Client Name: Date:

Serenity Zone Intake Form- MINOR

Minor (Under Age 18):

Name: _____ Date: _____
(First) (Last)

DOB: ____/____/_____ Age: _____ School: _____ Grade: _____

Referred by: _____

Parents/ Guardian Information:

Mother: _____ DOB: _____/_____/_____

Phone: _____ Email: _____
Voicemails OK? Yes □ No □ Texting? Yes □ No □

Father: _____ DOB: _____/_____/_____

Phone: _____ Email: _____
Voicemails OK? Yes □ No □ Texting? Yes □ No □

Marital Status (circle one): Single Married Separated Divorced Widowed Partnership

How many people are in the minor's household (including the minor)? _____

Mailing Address: _____
(Street) (Town) (State, Zip Code)

Siblings/ Children:

Name	DOB	Age

Client Name: Date:

Is your child currently seeing a psychiatrist? Yes: □ No: □
If yes, please complete the information below:

Psychiatrist's Name: _____ Phone: _____

Email: _____ Fax #: _____

Address: _____
(Street) (City) (State, Zip Code)

Current Psychotropic Medications:

Medication Name:	Dosage:	Frequency:	Purpose:	Prescribed by:

Are they compliant with taking their medication(s)? Yes □ No □

Is the minor currently experiencing stress in any of these areas?

□ Time Management □ Relationships
□ School □ Medical
□ Work □ Family
□ Financial □ Legal

Has the minor had any alcohol/substance abuse issues? Yes □ No □

Previous Counseling Experiences:

Has your child been in counseling in the past? Yes □ No □

If yes, how long ago? _____ For how long? _____

Name: _____ Phone: _____

Diagnoses: _____ May we contact them? Yes □ No □

Name: _____ Phone: _____

Client Name: Date:

Diagnoses: _____ May we contact them? Yes □ No □

Person completing this form: _____Relationship: _____

If you have brought a child for evaluation or treatment, first please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- ❑ Argues, "talks back," smart-alecky, defiant
- ❑ Bullies/intimidates, teases, inflicts pain on others, bossy, picks on others, provokes
- ❑ Cheats
- ❑ Cruel to animals
- ❑ Conflicts with parents (breaking rules, chores, homework, grades, choices in friends)
- ❑ Complains constantly
- ❑ Cries easily, feelings are easily hurt
- ❑ Difficulties with parent's paramour/new marriage/new family
- ❑ Dependent, immature
- ❑ Developmental delays
- ❑ Disrupts family activities
- ❑ Disobedient, uncooperative, refuses, non-compliant, doesn't follow rules
- ❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ❑ Dropping out of school
- ❑ Drug or alcohol use
- ❑ Eating (poor manners, refuses to eat, appetite increase or decreases)
- ❑ Extracurricular activities interfere with academics
- ❑ Failure in school
- ❑ Fearful
- ❑ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ❑ Fire setting
- ❑ Hypochondriac, always complains of feeling sick
- ❑ Immature, "clowns around," has only younger playmates

- ❑ Interrupts, talks out, yells
- ❑ Isolates self from others
- ❑ Lacks organization, unprepared
- ❑ Lacks respect for authority, insults, provokes, manipulates
- ❑ Learning problems
- ❑ Legal difficulties (truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales)
- ❑ Lying
- ❑ Low frustration tolerance, irritability
- ❑ Moody
- ❑ Nervous
- ❑ Need for high degree of supervision at home over play/chores/schedule
- ❑ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety
- ❑ Oppositional, resists, refuses, does not comply, negativism
- ❑ Prejudiced, bigoted, insulting, name calling, intolerant
- ❑ Procrastinates, wastes time
- ❑ Recent move, new school, loss of friends
- ❑ Relationship problems with *brothers/sisters* (fights, teasing/provoking, assaults)
- ❑ Relationship problems with *friends/peers* (fights, teasing/provoking, assaults)
- ❑ Rocking or other repetitive movements
- ❑ Runs away
- ❑ Sad, unhappy
- ❑ Self-harming behaviors (cutting, biting or hitting self, head banging, scratching self)
- ❑ Speech difficulties
- ❑ Sexual (preoccupation, public masturbation, inappropriate sexual behaviors)
- ❑ Shy, timid
- ❑ Stubborn
- ❑ Suicide talk or attempt
- ❑ Swearing (bathroom language, foul language)
- ❑ Temper tantrums, rages
- ❑ Thumb sucking, finger sucking, hair chewing

