CLIENT INFORMATION – PARENT (Child Client)

(Revised January 2024)

Today's Date: _____

Referring Agency/Person: _____

Client Name: _____ Form Completed By: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Phone (cell): _____

E-Mail: _____ (Confidentiality of email communication cannot be guaranteed.)

Date of Birth: _____

Gender: Male _____ Female _____ Ethnicity: _____

Birth History

Where was the client born? _____

Did the client's mother have any illness, injuries or operations during pregnancy? Yes No

If yes, please describe:_____

Was the client adopted? Yes No

If yes, please describe adoption process: _____

Family Information

Mother's Name _____

Mother's Address _____

City_____ State_____ Zip Code _____

Birthdate: _____ Occupation: _____

Employed by: _____

Telephone Number: _____ (Home) _____ (Work)

_____ (Cell) _____ (Other)

Father's Name _____

Father's Address (if different) _____

City_____ State_____ Zip Code _____

Birthdate: _____ Occupation: _____

Employed by: _____

Client Name: _____

Telephone Number: _____ (Home) _____ (Work)

_____ (Cell) _____ (Other)

What is the status of the client's parents' relationship? _____

Names of Siblings: Birthdates of Siblings:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If parents are remarried or living with someone else, please give names and birthdates of step-family members:

Name of step-family members: Birthdates of step-family members:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

To which relatives does the client feel closest and why? _____

Developmental History

Please describe any developmental delays or regressions (sleep difficulties, bed wetting, thumb-sucking, toilet training, etc: _____

_____

Does the client have any particular fears? Please describe: _____

_____

Has the client suffered any recent traumas or loses? (death of loved one/friend/pet, recent move, etc.):

_____

What special interests or hobbies does the client have? _____

_____

Educational Information

School: _____ Grade: _____ Teacher: _____

Did the client have any difficulty starting or continuing in school and if so, please describe? _____

_____

How does the client do academically? _____

How does the client do socially? _____

To which friends does the client feel closest and why? _____

Client Name: _____

Describe any school problems: _____

What kinds of discipline have been used with the child? _____

_____

What special interest, skills, or hobbies does the child have? _____

_____

Medical Information

Doctor: _____ Telephone Number:_____

Date of last physical:_____

May we contact the client's physician? Yes ____ No _____

Immunizations—are they current? Yes ____ No_____

Is client taking any medication or supplements? Yes_____ No_____If yes, list below:

Medication/Supplement	Dosage/Frequency	Begin Date	End Date	Prescribing Physician

What past and present health issues, including pain, has the client experienced?

Past health issues: _____

Current health issues/symptoms: _____

History of hospitalizations(s): _____

Please describe the client's current habits regarding nutrition and exercise: _____

_____

Has the client ever had weight/growth problems? Yes ____ No____

Mental Health Information

Has the client sought help in counseling or psychotherapy before? Yes No

If so, with whom? _____

Has the client ever been diagnosed with any of the following conditions? (please circle all that apply)

Autism Anorexia Anxiety Asperger's

Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD)

Bi-polar Disorder Borderline Personality Bulimia Conduct Disorder

Depression Learning Disability Oppositional Defiant Disorder (ODD)

Client Name: _____

Abuse Information

Is the client exposed to any substance use/abuse? Yes No

If yes, please describe: _____

Has the client experienced any emotional abuse? Yes No

If yes, please describe: _____

Has the client experienced any physical abuse? Yes No

If yes, please describe: _____

Has the client experienced any sexual abuse? Yes No

If yes, please describe: _____

Spiritual Information

What is the family's spiritual or religious background? _____

_____

Do you practice any type of religion or spirituality? (Please circle) Yes No

Buddhism Christianity Mormonism Islam Judaism Other

Are you a member of a local church, mosque or synagogue? Yes No

Congregation: _____

How often do you attend? _____

Do you have a favorite Bible story, verse or character? Yes No

If yes, please explain: _____

Presenting Concerns

What is the problem for which you are seeking counseling for the client? _____

_____

_____

_____

_____

_____

What changes would you like to occur as a result of counseling? _____

_____

_____

_____

_____

_____

_____

Client Name: _____

TREATMENT GOALS AND PHILOSOPHY

New Life Counseling is a Christ-centered, biblically based counseling ministry of Arizona Baptist Children's Services. We serve individuals, children, couples and families who are looking for new answers to old problems. Our goal is to help clients move beyond their current struggles to a place of peace and healing by providing effective solutions and coping strategies. These strategies are based on Christian principles integrated with recognized counseling techniques to help guide people to a meaningful relationship with God and others.

AVAILABLE SERVICES

New Life Counseling is an outpatient provider that employs counseling modalities which assist individuals, couples, and families in resolving their difficulties. **Counseling sessions are 50 minutes in length**.

