Christian Life Counseling of SWVA

**Child / Adolescent Information – Completed by Parent/Guardian**
**(AGES 17 AND UNDER)**

Person Completing Form: ______________________________ Relationship to Child: _________________________

Do you have legal custody of the child? YES NO

Child's Name: _____________________________________________________

Child's Age: _______ Child's Date of Birth: _____ / ________ / ___________

Phone Number: __________________________________________ Number for: __________________________________

May we leave voicemails? Yes No May we text? Yes No

Physical Address:

______________________________________________________________________________________________

______________________________________________________________________________________________

Mailing Address:

______________________________________________________________________________________________

______________________________________________________________________________________________

May we send mail to your home? Yes No

E-mail Address: _______________________________________________________________________

May we e-mail you? Yes No

Does the child have a guardian (court appointed)? Yes No If yes, name: _________________________

Emergency Contact: ________________________________________ Relationship: ________________

Phone Number: _____________________________________

Preferred Language: __________________________________

| | AGE |
|---|---|
| Child's Parents: ________________________________________ | __________ |
| Step-parents: ________________________________________ | __________ |
| Child's Brothers and Sisters: ________________________________________<br>B=Brother ________________________________________<br>S=Sister<br>SB=Step-brother ________________________________________<br>SS=Step-sister<br>HB=Half-brother ________________________________________<br>HS=Half-sister<br>________________________________________ | __________<br>__________<br>__________<br>__________<br>__________ |
| Presenting Problem (Why are you seeking Counseling?):<br>________________________________________<br>________________________________________<br>________________________________________<br>____________________<br>How long have you been dealing with this challenge? ____________________ | |
| (If any of above are deceased, put a "D" and year in the Age column.) Example: D1987<br>________________________________________<br>________________________________________ | __________<br>__________ |

Who does the child live with?: ________________________________________

Presenting Problem (Why are you seeking counseling for the child?):

________________________________________

________________________________________

________________________________________

How long have you been dealing with this challenge? ____________________

**Developmental History**

Do you know if the child's mother had any complications while she was pregnant? Yes No Unknown

If yes, what: ______________________________________________________________________

Were there complications when the child was born? Yes No Unknown

If yes, what: ________________________________________________________________________

**Risk**

Have the child ever tried to kill himself/herself, or thought about it/talked about it? Yes No

________________________________________________________________________________________________

________________________________________________________________________________________________

Has the child ever tried to hurt someone else, talked about it, or thought about it? Yes No

________________________________________________________________________________________________

________________________________________________________________________________________________

Has the child ever done anything to hurt himself/herself on purpose? Yes No

________________________________________________________________________________________________

________________________________________________________________________________________________

**Past Counseling, Mental Health Hospitalizations, or Support Groups**

Has the child ever had counseling, support groups, or mental health hospitalizations? When and where?

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

If the child has had previous counseling services, what was the outcome?

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Has the child previously received any diagnoses related to his/her mental health? If so, what, and when?

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

**Trauma**

Abuse: Yes No Decline to answer
Sexual Abuse: Yes No Decline to answer
Neglect: Yes No Decline to answer
Domestic Violence: Yes No Decline to answer
Other Trauma: Yes No Decline to answer

If you would like, can you say what happened?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Medical**

Have you ever been diagnosed with any of the following? (Circle)

| Allergies | Chronic Pain | Heart Disorder | Neurological Disorder |
|---|---|---|---|
| Asthma | Diabetes I or II | HIV / AIDS | Respiratory Disorder |
| Autism | Fibromyalgia | Hypertension | Seizures |
| Broken Bones | Head Trauma | Irritable Bowel Synd. | Thyroid Disorder |
| Cancer | Hepatitis _____ | Migraines | Other (add comment) |

Details, and/or Other:

______________________________________________________________________________
______________________________________________________________________________

Is the child allergic to any medications?: YES NO

______________________________________________________________________________
______________________________________________________________________________

Current Medical Complaints:

______________________________________________________________________________
______________________________________________________________________________

Date of last physical: _________________________ Date of last dental exam: _________________________

Are the child's immunizations current? Yes No Unsure

Primary Care Doctor: (Name, Address, Phone)

______________________________________________________________________________
______________________________________________________________________________

Will you sign a Release of Information for the child's doctor? Yes No

Is the child on Medications? If so, what?

