI and to provide you with a notice of his or her legal duties and privacy practices with respect to PHI.

• Your counselor reserves the right to change the privacy policies and practices described in this notice. Unless your counselor notifies you of such changes, however, your counselor is required to abide by the terms currently in effect.

• If Christina Szarka revises her policies and procedures, she will notify you by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision your counselor makes about access to your records, or have other concerns about your privacy rights, you are encouraged to discuss this with your counselor prior to your first session. If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to: Christina Szarka 7286 S. Yosemite St #150 Centennial, CO 80112. You may also send a written complaint to the Colorado Department of Regulatory Agencies, 1560 Broadway, Suite 1350, Denver, Colorado 80202. You have specific rights under the Privacy Rule.

IV. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on the date you sign this notice. Integrated Health Center, LLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that your counselor maintains. Christina Szarka, MSW will provide you with a revised notice by mail within ten business days prior to changes.

VII. Client Signature

I have read the above terms and understand them as stated. I have been informed of my therapist's policies and practices to protect the privacy of my health information.

_____

Client Name (Printed) Signature Date

_____

Therapist Name (Printed) Signature Date

Christina Szarka, MSW MSTL
7286 S. Yosemite St #150
Centennial, CO 80112
(303) 220-7319

AGREEMENT FOR SERVICE / INFORMED CONSENT

This Agreement is intended to provide _____ (herein "Patient") with important information regarding the practices, policies and procedures of Christina Szarka, MSW MSTL (herein "Therapist") and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under Colorado law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which
Patient and another individual, or entity, are parties.Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $100 per hour.

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the Psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The usual and customary fee for service is $85 per 50-minute session. At times, Therapist may suggest sessions of other lengths, and if accepted by Patient, the fee will be negotiated at that time. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist. If Patient wishes to use insurance benefits, a separate insurance fee consent will outline the fees specific to the individual's plan. From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed up on fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Patients are expected to pay for services at the time services are rendered. Therapist accepts all major credit cards, checks, and cash. There is a $35 returned check fee.

Cancellation Policy

Patient is responsible for payment of the agreed upon fee for any missed session(s). Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at 303-220-7319.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

Therapist Availability

Therapist has confidential voice mail that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24 -hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911 or their county crisis line or go to the nearest emergency room.

Therapist Communications and Social Media

Therapist may need to communicate with Patient in between sessions. Please review the following considerations, and indicate contact preferences below.

Email communication and text messaging is used only with Patient permission. If Patient chooses to communicate with Therapist by email, it should be with the understanding that all emails are retained in the logs of Patient's and Therapist's Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. If Patient chooses to use text messaging, it should be with the understanding that messages may be inadvertently seen by others, either by access to Patient's phone or via the preview window.

Emails or text messages Therapist receives from Patient and any responses may become a part of Patient's therapy record. Therapist does not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). In addition, if it's discovered that an online relationship has inadvertently been established, that relationship will be cancelled. This is because these types of casual social contacts can jeopardize Patient confidentiality as well as the therapeutic relationship.

Phone:_____

	Preferred		Okay to use
	Okay to leave voicemail		Do not use
	Okay to text		Would like text reminders

Email:_____

	Preferred		Okay to use
	Email appointment reminders		Do not use
			Send billing notices via email

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Patient Name (please print)

_____ _____

Signature of Patient (or authorized representative) Date

_____ _____

Signature of Therapist Date