



LORVEN CHILD AND FAMILY DEVELOPMENT

Client Information

Date: _____ Client Name: _____

Date of birth: _____ Social Security #: _____

Ethnicity: _____ Gender: Male Female

Parent/Legal Guardian: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Other Parent Name: _____

Address: _____ City/State/Zip: _____

Child Protective Services worker (name and phone number, if applicable): _____

Home phone: _____ OK to leave messages YES NO

Cell phone: _____ OK to leave messages YES NO

Work phone: _____ OK to leave messages YES NO

Email: _____

Employer: _____

Insurance: _____ ID #: _____

Doctor: _____ Date of Last Exam: _____

Allergies: YES NO If yes, please list: _____

List Medications: _____

Client:

Record No.:

Date of Birth:



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Consent for Services

You can expect *Lorven Child and Family Development* to provide professional services delivered in a respectful manner. Our goal is to ensure you receive client-centered treatment that encourages your participation.

- I hereby give my consent for treatment and/or services to be provided by *Lorven Child and Family Development*.
- I understand that I may refuse services at any time and that I can refuse a therapeutic modality without the threat of termination or discharge. If *Lorven Child and Family Development* does not offer an alternative therapeutic approach that is right for you, we will assist with referrals and/or recommendations that can best meet your needs.
- I acknowledge that confidentiality has been verbally explained, as well as limits to confidentiality as described in Client Rights; I understand that the provision of services is not contingent upon such consent and of the need for such release. I understand that confidential information may not be disclosed without written consent when federal statutes prohibit that release.
- I have received a copy of my rights as a client including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.
- I understand that I have the right to access behavioral health crisis services 24/7 by reaching 336-659-3030.
- I understand that I have the right to an individualized written treatment plan and may have access to my service plan at any time by asking my therapist or Director.
- I give my consent for *Lorven Child and Family Development* to access emergency medical care, in case of medical emergency during session.
- I understand that participation in treatment is necessary in order to achieve goals. Therefore, if I miss three scheduled appointments without giving 24 hours notice, *Lorven Child and Family Development* may refer me to another agency.
- We understand that parents may seek treatment for their child(ren) who are experiencing problems with separation and divorce. *Lorven Child and Family Development* does not offer counseling to any child or family until a permanent custody order is in place. Please be aware that the focus of treatment at *Lorven Child and Family Development* will be to assist your child(ren), as well as yourself, to deal with issues **after** custody has been determined. When a therapist is required to testify in Court regarding treatment, it no longer protects client/therapist confidentiality and diminishes the foundation of trust that is critical to the treatment process. **Please be aware that if the therapist is subpoenaed to Court, we have a \$500 retainer fee and bill at a rate of \$150 per hour for each hour spent in preparation, Court appearance, travel time and/or testimony.**

Signature of Client, Parent or Guardian

Date

Client:

Record No.:

Date of Birth:



LORVEN CHILD AND FAMILY DEVELOPMENT

Authorization for Use and Disclosure of Protected Health Information

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164) the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I, _____ (name of client or client's legally responsible person) authorize **Lorven Child and Family Development** to use or disclose to/with

Insurance Company: _____
(name of insurance company to whom the requested use or disclosure will be made)

THIS DATA SHALL INCLUDE (CLIENT MUST INITIAL BESIDE DATA TO BE USED OR DISCLOSED)

<input type="checkbox"/> Assessments	<input type="checkbox"/> Service Notes	<input type="checkbox"/> Substance Abuse/Treatment
<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Service Plans/Goals	<input type="checkbox"/> HIV/AIDS Information
<input type="checkbox"/> Psychological Evaluations	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Social, Developmental, Medical History
<input type="checkbox"/> Diagnoses	<input type="checkbox"/> Financial/Reimbursement	<input type="checkbox"/> Other: _____

PURPOSE OF USE OR DISCLOSURE (CLIENT MUST INITIAL BESIDE DATA TO BE USED OR DISCLOSED)

<input type="checkbox"/> At the request of the individual	<input type="checkbox"/> Assessment/Evaluation	<input type="checkbox"/> Coordination of Service
<input type="checkbox"/> Court Proceedings	<input type="checkbox"/> Determination of Benefits	<input type="checkbox"/> Other: _____