______________________________________________________________________________

**Family History of Mental Health**

Has any of the child's family members received a mental health diagnosis? If so, who and what?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Substance Use**

Does/has the child used substances (alcohol, drugs, tobacco?) YES NO UNSURE

If so, what?:

______________________________________________________________________________
______________________________________________________________________________

Additional Comments:

______________________________________________________________________________
______________________________________________________________________________

**Hobbies/Interests**

What is the child good at?:

______________________________________________________________________________
______________________________________________________________________________

What are the child's hobbies?

______________________________________________________________________________
______________________________________________________________________________

**Education/Occupational History**

Is the child a student? Yes No If Yes, Where: ______________________________ Grade: __________

Child's Teacher: ________________________ Is the child in Special Education Services? Yes No

Does your child have any challenges at school?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Legal History**

Does the child have any current or past criminal charges?

______________________________________________________________________________

______________________________________________________________________________

Is the child currently on Probation? Yes No

Are there any active restraining orders associated with the child? Yes No

Are there ongoing custody issues involving the child? Yes No

If so, what?

______________________________________________________________________________

______________________________________________________________________________

Is the child your: Biological child Step child Foster Child Adopted Child Grandchild Niece Nephew Other

Has the child been court-ordered to attend counseling? Yes No

**Home Rules**

Do you have rules for the child? Yes No

If so, what?

______________________________________________________________________________

______________________________________________________________________________

How does the child handle these rules?

______________________________________________________________________________

______________________________________________________________________________

Has child threatened/attempted to run away or stayed out all night? Yes No

If yes, what happened?

______________________________________________________________________________

______________________________________________________________________________

What do you and your spouse/partner DO when your child misbehaves?

You: ___________________________________________________________________

Spouse/partner: ___________________________________________________________

How is the child disciplined?

______________________________________________________________________________

______________________________________________________________________________

Has family ever been involved with Protective Services? ___________________________________________

When? _______________________ Reason: _____________________________________________________

By signing this form, I affirm, that to my knowledge, the information provided is correct on behalf of the child. I understand that the more information I provide, the better my counselor can support the child.

Guardian/Parent Signature: ___________________________________ Date: _________________________

**_________ Counselor Reviewed (Initials)**

**Notification of Privacy, Human Rights, and Informed Consent for Treatment**

This notice describes how private personal medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

**Your Privacy is important to us**: This notice describes how your health information may be used and disclosed while being served by Christian Life Counseling of SWVA (independent providers: Lisa F. Pugh, LPC, Tiffany McCann-Vaught, LPC 7 Kimberly Price, LPC). We are required to abide by the terms of this notice.

**Documentation**: Each time you receive services from us, we make a record of the contact. Types of information kept in your record may include written assessments, treatment plans, progress notes, diagnoses, treatment records, transition and/or discharge planning.

**Billing and payment use of your health information**: To receive payment of services, your health information may be sent to companies or groups responsible for payment coverage. A bill from (Lisa F. Pugh, LPC, Kimberly Price, LPC or Tiffany McCann-Vaught, LPC) is sent to the responsible party you have identified.

**Your Privacy Rights**: are defined under 45 CFR Parts 160 and 164, HIPPA, The American Reinvestment and Recovery Act of 2009, and The Commonwealth of Virginia's Code 35-115-80 and 35-115-90, Human Rights. The HIPPA Privacy Rule establishes rights for recipients of health care and provides clients with authority over their health care information.