Client Name: Date:

- ❑ Tics (involuntary rapid movements, noises, or word productions)
- ❑ Teased, picked on, victimized, bullied
- ❑ Truant, school avoiding
- ❑ Underactive, slow-moving or slow-responding, lethargic
- ❑ Uncoordinated, accident-prone
- ❑ Wetting or soiling the bed or clothes

Any other characteristics: _____
_____
_____
_____
_____

Office Use Only:
Clinician Assigned: _____

INFORMED CONSENT AND AGREEMENT FOR PSYCHOTHERAPY

CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

Confidentiality is the legal right to privacy for all clients who receive behavioral/mental health services. That is, all personal information presented in this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law. However, there are exceptions to upholding confidentiality. Understand that all information discussed in this office will remain confidential except under the following circumstances:

- You consent in writing for Serenity Zone to release and disclose information.

- The State of New York requires that if there is a reasonable possibility of child abuse, neglect, or elder abuse/neglect, this must be reported to the proper protective service agencies immediately. This law is designed to protect children from harm. In this instance a breach of confidentiality is required and permitted by New York Law.

- Ethically and legally, if there is a reasonable possibility of harming yourself or others, then as mandated reporters, Serenity Zone is responsible to inform others, in order to protect them or yourself. **For this reason if there is an emergency during our work together, whom would you like us to contact:**

Name: _____ Phone #: _____

Relationship to you: _____

- **If an insurance carrier or managed care company is paying for your treatment, you should be aware that your treatment records are available to them upon request. Though all insurance companies claim to keep such information confidential, it is possible that the insurance company might put your treatment information into a national medical databank. To further protect you, Serenity Zone will send them a Notice of Redisclosure, which prohibits them from making any further disclosure as is regulated by Federal and State Law. You always have the right to pay for services yourself to avoid the problems described above.**

- If you are a party in litigation, including divorce litigation, and your mental condition is an issue, your privilege may be waived. In custody cases, you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. A Serenity Zone clinician may be required to produce your records and/or testify at deposition or trial if he/she is served with subpoenas or court orders. Serenity Zone cannot provide you legal advice as to what actions may or may not waive your privilege.

- If Serenity Zone is away or unavailable, and another therapist is covering our practice, it may be necessary to share some information about our work together in order for the covering therapist to help you in an emergency situation.

- We frequently contact clients by Cellular Phone, Text, and Email. These technologies are not guaranteed of privacy. **Please circle whether you authorize contact by:**

Cell Phone YES / NO
Text YES / NO
Email YES / NO

- **NOTE TO PARENTS ABOUT CHILDREN'S CONFIDENTIALITY:** If your child participates in treatment, please understand the importance of allowing him/her to develop a confidential relationship with his/her SZ therapist. As such, you understand that most personal information that your child discusses with his/her therapist will not ordinarily be shared with you. Rather, your child's therapist will provide you with general summaries of your child's progress without private details. However, understand that this office is committed to informing you about unusual or dangerous symptoms or behaviors.

GENERAL OFFICE POLICIES

APPOINTMENTS:

Services are provided by appointment only. **Your scheduled appointment time is reserved specifically for you.**

PHONE CALLS:

Generally, there will be no charge for short phone conversations or letters. However, telephone contact, letters or reports of significant length with you or others about your treatment may be billed. Likewise, meetings outside the office related to your treatment will be billed including travel time and expenses. Serenity Zone is available to return calls Monday through Saturday between the hours of 9am and 8pm. If you leave a message for us and we do not respond within 24 hours, please call again to ensure that we received your message.

