Dr. Angela Jones, LMFT, LPC, RPT, CPFC
Art of Therapy Counseling & Consulting
Phone (407) 602-3377

CHILD/ADOLESCENT
Client Intake Form

Today's Date: ______________________

Note: In order for your child to be seen at our practice, you must have sole parental rights granted per the state of Florida's law, to include making decisions regarding medical and counseling appointments. In cases of shared custody and decision making both parents must sign this document acknowledging authorization of services prior to services rendered. Custodial documentation from the courts may be requested to keep on file at our office. Please sign and initial below for acknowledgement.

Parent A (or legal guardian) Printed Name: _________________________ **Signature:** __________________________ **Date:** ___________

Parent B (or legal guardian) Printed Name: _________________________ **Signature:** __________________________ **Date:** ___________

Please **print legibly**, providing information to questions below and **bring to your first session**.
All information you provide is protected as confidential.

Client Name: ____
(Last, First, Middle Initial)

Client Racial Ethnic Identity: □ American Indian/Alaska Native □Asian/Asian Indian
□Black/African American □Hispanic/Latino □Middle Eastern □Pacific Islander/Native Hawaiian □White/Caucasian

Client Birth Date: ______ /______ /______ Age: _____________ Gender: ________________

Client SSN: ______ - ______ - ______

School Attending: ___________________________ Grade: _________

Emergency Contact Information:

Name: _________________________ Phone: ____________________ Relationship to Client: _____________

Responsible Party Information (for billing purposes):

Name of parent/guardian (if under 18 years):

____
(Last, First, Middle Initial)

Address: ____
(Street and Number)

____
(City, State, Zip)

Home Phone: __________________________May we leave a message? □ Yes □ No

Cell/Other Phone: ________________________May we leave a message? □ Yes □ No

E-mail: ____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
How did you hear about Art of Therapy Counseling & Consulting Group, LLC? _________________________________

FAMILY INFORMATION

Legal Custodian (if applicable): Name: ____________________ Phone: ________________

Parent's Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Mother's Name: __________________ DOB: ____ / ____ / ____ Age: ____

Employer: __________________________

E-mail Address: __________________________

Home Phone: __________________________May we leave a message? □ Yes □ No

Work Phone: ________________________May we leave a message? □ Yes □ No

Cell/Other Phone: ________________________May we leave a message? □ Yes □ No

Preferred Number to Contact You (Please Circle): Home Work Cell/Other

Father's Name: __________________ DOB: ____ / ____ / ____ Age: ____

Employer: __________________________

E-mail Address: __________________________

Home Phone: __________________________May we leave a message? □ Yes □ No

Work Phone: ________________________May we leave a message? □ Yes □ No

Cell/Other Phone: ________________________May we leave a message? □ Yes □ No

Preferred Number to Contact You (Please Circle): Home Work Cell/Other

Others living in client's home:

Name	**Relationship to Client**	**Age**
______________________________	_________________________	_____________
______________________________	_________________________	_____________
______________________________	_________________________	_____________
______________________________	_________________________	_____________
______________________________	_________________________	_____________

INSURANCE INFORMATION SHEET (if applicable)

Client Name: ____

Street Address: ____

City, State, Zip: ____

Phone: (Home) ____________________ (Cell) ___________________ (Work) ________________

Email: ____

Marital Status: Married _____ Single _____ Divorced _____ Gender: Male _____ Female ______

Date of Birth: ________________________ Social Security #: ______________________________

Insured's Name: ____

Insured's Address: ____

City, State, Zip: ____

Client's Relationship to Insured: Self _______ Spouse _______ Child _______ Other ____________

Insured's Date of Birth: ________________ Insured's Social Security #: __________________

Insured's Employer: ____

Primary Insurance Carrier: ____

Primary Insurance Phone #: ____

Primary Insurance ID#: ____

Member #: ___________________Group #: ____________________________________

Secondary Insurance Carrier: ____

Secondary Insurance Phone #: ____

Secondary Insurance ID#: ____

AUTHORIZATION INFORMATION: (Please enclose a copy of authorization letter if available)
1. Number of Sessions: ________________________________