**The HIPPA Privacy Rule Gives You the Right to**:

- **Access to review and gain copies of your health records and make corrections**: You have the right to have access to your medical record in order to inspect, challenge, copy, amend, or correct it. The right is not absolute. In certain situations, access may be denied if a physician or psychologist believes that reviewing your records would result in harm to self or others. Make this request by contacting your counselor. If denied access, you will receive a timely, written notice of the decision and reason. A copy of this written notice becomes a part of your record.
- **Receive an accounting of disclosures**: You have the right to receive an accounting of all disclosures of your protected health information that were not part of providing treatment, receiving payment, or other health care operations, or already authorized by you.
- **Request a Restriction of Specific staff access to Your records**: You have the right to request a restriction of use with use and disclosure of your protected health information. We seriously consider all restriction requests and you will be informed whether we are able to use the restriction and still offer effective services, receive payment, and maintain health care operations. Legally we are not required to agree to a restriction if the restriction keeps us from providing or billing for services.
- **Receive Private & Confidential Communication**: You have the right to receive confidential communications about your protected health information.
- **Change How we contact you**: You have the right to request an alternative mode of communication or contact for billing purposes and for service related contacts such as calls to remind you about an appointment.

**Use & Disclosure of Information**:

- "**Use" of Your Health Information**: Upon signing the Notification of Privacy, Human Rights and Informed Consent for Treatment form, you are allowing me to use and disclose necessary health information about you within the private practice and with business associates in order to provide services, collect payments for services provided, and conduct other day to day business practices.
- **Minimum Necessary Rule**: We use the minimum amount of health care information necessary when responding to appropriate needs for information.
- **"Disclosure" of your health information**: We are required to get your authorization to use or disclose your protected health information when it is shared outside of the private practice. Communication and coordination of services with other providers or agencies may be necessary during the course of providing care. We use a written Authorization for Release of Protected Health Information form that specifically states what information will be given to whom, for what purpose(s), and is signed by you or your legal representative. You have the ability to revoke a signed authorization but it would not

apply to any sharing of information that already occurred under that authorization. You have a right to obtain a copy of any authorizations you sign.

- **When We cannot Confirm or Deny**: If we are approached with a request for your health care information that we believe to be unauthorized or for which we have no current or active authorization to disclose information signed by you, then we cannot confirm or deny either that you are a client or that we possess health care information about you. If you have needs that require me to communicate with others for any purpose, such as transportation or appointment dates and times, please notify me so that we can gain an appropriate authorization for the specific types of communication necessary.

**Other Ways We May use Your Health Information:**

- **Consultation**: In order to effectively provide services, we may consult within the private practice. During consultation health information about you may be shared. In day-to-day business practices, trained staff may handle and use your health information when filing documents, storing and securing files and folders, process insurance authorizations perform billing functions, or assure that your information is current and readily accessible to our clinical staff.
- **Quality Improvement**: As a part of our continuous quality improvement efforts to provide the most effective services, your record may be reviewed and audited by staff to assure accuracy, completeness and organizations. Your health information may also be reviewed during audits by state, federal and/or private oversight or regulatory boards.
- **Enhancing Your Healthcare**: We may provide the following support to enhance your overall health care and may contact you to provide: appointment reminders by phone call, text, email or letter informing you about treatment options or information about health-related benefits and services that may be of interest to you.
- **Specific Circumstances for Disclosure**: Although you have the right to give or not give consent to the disclosure of your health information, we are allowed by federal and state law in certain circumstances to disclose specific health information about you without your consent, authorization, or opportunity to agree or object. Communication or sharing of information may occur for the following:
- **As required by law** (example: court-ordered warrant, Virginia Health Information)
- **Public Health activities** (example: communicable diseases)
- **Judicial and Administrative proceedings** (example order from a court or administrative tribunal, or legal counsel to the agency, or Inspector General)
- **Law enforcement** purposes (example: reporting of gunshot wounds, limited information requested about suspects, fugitives, material witnesses, missing persons, criminal conduct on agency premises).
- **To avert a serious threat to health and safety** (example: in response to a statement made by client to harm self or another or substantial property damage.)
- **To protect children or incapacitated adults who are victims of abuse, neglect or exploitation** by reporting suspected abuse to the Department of Social Services - Child or Adult Protective Services.

