Confidential Minor Intake

_______________________ Referred By _______________________ Date

_______________________ Minor's Name _______ Birthdate _______ Age

_______________________ Address _______________________ City _______ Zip

_______________________ Home Phone _______________________ Cell Phone (If applicable)

_______________________ Father's Name _______ Birthdate _______ Age

_______________________ Address _______________________ City _______ Zip

_______________ Home Phone _______________ Father's Cellphone May I contact you at home and say who I am? Yes No

_______________________ Father's employer _______________________ Work Number May I contact you at work? Yes - No

_______________________ Father's Email Would you like to receive my newsletter regarding parenting? Yes - No

_______________________ Mother's Name _______ Birthdate _______ Age

_______________________ Address _______________________ City _______ Zip

_______________ Home Phone _______________ Mother's Cellphone May I contact you at home and say who I am? Yes No

_______________________ Mother's employer _______________________ Work Number May I contact you at work? Yes - No

_______________________ Mother's Email Would you like to receive my newsletter regarding parenting? Yes - No

Marital status of parents: Married Divorced Separated Single Deceased

If parents are separated or divorced, parent child is currently living with and custody arrangements

____

____

(documentation of custody arrangement may be requested)

Names of step parents (if applicable)

_______________________ Steparent's Name _______ Birthdate _______ Age

_______________________ Steparent's Name _______ Birthdate _______ Age

Sibling's Names (include all) Ages Please note address (if different)

Name	Birthdate	City/State

Additional Comments on Children or Parents' Marital History:

____

____

____

School	Teacher/School counselor	Current Grade	Current GPA

School History	Grade	Age	Dates Attended

Church affiliation (if any)	Pastor

Minor's interests or hobbies

____

____

Is minor currently under medical treatment? Yes/No If yes, name of Doctor:

____

Any medication currently taking? Yes/No If yes, please list:

____

____

Please describe any current or chronic diagnosed medical conditions or disabilities

____

____

____

Is the minor currently involved in any legal matters, including custody disputes or insurance settlements? If so, please describe:

____
____
____
____

Previous counseling experiences:

Counselor ________________________ Length of counseling ____________________
Dates ___________________ Location _________________________________

Counselor ________________________ Length of counseling _____________________
Dates ___________________ Location _________________________________

Reason for seeking counseling (Describe presenting problem, including length & precipitating event, if applicable)

____
____
____

Goals for counseling -

____
____
____

Please circle any appropriate answers:

Current or previous alcohol or drug abuse Eating disorders

Family member's current or previous alcohol or drug abuse

Habits minor is struggling with: _________________________________

Anger difficulty History of sexual abuse History of physical abuse

Changes in sleep Changes in level of energy Changes in eating habits

Behavior problems Parents' arguing frequently Recent move

Recent loss of a loved one School difficulties Anxiety difficulties

Learning Disabilities History of Head Trauma

To your knowledge, has the minor ever had suicidal thoughts? If yes, please explain:

____
____

Brief description of child's life stressors from ages 1 to 3: ____
____
____

Give a brief history of relationships with:
Father____

____

Mother ____

____

Brothers/Sisters ____

____

Others ____

____

Are there additional comments you would like to tell us about the minor?

____

____

____

____

____

Signature of individual providing minor's information ___________________________________

PARENTAL CONSENT FOR TREATMENT OF A MINOR

I authorize Kate Pieper, LMFT, CCISM, # 36556 to provide psychotherapy for the minor listed below. By signing this agreement, I am certifying that there is no custodial arrangement which prohibits this minor from receiving treatment under this authorization.

I also understand the therapeutic alliance Kate will be establishing with the treatment of my son or daughter. Although parents will be apprised of the progress of therapy and parenting suggestions may be made, I understand the confidentiality between the minor and Kate will be respected as a necessary part of therapy.

____________________________ ________ ______ __________________

Minor's Name Birthdate Age S.S.#

___________________________ ___________________ _________

Address City Zip

_______________________ _________________

Home Phone Cell Phone

_______________________________ ____________________________

Parent/Guardian's Name (printed) Parent/Guardian's Signature

____

Date

_______________________________ ____________________________

Parent/Guardian's Name (printed) Parent/Guardian's Signature

____

Date

_______________________________ ____________________________

Minor’s Name (printed) Minor’s Signature

____

Date

Fees, Insurance and Confidentiality

THE STANDARD FEE for a psychotherapy session is $110.00 per fifty-minute session and 160.00 per 90-minute session. Group therapy sessions have rates that vary with the type of group. Phone Sessions will be billed at your normal psychotherapy rate. Mediation and court appearances will be billed at the rate of $200.00 per hour, regardless of your established fee for psychotherapy. Letters will be billed at your psychotherapy fee for hour(s) spent in preparation. Court reports, psychological evaluation reports, and legal reports will be billed at the rate of $110.00 per hour spent in preparation, regardless of your established fee for psychotherapy, with a minimum charge of at least $250.00. Also, there are additional charges for psychological testing and for copying of records.