2. Start and End Dates: _______________________________

3. Authorization #: ___________________________________

Dr. Angela Jones, LMFT, LPC, RPT, CPFC
Art of Therapy Counseling & Consulting
Phone (407) 602-3377

MENTAL HEALTH HISTORY

1. Mental Health/Substance Abuse Family History to include client (please provide relationship, diagnosis and/or substance used): ____
____

2. Has the client previously received any type of mental health services (counseling, psychotherapy, psychiatric services, etc.)?
□ Yes □ No

(If you selected yes, please fill out the following):

Month/Year	Provider	Outcome

3. Is the client currently taking any prescription medication?
□ Yes □ No

Please list: ____
____

4. Has the client ever been prescribed psychiatric medication? □Yes □ No

Please list and provide dates: ____
____

5. Does the client currently see a psychiatrist or another mental health provider? □Yes □ No
If yes, may we contact them to coordinate care? □Yes □ No
If you answered yes, lease list the information of the current psychiatrist or mental health provider:____

6. May we contact the client's primary care provider (PCP) to coordinate care? □Yes □ No
If you answered yes, lease list the information (name and phone number) of the current primary care physician (PCP):
____

Dr. Angela Jones, LMFT, LPC, RPT, CPFC
Art of Therapy Counseling & Consulting
Phone (407) 602-3377

GENERAL HEALTH AND MENTAL EVALUATION

1. How is the client's current physical health? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems the client is currently experiencing:
____

2. How are the client's current sleeping habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems the client is currently experiencing:
____

3. How many times per week does the client generally exercise? __________
What types of exercise does the client participate in? ______________________________

4. Please list any difficulties the client experiences with appetite or eating patterns:
____

5. Is the client currently experiencing overwhelming sadness, grief, or depression? □Yes □ No
If yes, for approximately how long? ________________________

6. Is the client currently experiencing anxiety, panic attacks, or have any phobias? □Yes □ No
If yes, when did you begin experiencing this? ____________________________

7. Is the client currently experiencing any chronic pain? □Yes □ No
If yes, please describe ____________________________

8. Does the client drink alcohol more than once a week? □Yes □ No
If yes, how often does the client consume alcohol? □ Daily □ Weekly □ Monthly
□ Infrequently

9. Does the client engage in recreational drug use? □Yes □ No
If yes, how often does the client engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently
Please provide name of drugs used. ____

10. Is the client currently in a romantic relationship? □Yes □ No
If yes, for how long? __________________

11. Is the client sexually active? □Yes □ No
If yes, for how long? __________________

12. Is the client heterosexual, bi-sexual, or homosexual? Please circle.
On a scale of 1-10, 10 being best, how would the client rate the relationship? __________

13. What significant life changes or stressful events has the client experienced recently?
____
____

GENERAL HEALTH AND MENTAL EVALUATION Cont'd.

14. **FAMILY MENTAL HEALTH HISTORY:** In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse: □Yes □ No
Anxiety: □Yes □ No
Depression: □Yes □ No
Domestic Violence: □Yes □ No
Eating Disorders: □Yes □ No
Obesity: □Yes □ No
Obsessive Compulsive Behavior: □Yes □ No
Schizophrenia: □Yes □ No
Suicide Thoughts: □Yes □ No
Suicide Attempts: □Yes □ No

15. **INDIVIDUAL MENTAL HEALTH HISTORY:** Please check all that the client may have experienced in the past. If yes, please note the date in the space provided next to the item.

Alcohol/Substance Abuse: □Yes □ No
Anxiety: □Yes □ No
Anger Issues/Controlling Behavior: □Yes □ No
Depression: □Yes □ No
Domestic Violence: □Yes □ No
Eating Disorders: □Yes □ No
Grief and loss: □Yes □ No
Legal issues: □Yes □ No
Obesity: □Yes □ No
Obsessive Compulsive Behavior: □Yes □ No
Schizophrenia: □Yes □ No
School problems: □Yes □ No
Suicide Attempts: □Yes □ No

16. Has the client or any other family member received help for drug or alcohol dependency? □Yes □ No
If yes, when?___________________________________Where? ____

17. Have the parent(s) of the client ever been concerned about the client's use of drugs/alcohol? □ Yes □No

18. Has the client been concerned or felt guilty about his/her use of drugs/alcohol? □ Yes □ No

19. Has anyone ever expressed concern about the client's use of drugs/alcohol? □ Yes □No
If yes, who? ____

20. Are drugs used in the home? □ Yes □No
If so, what and by whom? ____

21. Is alcohol used in the home? □ Yes □No
If so, what and by whom? ____

GENERAL HEALTH AND MENTAL EVALUATION Cont'd.