**Specialized Government Functions**: We may communicate with state and federal government in certain situations and for certain purposes without your permission. These include: Military Services (ex: in response to appropriate military command to assure the proper execution of the military mission); National Security and Intelligence activities (ex: in relation to protective services to the President of the United States); State Department (ex: medical suitability for the purpose of security clearance); Correctional facilities (ex: to correctional facility about an inmate); Workers Compensation to facilitate processing and payment; Coroners and Medical Examiners for identification of a deceased person or to determine cause of death. Documentation will be included in your health record of information disclosed without authorization or those not covered under the permissions granted in the Notification of Privacy, Human Rights and Informed consent for Treatment or your Individualized Service Plan.

**Breach Notification**: The Health Information Technology for Economic and Clinical Health Act (HITECH), which is part of the American Recovery and Reinvestment Act of 2009 (ARRA) enacted February 17, 2009, requires that we notify you if we discover that your health care information is ever disclosed to, accessed by, or used by an unauthorized person or entity. It also applies to disclosures of protected health information, which compromises the security and privacy of the health information. This type of unauthorized exposure to PHI is referred to as a “breach” and applies to me and my business associates. We must respond to the breach events by notifying any and all clients whose information was accessed or disclosed and notify the federal government my

informing the Department of Health and Human Services. In the event of a privacy breach of your health information, you will receive formal written notification.

Use or disclosure of protected health information that is incident to an otherwise permissible use or disclosure and occurs despite reasonable safeguards and proper minimum necessary procedures would not be a violation of the Privacy Rule pursuant to 45 CFR 164.502(a)(1)(iii) and, therefore, would not qualify as a potential breach. Violations of administrative requirements, such as lack of reasonable safeguards or a lack of training, do not themselves qualify as potential breaches under this law.

**Disposition and Retention of Medical Records Upon Discharge**: As directed by the Code of Virginia, we have included this information to inform you of how we handle medical records of persons who are no longer receiving services from the private practice. You are welcome to contact us at: 602 Radford Street, Christiansburg, VA 24073 or 540-382-1751 if you have any questions.

The standard procedure is to retain medical records for a period of at least six (6) years past the date of discharge. At that time, if there is no indication that the discharged individual is planning to return to our agency to receive services, then the medical records for that individual may be destroyed per Virginia (18VAC85-20-26) which state that practitioners must maintain a patient record for a minimum of six (6) years following the last patient encounter with the following exceptions:

- Records of a minor child, including immunizations, must maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time foe record retention of six (6) years from the last patient encounter regardless of the age of the child
- Records that have previously been transferred to another practitioner or health care provider to the patient or his personal representative; or
- Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

**As a client of Christian Life Counseling of SWVA (independent providers Lisa F. Pugh, LPC , Kimberly Price, LPC and/or Tiffany McCann-Vaught, LPC) you have the following rights**:

- To receive services in the least restrictive environment, and to be free from any unnecessary use of seclusion, restriction, or time out. To be treated with dignity and in a professional and courteous manner; to be protected from harm including abuse, harassment, neglect and exploitation.
- To use your preferred or legal name.
- To have your protected health information treated with confidentiality and not released without written consent, except for situations required by law as noted previously. You have the right to determine what information is disclosed, to whom, and the purposes for which it will be used. You have the right to be provided an accounting of disclosures.
- To read, request amendment to, or obtain a copy of your service record, except in instances as noted in this privacy notice. You have the right to be notified of changes in the regulations regarding privacy of protected health information.
- To receive services meeting your individual needs and abilities according to law and sound therapeutic practice. To be involved in all aspects of services provided to you, and provided information to help you make decisions. To ask questions of your counselor about services including treatment and discharge planning and to share any concerns regarding services provided to you. To be provided with general information about services, policies, and rules in writing and in the manner format and language easily understood by me. To be provided help in learning about/applying for public services or benefits to which you may be entitled.
- To not to be included in any experimental program or research without your knowledge and written consent.
- To have opportunities to communicate in private with lawyers, judges, legislators, clergy, licensed health care practitioners, legally authorized representatives, advocates, and the Inspector General; and have access to an advocate or representative, self-help groups, and legal services.
- If you have a compliant regarding me or the services provided, you have the right to have make your compliant without negative action being taken against complaining.
- To be afforded the opportunity to have an individual of your choice notified of my general condition, location, and transfer to another facility