CANCELLATIONS:

Normally APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE WILL BE CHARGED EITHER THE INITIAL APPOINTMENT FEE OR THE REGULAR SESSION FEE. If an emergency arises and you cannot keep your appointment, please call so that we can discuss the possibility of rescheduling. MONDAY APPOINTMENTS MUST BE CANCELED BY FRIDAY 5PM. Missing **"three"** consecutive appointments will constitute voluntary termination of your treatment.

TERMINATION:

You are making the choice to begin psychotherapy. When it is time for therapy to end, it is important to complete the last sessions. These are an important part of the therapeutic process. If you decide at any time that you want to terminate, please inform us so we can discuss the process.

PROFESSIONAL SERVICES AND RATES

FEES:

Fees are set for a 30, 45 or 60 minute psychotherapy session (depending on your insurance plan). Please make checks payable to Serenity Zone and present them at the beginning of each session. Fees are due when services are rendered. Returned check fee is $25.00.

If you fail to pay your outstanding bill, it can result in your bill being turned over to a Collection Agency or submitted directly to small claims court.

OTHER SERVICES:

Charges for other services, such as hospital visits, consultations with other therapists, home visits, or any court-related services will be based on the time involved in providing the service at our regular fee schedule.

COMMITMENT:

We realize that our services involve a substantial amount of money and time, although they are well in line with similar professionals' charges. We encourage you to make a commitment to yourself that you are willing to work hard and honestly with yourself and us to make the most of your sessions.

Please do not hesitate to ask any questions about therapy, the process, our experiences and qualifications, risks and benefits of therapy or any concerns you may have. We look forward to working with you.

By signing below, I understand and agree with all the policies in this Intake.

Client Signature: _____

INSURANCE CLAIM/FINANCIAL RESPONSIBILITY

Name of Insured: _____ DOB:_____/_____/_____

I authorize this office to release any information necessary to process the insurance claims. I understand that I am fully responsible for all charges, regardless of insurance coverage. Verification of coverage is not a guarantee of payment. Serenity Zone is not responsible for your insurance misquoting benefits. Serenity Zone expects prompt payment of services rendered, notwithstanding any insurance or other 3rd party arrangements. By signing this agreement and

accepting treatment from Serenity Zone, you agree that Serenity Zone has the right to discontinue future treatments if you have invoices outstanding more than 30 days.

Signature of Insured: _____

HIPAA Information- New York Notice Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. These are rules and restrictions on who may see or be notified of your Protection Health Information (PHI). Additional information is available from the U.S. Department of Health and Human Services at: www.hhs.gov. You are advised of the following policies:

1. Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your case are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your case. Client files are stored in a locked file cabinet. You agree to the normal procedures utilized within my office for the handling of charts, client records, PHI and other documents or information.

2. Communication between therapist and client may occur by telephone, e-mail, US mail, of by any means convenient for the practice and/or as requested by you. It is your right to inform us how you wish to receive information and to limit what we disclose, except it is against the law, or in an emergency, or when the information is necessary to treat you.

3. The practice of psychotherapy may utilize a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to our attention in written form.

6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.

7. You will have access to your records in accordance with state and federal laws. We may deny your access to PHI under certain circumstances, but you may have this decision reviewed.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the client.

9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within our office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in this HIPAA Information Form – New York Notice Form:

Signature: _____

SERENITY ZONE LCSW PLLC
4025 Austin Blvd Island Park, NY 11558
(516) 415-2190
Fax: (516) 432-0760
WELIVSTRESSFREE@LIVE.COM

Consent to Release Confidential Information:

Client's Name: _____ DOB: ____/____/_____

I, hereby authorize: Serenity Zone LCSW PLLC, to exchange information about my treatment with:

Name: _____ Profession: _____

Client Name: Date:

Phone: _____ Fax #: _____

Address: _____

I acknowledge that such discloses the fact that the named person has received mental health treatment services. This disclosure of records is required for evaluation, treatment planning, and coordination of services or, for the following purposes and shall be limited to the following specific information either orally, in writing or by photocopy or fax.

I, the undersigned, understand that I may revoke this consent at any time. If not previously revoked, this consent terminates at the completion of treatment with Serenity Zone LCSW PLLC. I understand I am entitled to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

Client's Signature: _____ Today's Date: _____