22. Does anyone in the home smoke? □ Yes □No
If so, who does and how much? ____

23. Check which of the following the client uses, and note the amount and frequency of each:

□ Caffeine: ______________________________
□ Coffee: ____________________________
□ Soda: _____________________________
□ Other Drinks □ Pills: _________________
□ Alcohol:___________________________
□ Cocaine, Crack: ___________________

□ Tobacco:______________________
□ Marijuana: _____________________
□ LSD: _________________________
□ Inhalants: _____________________
□ Other: ____________________

INTERESTS, ACCOMPLISHMENTS, AND ADDITIONAL CONCERNS

1. What are the client's main hobbies, interests, and talents?
____

2. What are the client's greatest areas of accomplishment?
____

3. What does the client enjoy doing most?
____

4. What does the client dislike doing most?
____

5. How much time does the client spend on the following:

Doing homework? _________ Playing video games? _________ Exercising? _________Sleeping? _________
Watching TV? _________On the computer? _________ Socializing with friends? _________
Texting/Talking on the phone _______________

6. Below is a common checklist of concerns for children and adolescents.
(Please check all that apply to the client)

____Careless
___Poor sustained attention
___Doesn't listen
___Poor follow-through
___Poor organization
___Loses things
___Easily distracted
___Forgetful in daily activities
___Poor decision-making
___Frequent trouble at school

___Fidgets
___Out-of-seat
___Runs about
___Problems being quiet
___Talks excessively
___Calls out
___Doesn't wait turn
___Interrupts
___Negative peer group

___Loses temper
___Argumentative with adults
___Angry or resentful
___Refuses to comply
___Deliberately annoys
___Projects blame
___Easily annoyed
___Spiteful or vindictive
___Low self-esteem

___Bullies
___Destroys Property
___Physical fights
___Cruel to animals/people
___Uses a weapon
___Steals
___Truant from school
___Sets fires
___Poor peer relationships

ADDITIONAL INFORMATION

1. Is the client currently in school? □Yes □ No If no, please explain:
____

2. Is the client currently on probation? □Yes □ No If yes, please explain why and how long:
____

3. Does the client enjoy school? □Yes □ No Is there anything stressful about going to school?
____
____

4. Does the client consider themselves to be spiritual or religious? □Yes □ No If yes, describe their faith or belief:
____

5. What does the client consider to be some of their strengths?
____
____

6. What does the client consider to be some of their weaknesses?
____
____

7. Why is the client here in therapy (counseling)?
____
____
____

7. How much was the client pressured to come to therapy (counseling) today? (please circle)
Not at all pressured A little pressured Somewhat pressured Quite Pressured Very pressured

8. What is the goal to be accomplished out of the client's time here in therapy (counseling)?
____
____

I give permission to Art of Therapy Counseling & Consulting Group, LLC to treat the minor I am bringing for counseling.

___________________________	______________________________	__________
Printed name of Parent/Guardian	Signature of Parent/Guardian	Date
___________________________	______________________________	__________
Printed name of minor agreeing to participate	Signature of Minor	Date

How did you hear about Art of Therapy Counseling & Consulting Group, LLC? ________________________________

Would you like to join our email list for upcoming workshops and groups? □Yes □ No E-mail: ____________________________

We respect your email privacy. You will not receive unsolicited marketing. We will not share, transfer, sell or rent your information. *Please note: Email correspondence is not considered to be a confidential medium of communication.

Dr. Angela Jones, LMFT, LPC, RPT, CPFC
Art of Therapy Counseling & Consulting
Phone (407) 602-3377

Note: All information requested in this form will be kept confidential

AUTHORIZATION FOR TWO-WAY RELEASE OF INFORMATION

I (we), the undersigned authorize: ______________________________
Name of provider/agency holding information

____
Address of provider/agency holding information

-to release information relevant to the assessment and treatment of the undersigned to Art of Therapy Counseling and Consulting Group (AOT), LLC. I (we) also authorize AOT to release relevant information to the person and/or agency listed above.