Information requested should be mailed to this address: _____

REDISCLASURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C), substance abuse treatment information protected by federal law (42 C.F.R. Part 2), or HIV/AIDS information (G.S. 130A-143), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these three laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

Initial Authorizing the Release of Substance Abuse Treatment Information

Initial Authorizing the Release of HIV/AIDS Treatment Information

REVOCAION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Notice of Privacy Practices, a copy of which has been given to me. If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

Date of expiration, if less than one year

Event, if less than one year

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that *Lorven Child and Family Development*, will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Signature of client Date

Staff signature Date

Signature of legally responsible person, if required Date

Client:

Record No.:

Date of Birth:



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I, _____ (name of client or client's legally responsible person) authorize **Lorven Child and Family Development** to use or disclose to/with

Doctor: _____ (name of doctor to whom the requested use or disclosure will be made)

THIS DATA SHALL INCLUDE (CLIENT MUST INITIAL BESIDE DATA TO BE USED OR DISCLOSED)

<input type="checkbox"/> Assessments	<input type="checkbox"/> Service Notes	<input type="checkbox"/> Substance Abuse/Treatment
<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Service Plans/Goals	<input type="checkbox"/> HIV/AIDS Information
<input type="checkbox"/> Psychological Evaluations	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Social, Developmental, Medical History
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Signature of client Date

Staff signature Date

Signature of legally responsible person, if required Date

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Agreement to Pay

- I agree to pay for services that I receive at *Lorven Child and Family Development* (including individual, couples and family therapy, collateral contact and court appearances). I agree that it is my responsibility to inform *Lorven Child and Family Development* of any change that may affect my co-pay. This may include, but is not limited to, change in income, change in insurance or Medicaid coverage, etc. Failure to notify *Lorven Child and Family Development* of such changes may result in my fee reverting to the fees listed below.

The fee for Intake =	\$150.00
The fee for Individual and Play Therapy =	\$100.00 per 45 mins.
The fee for Individual and Play Therapy =	\$160.00 per 75 mins.
The fee for Family Therapy with or without client =	\$100.00
Court Appearance/Testimony =	\$500.00 retainer fee & \$150.00 per hour (min. 2 hours)
Collateral Contact =	\$60.00 per hour
My insurance coverage =	\$_____ per visit
My co-pay =	\$_____ per session

- I agree that I will pay \$_____ per session.
- I authorize *Lorven Child and Family Development* to bill **Medicaid/Health Choice** for services provided by this company. It is my responsibility to report any changes in my insurance status and any information about additional insurance coverage to *Lorven Child and Family Development*. I will be responsible for any charges incurred as a result of failure to notify *Lorven Child and Family Development* of any insurance status.
- Authorization to Collect Insurance** - I authorize *Lorven Child and Family Development* to release only information necessary to process insurance claims on services provided by this company. I authorize this office to apply for benefits on my behalf for covered services rendered and request that payment from my insurance company be made directly to *Lorven Child and Family Development*. I understand that it is my responsibility to notify *Lorven Child and Family Development* of any change in my insurance coverage or benefits. I understand that I may be responsible for claims not paid by my insurance company as a result of such change.

Signature of Client, Parent or Guardian

Date

Client:

Record No.:

Date of Birth:



LORVEN CHILD AND FAMILY DEVELOPMENT

Symptom Checklist

Client Name _____ Date _____

Please check all items that apply to you. *All information is strictly confidential.*

BEHAVIOR

- Does things without thinking
- Destroys property or belongings
- Steals
- Lies often
- Refuses to accept responsibility and blames others for their misbehavior
- Deliberately annoys other people
- Engages in self harm behavior such as hitting self, punching self, banging head against wall/floor
- Has run away from home
- Has attempted or talked about suicide
- Argues when told to do something
- Delays doing as asked
- Cruel to animals
- Wants everything his/her own way
- Often tries to be the center of attention
- Has temper tantrums, how frequent _____
- Acts like a younger child
- Curses
- Sets fires on purpose
- Bullies, threatens or intimidates others
- Nervous habits (example: fidgeting, tapping hands or feet)
- Often pouts and sulks
- Prefers to be alone/avoids activities
- Always seems to be "on the go"
- Acts as if driven by a motor
- Constantly in motion
- Impulsive
- Defiant
- Unable to control immediate reactions
- Will act without considering consequences
- Difficulty taking turns, waiting, or sharing
- Other:

ACADEMIC

- Is truant from school
- Grades have dropped

- Does not complete assignments in the classroom
- Does not do homework
- Learning disability ____ and/or mental retardation ____
- Feels unfairly treated by teachers or authorities
- Short attention span
- Often clowns in class
- Refuses to go to school
- Is poorly organized in seatwork
- Poor handwriting /sloppy work
- Can't sit still
- Makes grades below ability
- Has difficulty working in groups
- Rarely speaks up in class
- Rarely works without individual attention
- Has had detentions, suspensions or was expelled
- Test anxiety
- Fears teacher
- Trouble on the bus
- Other:

THINKING

- Seems preoccupied with certain thoughts
- Daydreams more than most
- Says or does things over and over
- Hears or sees things that aren't there
- Seems unaware at times of what is happening around him/her
- Trouble concentrating
- Ideas that don't make sense
- Nervous mannerisms such as nail biting, skin picking, leg jiggling
- Other:

FEELINGS

- Is upset by any changes in routines or schedules
- Lots of fears
- Lacks self-confidence

Client:

Record No.:

Date of Birth:

- Feels sad a lot
- Cries easily
- Does not seem to feel guilt
- Is extremely critical
- Panic attacks
- Mood swings
- Worries too much about different things
- Becomes easily annoyed or irritable
- Feels afraid something awful might happen
- Obsessive or compulsive behavior
- Withdrawal from others
- Loss of motivation
- Lack of energy
- Constantly on guard, watchful or easily startled
- Appears to be detached from others or activities
- Seems afraid to make mistakes/easily embarrassed
- Does not like to be touched
- Resents even gentle criticism
- Has an "I don't care" attitude
- Has a "you can't make me" attitude
- Feels angry a lot
- Feels bored a lot
- Is afraid of "rough" play
- Has frequent nightmares
- Other:

FAMILY

- Gets along poorly with brothers ___ sisters ___
- Gets along poorly with mother ___ stepmother ___
- Gets along poorly with father ___ stepfather ___
- Avoids contact with family members
- Parents get along poorly with each other
- Clings to parents
- Other:

SOCIAL

- Hangs around with a bad crowd
- Is too easily led by others
- Chooses friends a lot younger ___ a lot older ___
- Is often teased by others
- Doesn't like being alone
- Has few friends
- Tattles on other children
- Teases other children
- Seems shy
- Often boasts
- Often interrupts others
- Won't argue or fight back when most would
- Fights
- Has ever been sexually molested
- Other:

PHYSICAL

- Frequent physical complaints
- Sleep: trouble falling asleep ___ sleeps too much ___
- Is tired much of the time
- Is seriously overweight ___ underweight ___
- Lost ___ or gained ___ a lot of weight
- Hearing problems ___ Speech Problems ___
- Poor bladder control during the day
- Wets the bed at night
- Poor bowel control
- Is clumsy and awkward
- Frequently becomes ill on school days, while at school or away from home
- Has ever been physically abused
- Physically aggressive toward others
- Other:

Any number of life events can cause stress, or changes in mood and behavior.

My child has experienced the following: (PLEASE CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> Adoption or foster care placement | <input type="checkbox"/> Parental divorce |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Parent remarriage |
| <input type="checkbox"/> Death of a friend or family member | <input type="checkbox"/> Parent on military leave |
| <input type="checkbox"/> Family financial problems | <input type="checkbox"/> Recent addition to family (birth or adoption) |
| <input type="checkbox"/> Illness in the family | <input type="checkbox"/> Recent move to a new residence |
| <input type="checkbox"/> Incarcerated parent | <input type="checkbox"/> Recent move to a new school |
| <input type="checkbox"/> Marital / Parent relationship stress | <input type="checkbox"/> Traumatic event |
| <input type="checkbox"/> Medical illness or disability | |