

# CLIENT INFORMATION FORM (Minor child/adolescent)

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Client's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Okay to call at home? Yes  No  Okay to leave a message? Yes  No

Other Phone: \_\_\_\_\_ Is this a cell phone? Yes  No  Okay to leave a message? Yes  No

Client's DOB/Age: \_\_\_\_\_ School Attended \_\_\_\_\_ Grade: \_\_\_\_\_

Client's Mother: \_\_\_\_\_ Client's Father: \_\_\_\_\_

Parent's Relationship Status: \_\_\_\_\_ Client lives with: Both  Mother  Father

Custody Arrangements: N/A  Mother Primary  Father Primary   
 (Father visitation)  (Mother visitation)  Other  \_\_\_\_\_

Joint  \_\_\_\_\_ Other  \_\_\_\_\_  
 (How divided?) (explain)

*Emergency Contact* Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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

List any health problems/medications the client is taking: \_\_\_\_\_ How were you referred to me? \_\_\_\_\_

Has client been to counseling before? Yes  No  With whom and when? \_\_\_\_\_

Was it helpful? Yes  No

**Please list any other children**

Name	Age	In home?	Health Issues?	Name	Age	In home?	Health Issues?
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

What is your goal, or reason for being here today? \_\_\_\_\_

<i>Over the last week, has the client demonstrated any:</i>	Not at All	Some what	A Lot
Anxiety, worry, or fear			
Sadness or discouragement			
Difficulty concentrating			
Sleep changes or problems			
Irritability and/or frustration			
Withdrawal from family/friends			
Noticeable Appetite changes			
Loss of interest or motivation			
Discouragement/hopelessness			

<i>Has the client ever done any of the following:</i>	Yes	No
Run away from home.		
Set fires		
Been truant from school		
Been physically cruel to animals		
Had Juvenile Court involvement		
Deliberately destroyed others property		
Attempted Suicide		
Talked of Suicide, or have given you any reason to believe they're thinking of killing or hurting themselves		

**Insurance Reimbursement Data:**

(Note: all information is held in strict confidence and privacy as per state and federal HIPAA regulations)

To correctly obtain reimbursement from your insurance or EAP program, it's necessary to collect the following information. For EAP visits, insurance data helps ensure any necessary referrals made to you are covered, and to verify that when EAP visits are complete, the client can transition to those benefits for treatment if needed or desired.

Insurance Company: \_\_\_\_\_ Your Social Security #: \_\_\_\_\_

Your Date of Birth/Age: \_\_\_\_\_ Insurance ID: (From your insurance card) \_\_\_\_\_

Your Employer: (if a casino group, also indicate your property) \_\_\_\_\_ Phone#: \_\_\_\_\_

May you be contacted at work? Yes  No  Are you the policy holder? Yes  No

***If you are not the policy holder:***

Their Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Their Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Social Security #: \_\_\_\_\_

**Statement of Understanding**

**Appointment Policy:** Please give a *minimum of 24 hours notice* for cancellation. If 24 hour notice is not given, a \$50 fee will be assessed. Please be advised that children cannot be left unattended in the waiting area. Appointments are generally 45 to 50 minutes. If you are late, it will impact the time in session. If for any reason I am late, There will be a complete session.

**Financial policy:** Payment is expected at the time of service. This can be accomplished through insurance or EAP program reimbursement (*exclusive of any co-payment or co-insurance percentage required*). To do so, you give me permission (for the purpose of billing and authorization of treatment) to exchange information about treatment with your insurance company or EAP program. If you choose to waive these permissions, and seek reimbursement on your own, I can provide you with an appropriate invoice upon completion of treatment. If your insurance carrier or EAP program disallows a claim for services, or does not remit payment within 120 days, it will be your responsibility to pay the balance. My schedule of service fees is as follows:

Initial Assessment Session= \$100.00	Alcohol & Drug Assessment* = \$250.00
Individual Therapy Session = \$80.00	Written Letters or Report* = \$100.00 p/hour (\$50.00 minimum)
Couple Therapy Session = \$90.00	Court Involvement* = \$350.00 p/hour (Including travel)
Family Therapy Session = \$100.00	*not certified for Domestic Violence, CPS, or Probation Dept assessments.

I do not perform work disability (FLMA) assessments or return to work assessments.  
I do not provide assessment or counseling services for any form of court related matters.

<b><u>Crisis:</u></b> If you have an emergency after hours, the following facilities offer emergency crisis service 24 hours a day, 7 days a week to both adults & adolescents. UMC offers services for children as well.		
Spring Mountain Treatment Center 7000 Spring Mountain Rd (702) 873-2400	University Medical Center 1800 W. Charleston Blvd (702) 383-2000	Monte Vista Hospital 5900 West Rochelle Ave 364-1111

**Agreement:** By signing below, you declare that you are the legal guardian of this minor and give consent for treatment. As the responsible party for this minor, you acknowledge reading, understanding and agreeing with the terms as outlined in this statement of understanding. You also acknowledge receiving a copy of the privacy policy.