______________________________ ______________
Printed name of client Date of Birth

______________________________ ______________
Printed name of client Date of Birth

I (we) understand all information to be obtained from the provider/agency above is to be kept confidential and cannot be released by the recipient without our written consent. This authorization will expire one year from the date of signature or upon termination of services with AOT, whichever first. I (we) understand we have the right to withdraw this authorization for release of information at any time.

______________________	______________	______________________
Printed Name of Parent or Legal Guardian	Relationship to Client	Signature and Date
______________________	______________	______________________
Printed Name of Parent or Legal Guardian	Relationship to Client	Signature and Date
______________________	______________	
Printed Name/Signature of Witness	Date	

Dr. Angela Jones, LMFT, LPC, RPT, CPFC
Art of Therapy Counseling & Consulting
Phone (407) 602-3377

INFORMED CONSENT TO THERAPY AND CLIENT NOTICE OF RIGHTS

Client name: ____

Welcome to Art of Therapy Counseling and Consulting Group, LLC. Congratulations on taking the first and an extremely important step towards achieving your goals. Below you will find information on counseling as well as your rights as a client. Here at Art of Therapy Counseling & Consulting Group (may hereinafter be referred to as AOT), your treatment will be based on the standard practices, training, and experiences of marriage and family therapists, psychotherapists, professional counselors, social workers, psychologists, and life coaches.

How Counseling & Therapy Works:

The process of counseling (also known as therapy) will begin with an intake process designed to evaluate your needs and goals so that we can together come up with a treatment plan. This usually takes one session, but could take several, depending on the circumstances. If you or your therapist believes someone else could better meet your needs, you have the option of referrals to other professionals being provided to you. Your therapy sessions will end once your goals have been accomplished or you decide you do not need therapy anymore and terminate sessions.

Ending Therapy Sessions:

As stated above, you have the right to end therapy at any time. It is recommended that you have at least one more face-to face session to end therapy services verses terminating over the phone, mail, e-mail, or not showing up to a scheduled session. Upon discharge, you may be provided with a Client Satisfaction form to provide the therapist with feedback on the therapy process and your experience. We are always looking to improve services; therefore, your feedback is important to us.

Your Rights as a Client:

As a client, you have all of the rights established by the state of Florida governing clinical practices. These include the rights of consent to treatment, of seeking disclosure from your therapist about his or her qualifications, of requesting a different therapist, of ending treatment at any time, of accessing the client grievance procedures, and of having the records of your treatment kept in confidence. At any point you feel you have been harmed or mistreated, and efforts to discuss this with therapist are unsatisfactory, you may contact the Florida Department of Behavioral Health and Developmental Disabilities for appropriate grievance procedures. By initialing below, I am acknowledging understanding of the policies in this paragraph.

____
Responsible party's initials on line above

Emergency Contact:

Your therapist will provide you with a voicemail/contact phone number and will let you know his/her availability in an emergency. In the event of a mental health emergency in which you are not able to contact your therapist, you should call 911immediately or go to the nearest hospital emergency room. By initialing below, I am acknowledging understanding of the policies in this paragraph.

____
Responsible party's initials on line above

Court Subpoena's and Personal Legal Matters:

I understand that in order for my therapist's work to remain effective, it is in my and/or my child's best interests to not involve my therapist in legal proceedings outside of those covered in the confidentiality statement. The rate for legal depositions, requested by either myself or my attorney, is $2000.00 total for a maximum of 4 hours. Cancellation fee is $2500.00 if less than 48 business hour notice. **Clients are discouraged from having their therapist subpoenaed. Even though the client is responsible for fees, this does not mean the therapists' testimony will be solely in the client's favor.** My therapist at AOT will only testify to the facts of the case and to her professional opinion. I understand the rate for a requested court appearance, with or without my therapist's testimony is $500.00 per hour. A retainer of $5000.00 is due in advance. If a subpoena or notice for my therapist to meet an attorney(s) is received