To make a complaint:

- You can talk with your counselor to resolve the issue
- If you feel that we have not resolved the issue. You can contact the Local Human Rights Advocate DBHDS Southwest Satellite Office, 340 Bagley Circle, Marion, VA 24354. Phone (276) 783-1219 or toll free (877) 600-7434.
- You can contact the VA Board of Counseling, 9960 Mayland Dr, Richmond, VA 23233 (804) 367-4610, https://www.dhp.virginia.gov/counseling

**Informed Consent for treatment:**

I, ______________________________ hereby agree to receive services and consent to the standard and customary procedures of evaluation and treatment as prescribed by Christian Life Counseling of SWVA (independent providers Lisa F. Pugh, LPC, Kimberly Price, LPC and Tiffany McCann-Vaught, LPC

[ ] myself (adult) or [ ] myself (emancipated youth)

[ ] My minor child __________________________________________

[ ] _________________for whom I serve as the legal guardian (must provide documentation as to proof of guardianship)

**I understand** that my agreement and consent applies to all services I, or the person whom I am signing for may receive during care. This signed Notification of Privacy, Human Rights and Informed Consent for Treatment form is valid for up to one year from the date of the signature, until time of voluntary discharge, or upon revocation.

In addition to my informed consent for treatment, I authorize the following:

**Medical Emergency**: In the event of a medical emergency, I hereby authorize Lisa F. Pugh, LPC, Kimberly Price, LPC or Tiffany McCann-Vaught, LPC to apply basic first aid and CPR measures, to call my personal physician, and/or to call the local rescue squad if it is indicated. I further give my consent for the transport of myself, or the person for whom I am signing, if necessary to facilitate medical care. They may also contact the person/agency listed below as those to be notified in case of an emergency.

Emergency Contact: _____________________________Relationship___________________________________

Phone #___________________________Cell #________________________Work #______________________

**Transportation**: They may transport the individual named on this consent on an as needed basis in the course of delivering services. The individual, parent, legal or authorized representative signing this consent agrees to release Lisa F. Pugh, LPC and Tiffany McCann-Vaught, LPC from all liability and responsibility regarding personal injury due to accidents which may occur while being transported in the course of receiving services.

**Financial Consent to Pay**

- I agree to notify (independent providers Lisa F. Pugh, LPC, Kimberly Price, LPC and/or Tiffany McCann-Vaught, LPC) of any changes in financial/insurance information. I agree to pay all non-covered charges for services provided. I shall pay these charges at the time of service unless alternative arrangements are made.
- I hereby authorize payments directly to the independent providers Lisa F. Pugh, LPC , Kimberly Price, LPC and/or Tiffany McCann-Vaught, LPC, for any third party benefits to which I am entitled. I agree to pay 100% of any co-payments or deductibles. I further authorize the release of medical/clinical information necessary in order to process third party claims.
- I understand that by signing this consent, HIPPA regulations permit independent providers Lisa F. Pugh, LPC, Kimberly Price, LPC and/or Tiffany McCann-Vaught, LPC, to use established collection procedures, including debt-set off and/or a collection agency that operates as a business associate of independent providers Lisa F. Pugh, LPC, Kimberly Price, LPC and/or Tiffany McCann-Vaught, LPC, if I do not meet my payment responsibilities. This signed consent permits the limited disclosure of my

protected health information necessary to recover payment. I understand that I will be charged for any collection fees and/or legal fees in recovery payment for services.