EMERGENCY OR URGENT NEEDS – I do provide phone counseling for emergency or urgent needs that may occur during your time of being a client here. Please note Emergency or Urgent Calls will be billed at your regular hourly rate. If you have an emergency or urgent need, please call my business line and press 0. My answering service will connect you to me or notify me of your need.

FEE PAYMENTS and co-pays are presented ahead of the session, unless prior arrangements are made.

REGARDING INSURANCE: *Be aware of your deductible and co-pay per your insurance benefits. I recommend you make a call to your insurance to verify the coverage for mental health*. I am a Preferred Provider for many insurances. However you are responsible to insure the details of your coverage. Co-payments will be made before the start of each session. For insurance plans that I am not a provider, payment will be made in full before each appointment and a Superbill (submittal form) will be given to you so you may bill your insurance company for reimbursement, unless other arrangements are made.

YOUR APPOINTMENT TIME reserves a counseling time for you. Missed sessions will be billed at your full fee unless the appointment has been canceled 24 hours in advance of the scheduled time. *A missed session will not be rescheduled automatically. You must call to reinstate appointments, or mention during canceling that you wish another appointment*.

SOCIAL MEDIA POLICY– As a professional therapist, I do not accept friend or contact requests from current or former clients on any of my personal social networking sites. I believe adding clients could compromise your confidentiality and our respective privacy. Please do not contact me through a Social Networking site (Twitter, Facebook, LinkedIn, etc.) These sites are not secure and I may not read them in a timely manner for your needs. You are welcome to follow any of my business (Kate Pieper, LMFT – A Brave Compassionate Journey) Facebook Page, Instagram, and Twitter accounts. However, communication cannot be made through that forum. Please be aware I cannot insure your privacy if you comment on these posts. However, I have followers across the world, if you do not identify yourself as a client, chances are others will not know.

EMAIL POLICY for myself and clients – I prefer using email only to arrange or modify appointments. Please do not email regarding content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate content, please be aware all emails are retained in the logs of your and my internet service providers. These logs are, in theory, available to be read by the system administrator of the internet service provider. Also, these emails received and responded to will become part of your legal record.

MY PURPOSE is to provide excellence of service to each of my clients. Still, the success of therapy does not just depend on the skill of the therapist. Many other factors, such as the client's openness to working with difficult material, help to determine the outcome of therapy. If you have any questions regarding your progress in therapy at any point during therapy, please communicate this with me. I am open to growing and learning as we journey together.

CONFIDENTIALITY Information and records regarding clients are kept confidential unless a signed, written consent form is obtained to release records. The court and legislature have determined that confidentiality cannot override the obligation of a therapist to report child abuse, elder abuse, or threats to harm oneself or others.

I UNDERSTAND AND AGREE TO THE ABOVE. MY FEE IS ___. IT IS MY RESPONSIBILITY TO NOTIFY *Kate Pieper, LMFT* AT LEAST 24 HOURS PRIOR TO MISSING A SCHEDULED APPOINTMENT. I AGREE TO PAY THE FULL FEE FOR EACH MISSED SESSION I CANCEL WITHOUT GIVING PROPER NOTICE.

______________________________ Mother's Signature	________________ Date
______________________________ Father's Signature	________________ Date
______________________________ Minor's Signature	________________ Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that we have provided.
Kate Pieper's Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change the notice, you may obtain a copy of the revised notice from my office by contacting me at (530)268-3558.

If you have any questions about our Notice of Privacy Practices, please contact me at
10091 Streeter Road, Suite 5, Auburn, CA 95602 (530) 268-3558.

I acknowledge receipt of the Notice of Privacy Practices of Kate Pieper, LMFT.

Signature: ______________________________ Date:_______________________________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain the patient(s) acknowledgement of his or her receipt of the Notice of Privacy Practices, including _________________________. However, because of ___________________________________, we were unable to obtain the patient's acknowledgement.

Signature of Provider: _______________________ Date:_________________________________