INFORMED CONSENT TO THERAPY AND CLIENT NOTICE OF RIGHTS CONT'D.

without a minimum of 48-hour notice there will be an additional $500.00 "express" charge. If the case is reset with less than 72 business hours' notice, then I will be charged $500 (in addition to the retainer of $1500.00). There is also a fee for travel reimbursement. I understand all requested deposition and court appearance fees must be paid in full 30 days prior to the scheduled deposition or trial, unless other arrangements have been made in writing. The party requesting the deposition or court appearance is responsible for full payment. I understand that these fees are not covered by insurance, and I will be fully financially responsible. By initialing below, I am acknowledging understanding of all the policies in this paragraph.

____
Responsible party's initials on line above

Other Legal Related Fees:

1. Preparation time (including time for submission of records): $450.00/hour
2. Phone calls: $450.00/hour
3. Depositions: $2000.00 total (maximum 4 hours)
4. Time required in giving testimony: $500.00/hour (2 hour minimum)
5. Mileage: $0.55/mile
6. Travel time away from office due to depositions, testimony, or other legal and/or court actions: $450.00/hour (1 hour minimum)
7. All attorney fees and costs (including travel) incurred by the therapist as a result of the legal action.
8. Filing a document with the court: $450.00
9. The minimum charge for a court appearance: $1450.00 per day

By initialing below, I am acknowledging understanding of the fees above.

____
Responsible party's initials on line above

Payment, Fees, and Expectations:
I hereby consent to my provider at Art of Therapy Counseling & Consulting Group, LLC to treat me for counseling and psychotherapy services. In addition to appointments, I may be charged for other professional services to include telephone conversations longer than 10 minutes, requests for filling out additional forms, writing reports/summaries, and any other services that I may require. I understand that I am financially responsible for all charges regardless of insurance. I may seek insurance reimbursement on my own, but am aware my insurance provider may not cover services at AOT. Some services that I require may not be covered under existing insurance policies and I agree to assume full financial responsibility for those services. If I become involved in litigation, in which AOT's participation is required, I will be expected to pay administrative fees for the professional time required. Due to the complexity and difficulty of legal involvement, fees for preparation and attendance at any legal proceeding in the local area are covered above. Each counseling/psychotherapy session is generally 45 minutes in length and may be scheduled at varying time intervals including weekly, bi-weekly, or monthly. AOT's standard fee is $200.00 per session but this fee may be adjusted based on my family size or income. If my insurance company is billed, I understand the standard fee of $200.00 for initial session and $200.00 for consecutive sessions will be billed and I am responsible for the co-pay. The agreed upon initial assessment fee is _______ with additional session fees in the amount of _______ with a co-pay of _______. Planned sessions lasting longer than 60 minutes will be charged in 15 minute increments. I also understand if I wish to pay with cash I must bring exact cash for payment of services as AOT may not always have change.

Records Requests from Client

1. A charge of $25.00 will be collected for administrative costs.
2. Postage charge, plus tax may also be charged.
3. The following fees will apply for copying documents:
    a. $1.00 per page for the first 25 pages
    b. $0.25 per each additional page
4. For records that are not in paper form, therapist shall be entitled to recover the full reasonable cost of reproduction.
5. $450.00 per document for letters and treatment summaries.

INFORMED CONSENT TO THERAPY AND CLIENT NOTICE OF RIGHTS CONT'D.

Records Requests from Someone Other Than Client:

1. A charge of $25.00 will be collected for administrative costs.
2. Postage charge, plus tax may also be charged.
3. The following fees will apply for copying documents:
    a. $1.00 per page
    b. $2.00 per page for non-paper documents printed
    c. A fee of $5.00 for each year of records requested
4. $450.00 per document for letters and treatment summaries.

By initialing below, I am acknowledging understanding of the policies in this paragraph.