- I will be charged $35 for any payments returned as non-sufficient or non-payable.
- I understand that I can be charged a $45 for a no show for an appointment. I will give 24 hour notice if possible.
- I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records., 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically when my financial obligations to the independent providers Lisa F. Pugh, LPC, Kimberly Price, LPC and/or Tiffany McCann-Vaught, LPC,. This consent includes information placed in my records after the date indicated below.

I have read or had read to me the Notification of Privacy, Human Rights, and Informed Consent for Treatment.
I understand that I can have a copy of this agreement.

____________________________ _________________
Client/Parent/Guardian Signature Date

____________________________ _________________________________
Client/Parent/Guardian (Print) Client Signature (Minor)

____________________________ _________________
Counselor (Independent Provider) Date

Christian Life Counseling of SWVA

**FINANCIALLY RESPONSIBLE PARTY (GUARNTOR) INFORMATION – Insurance**

Guarantor Name: ________________________________Date of Birth: ____________

Guarantor Address: ___________________________________________________

Guarantor relationship to client (circle one) Mother, Father, Self, Other: ____________

Home Phone ___________SSN: ______________Driver's License #: _____________

Guarantor's Employer: ___________________Work phone: ________________

Occupation: ______________________

## Insurance

Do you have insurance and want CLC of SWVA to bill insurance for your services? Yes No

**If yes, please complete the following questions.**

Is this private practice an approved provider? Yes No Unsure

Primary Insurance Co. Name: ________________________Phone: ______________

Insurance Co. Address: __________________________________________________

Subscriber's name: ______________________ Relationship to Client: _____________

Subscriber's DOB: ___________Group # _______________SSN: ______________

Secondary Insurance Co. Name: ________________________Phone: ______________

Insurance Co. address: __________________________________________________

Subscriber's name: ___________________________ Relationship to Client: _____________

Subscriber's DOB: ________Group # _______________SSN: ______________

Lisa F. Pugh, LPC, Kimberly Price, LPC and Tiffany McCann-Vaught, LPC, are independent providers and bill separately for their services. I hereby authorize and request my insurance to pay directly to Lisa F. Pugh, LPC, Kimberly Price, LPC and Tiffany McCann-Vaught, LPC, the amount due for services rendered. Release of information: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject at state and federal confidentiality requirements. I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Lisa F. Pugh, LPC, Kimberly Price, LPC and Tiffany McCann-Vaught, LPC,. If my provider is contracted with the insurance company, I will be responsible for all co-pay, deductible, and non-covered services as determined by the insurance plan. However, if the insurance does not cover services or does not pay within 90 days, I will be responsible for the entire amount due. We do not participate in court appearances and proceedings of civil matters (including custody, separation, divorce etc.)

Guarantor Signature: ___________________________________

Print Name: _______________________________ Date: _________________

Christian Life Counseling of SWVA

**FINANCIALLY RESPONSIBLE PARTY (GUARNTOR) INFORMATION – SELF PAY**

Guarantor Name: ___________________________________Date of Birth: _____________

Guarantor Address: _______________________________________________________

Guarantor relationship to client (circle one) Mother, Father, Self, Other: _____________

Home Phone ____________SSN: _______________Driver's License #: ______________

Guarantor's Employer: ____________________Work phone: _________________

Occupation: _______________________

**By signing this agreement, I wish to self-pay for my services.**
In doing so, I receive an automatic 50% discount which will be $45 per session.

I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Lisa F. Pugh, LPC, Kimberly Price, LPC or Tiffany McCann-Vaught, LPC.

I will be responsible for the entire amount due by cash, check, credit or debit card at the time of service.

I will be charged $35 for any payments returned as non-sufficient or non-payable.

I understand that I can be charged a $45 for a no show for an appointment. I will give 24 hour notice if possible.

We do not participate in court proceedings (including custody, separation, divorce etc.)

Guarantor Signature: _____________________________________

Print Name: _________________________________ Date: __________________