Signature: \_\_\_\_\_

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

As a mental health care provider (therapist), I will create and maintain treatment records that contain individually identifiable health information about you. The purpose of this policy is to explain the privacy and confidentiality of those records and the information contained therein, as well as how this information may be used and disclosed, how your records are protected, and your rights related to them. *(PLEASE REVIEW IT CAREFULLY)*

**Terms Defined:**

**Personal health information (PHI)** is any individually identifiable health information that is created or received by a health care provider (me), health plan, or others and relates to:

- 1) any physical or mental health condition of an individual (you);
- 2) the provision of health care (e.g., psychotherapy) to an individual (you);
- 3) the payment for the provision of health care to an individual (you).

**Treatment** is when I provide, coordinate or manage your health care and other services related to your health care. This *could* include consultation with another health care provider, such as your family physician or another therapist.

**Use** applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

**Disclosure** applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

**Health Care Operations** are activities that relate to the performance and operation of my practice.

(Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.)

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***PLEASE NOTE:*** Confidentiality is vital part of your comfort level as well as achievement in therapy. As such, our **conversations** (i.e. anything we say to one another) are held in strictest confidence and are kept private. I hold this principle to be absolute.

Only in rare circumstances, as outlined in this policy, *could* some element of our conversation be disclosed. These circumstances usually involve injury or possible injury to yourself or others.

As detailed in **(NAC 641A.243)**, pursuant to Nevada Revised Statute 641A I am required to:

"prepare and maintain in a timely manner a record for each of his clients which: (a) Sets forth his assessment of the problems of the client, plan of action for the client, course of treatment for the client and progress notes regarding the course of treatment of the client; and; (b) Includes copies of other relevant documentation"

These are considered your "*Psychotherapy Notes*" and are kept separate from the rest of your PHI. They are also given a greater degree of protection.

Also, under no circumstances, are our conversations ever recorded, either in writing or via electronic means without your written consent.

There are however, some circumstances where PHI or other information relating to you can be released. These are as follows:

**Uses / Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. I also need to obtain an authorization before releasing your psychotherapy notes.

An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when asked for information for purposes outside of treatment, payment and health care operations, I will obtain a written authorization from you before releasing this information.

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 I have relied on that authorization for any action; or if the authorization was obtained as a condition of obtaining insurance coverage.

**Uses / Disclosures without Consent or Authorization**

***Please Note:*** *I, or my representative, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.*

I may use or disclose your PHI without written authorization, to carry out payment, or health care operations.

*(Continued on Reverse)*

## Uses / Disclosures without Consent or Authorization

(continued)

If I become aware that you may be, or have direct knowledge of the, abusing, exploiting or neglecting a child under age 18, a developmentally disabled person, or an elderly person, a report must be made to the appropriate authorities.

If you are in such mental or emotional condition as to be dangerous to yourself or to the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

If you tell me of a serious threat (imminent) of physical violence to be committed by you against a reasonably identifiable victim or victims.

If disclosure is compelled by a court pursuant to an order of that court.

If disclosure is compelled by a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.

If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum (e.g., a subpoena for mental health records), notice to appear, or any provision authorizing discovery in a proceeding before a court or administrative agency.

If disclosure is compelled by a board, commission, or administrative agency pursuant to an investigative subpoena issued pursuant to its lawful authority.

If disclosure is compelled by an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum (e.g., a subpoena for mental health records), or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.

If disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.

If disclosure is compelled by the patient or the patient's representative by corresponding federal statutes or regulations (e.g., federal "HIPAA," regulations which requires this Notice).

If disclosure is compelled or permitted, in the event of your death, to the coroner in order to determine the cause of your death.

If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, including but limited to, audits, criminal or civil investigations, or licensure or disciplinary actions.

If disclosure is compelled by the U. S. Secretary of Health and Human Services to investigate or determine my compliance with federal regulations.

If disclosure is otherwise specifically required by law.

## You're Rights

You have the right to request restrictions on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment, or health care operations. I am not, however, required to agree to your requested restriction. If I do agree, a written record of the agreed upon restriction will be maintained.

You have the right to receive confidential communications of protected health information from me by alternative means or at alternative locations.

You have the right to inspect and copy protected health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute – in other words, I am permitted to deny access for specified reasons. For instance, you do not have this right of access regarding your "*Psychotherapy Notes.*"

You have the right to amend protected health information in your records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to amend is not absolute – in other words, I am permitted to deny the requested amendment for specified reasons. You also have the right, subject to limitations, to provide me with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record.

You have the right to receive an accounting from me of the disclosures of protected health information made by me in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. In other words, I am permitted to deny the request for specified reasons. I do not have to account for disclosures made in order to carry out treatment, payment or health care operations. I also do not have to account for disclosures of protected health information that are made with your written authorization.

## Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision regarding access to your records, first please discuss it with me. As a sole practitioner, I am this practice's *privacy officer*.

You may also send a written complaint to:

U.S. Department of Health and Human Services  
2201 Sixth Ave., Suite 800,  
Seattle, WA98121.

I reserve the right to change these policies and practices; however, unless I notify you of such changes, I am required to abide by the terms currently in effect. If these policies and practices change, you will be provided a copy of the revised notice.