____
Responsible party's initials on line above

Cancellations, No-shows, and Late Arrivals:

AOT has the right to reschedule my session if I am more than 10 minutes late, however, no fee will be charged for the missed session. If I cannot make my appointment, I agree to notify AOT at least 24 hours in advance, or as soon as possible, **prior** to the scheduled appointment time in order to avoid late charges. If I forget an appointment, I am still financially obligated to pay the full cost of the appointment to cover for staff and administrative costs. AOT requires all new clients to either leave a signed, undated check on file for the amount of a session for such eventualities, or to authorize a charge on their credit card for missed and late cancelled appointments. All fee balances must be paid prior to the next scheduled appointment. I understand that my insurance plan will not cover these charges. I understand that if I have three late cancellations and/or 2 no shows, therapy may be terminated. By initialing below, I am acknowledging understanding of the policies in this paragraph.

____
Responsible party's initials on line above

Returned Checks:

AOT will assess a returned check fee of $35.00 in addition to the amount of the returned check. In cases of repeated returns of checks by a client, AOT reserves the right to no longer accept checks by me. If I stop attending sessions and owe a balance, AOT will seek to recoup fees by first contacting me. If I avoid AOT, am unable to be reached by AOT, or refuse to pay, AOT reserves the right to provide my name, contact information, and amount owed to a collection agency. I acknowledge that by not paying for services already received, I am waiving my right to confidentiality for the purposes of collections only. By initialing below, I am acknowledging understanding of the policies in this paragraph.

____
Responsible party's initials on line above

Confidentiality:
I understand that information obtained during the course of treatment will not be released without consent, except in the case of emergency or as required by law. I understand that confidentiality is waived if a client becomes a danger to self or others, if session records are subpoenaed by court of law, in the case of physical or sexual abuse of minors, the elderly, disabled, or incompetent others, and in an effort for AOT to collect debts. I also give authorization for AOT to release any and all information regarding diagnosis, treatment, and prognosis with respect to any mental condition and / or treatment to my insurance company (s) or its legal representative as indicated and considered to be necessary for obligations of the insurance company to be fulfilled and for determination of eligibility benefits under my existing policy. By initialing below, I am acknowledging understanding of the policies in this paragraph.

____
Responsible party's initials on line above

Dr. Angela Jones, LMFT, LPC, RPT, CPFC
Art of Therapy Counseling & Consulting
Phone (407) 602-3377

INFORMED CONSENT TO THERAPY AND CLIENT NOTICE OF RIGHTS CONT'D.

I acknowledge that I am voluntarily consenting to treatment and that this consent may be revoked at any time. By signing this form, I understand and I agree with the terms and conditions of this form. Please initial below.

_____I have seen and read the information contained in this Welcome Note & Notice of Rights.

_____I have seen and/or been offered a copy of Art of Therapy Counseling & Consulting Group confidentiality policy practices as mandated by the *Health Information Portability & Accountability Act* (HIPAA).

_____I consent to Art of Therapy Counseling & Consulting Group to provide treatment as described in this form.

_____I consent to allowing my therapist to consult with other providers for myself and/or my family.
_____I will pay for my therapy expenses as described above.

_____I hereby authorize payment directly to Art of Therapy Counseling & Consulting Group of any benefits due me for counseling/psychotherapy. I understand that I am responsible for any amount not covered by my insurance.

Parent A: Printed Name:_________________________________ Signature: _________________________________

____I consent to Art of Therapy Counseling & Consulting Group to provide treatment as described in this form.

Parent B (if applicable): Printed Name:______________________________ Signature: _______________________

_____I consent to Art of Therapy Counseling & Consulting Group to provide treatment as described in this form.

*Please **initial** if using insurance or EAPs:*______________I hereby authorize the release of healthcare information necessary to process any claims generated by Art of Therapy Counseling & Consulting Group.

I acknowledge that I have received a copy of Art of Therapy Counseling & Consulting Group LLC (AOT) informed consent to confidentiality/Notice of Privacy Practice for Protected Health Information. I understand that AOT has the right to change/update its' Notice of Privacy Practice for Protected Health Information.

____ _______________
Client's Name (Print) Date

____ _______________
Client's Signature Date

____ _______________
Parent or Legal Guardian's Name (Print) Date

____ _______________
Parent or Legal Guardian's Signature Date

____ _______________
Parent or Legal Guardian's Name (Print) Date

____ _______________
Parent or Legal Guardian's Signature Date

____ _______________
Witness Name (Print) Date

____ _______________
Witness Signature Date