CANCELLATION NOTICE or "NO SHOW" APPOINTMENTS

A 24-hour notice is required when canceling or rescheduling an appointment *except* in cases of an emergency. Your counselor reserves the right to determine what constitutes an emergency. A $50 fee will be assessed for any "no show" or a rescheduled appointment with less than 24 hours notice. Arriving 15 minutes or more late to a scheduled appointment will be considered a "no show" appointment. If payment for services is handled through a third-party and the third-party does not cover the late cancellation fee or "no show" fee, then the fee will be assessed to the client. Failure to cancel in advance two times or if the client has two "no show" appointments may result in termination of services.

FEE FOR SERVICES

Payment is expected at the time of service, which may include auto charging of a credit card, cash or check. Any outstanding sessions will need to be paid prior to continuing counseling services.

LEGAL SERVICES AND LETTERS

Because we are committed to God's healing and redemption in our client's lives, we do not voluntarily provide forensic or legal services, which are assessments, treatments or recommendations to the courts and legal community (this includes custody related issues). In the event that a judge's order is issued for our counselor's records and/or testimony, at the discretion of the counselor, records may be given, but the therapeutic counseling relationship may be terminated and a referral to another professional will be made. Cases requiring court-ordered involvement with the legal and judicial system (i.e. communication with attorneys, forensic research, and judge-ordered court appearances) will also be prorated at a rate equal to double the counseling fee with a 15-minute minimum. Additionally, any letters (medical, legal, employment) written will only state factual information of the dates counseling services took place and where. We do not diagnose or give medical recommendations and require a signed medical release for treatment plans and/or additional progress notes.

CLIENT RIGHTS

The rights and well-being of our clients are primary concerns to the counselors of New Life Counseling. We strive to provide quality care to our clients in caring and ethical atmosphere. Each client accepted for services shall be afforded the basic right to:

- Treatment and services under conditions that support personal liberty and restrict such liberty only as necessary to comply with treatment needs
- A reasonable explanation of all aspects of one's own condition and treatment
- Be informed in advance of charges for services

Client Name: _____

- All available services without discrimination because of race, creed, color, sex, age, handicap, national origin, or marital status

- Refuse treatment at any point in the treatment process

- Confidentiality of records; within guidelines of state law

- Be informed, in appropriate language and terms, of rights including the right to legal counsel and other requirements of due process

- Referral, as appropriate, to other providers of behavioral health and other services

URGENT/EMERGENCY CARE

Arizona Baptist Children's Services/New Life Counseling does not provide crisis services. If you are in need of crisis services you are encouraged to contact the local crisis center, go to the nearest emergency room or call 911 for assistance.

PARENT RESPONSIBILITY

Parents/guardians are responsible for supervising their children at all times while at the New Life Counseling office. Parents/guardians are financially responsible for any damages their children may cause while in the office or public restrooms.

NO WEAPONS POLICY

No weapons are allowed on the premises of New Life Counseling or in your possession during sessions with representatives of New Life Counseling. Our staff will take the necessary reporting steps in the event that you are found to be in possession of any type of weapon. This strict policy is designed to ensure the safety of everyone.

NO ALCOHOL OR STREET DRUGS

Do not attend counseling sessions if you have taken alcohol or street drugs.

CUSTOMER SATISFACTION SURVEY

When you are discharged you will be asked to fill out a client satisfaction survey or the survey will be mailed to you. This allows you to comment on the quality of your services at New Life Counseling. We strongly encourage you to honestly fill out this survey to provide us with information to improve the quality of our services.

Client Name: _____

FINANCIAL AGREEMENT

NEW LIFE COUNSELING offers Christ-Centered, Biblically Based counseling at an affordable rate. Standard fees are $90 per 50-minute counseling session. (Some counselors will schedule 75 minute sessions for family or marital counseling – fees for these sessions are 1 ½ times the standard rate at $135.) Unfortunately, AZ law does not allow NLC to accept health insurance, AHCCCS, Medicare or Medicaid as payment for services.

All clients (new and active) will be required to securely keep their credit cards on file for New Life Counseling to hold their appointment, as well be charged for their counseling session on the day of their appointment. Clients will be responsible for counseling fees and any outstanding fees (i.e. no shows, late cancellations) as well as notify New Life Counseling if they need to change their credit card or have insufficient funds. Sponsored/third party payments will be billed according to New Life billing procedures (once a month). If an agreed upon third party does not pay, the client will be responsible to pay the fees. The client will be informed in advance of any changes in the agreed upon fees for service.

Accepted method of payments include cash, credit, debit, HSA card or personal check. Checks are to be made payable to ABCS/NEW LIFE COUNSELING. Donations to ABCS/NEW LIFE COUNSELING are tax deductible, but counseling fees are not.

If clients need to cancel a scheduled appointment, they must provide at least 24 hours-notice. Otherwise if clients do not provide adequate notice or attend the scheduled appointment, the client (or payee who has card on file) will be billed $50.00 for the missed appointment. Clients are also responsible to pay for missed sponsored sessions. If there is a scheduling emergency, call the NLC office or counselor as soon as possible and client will be billed at the discretion of the counselor.

I _____agree to pay (please check one):

____$90 per session
____ $_____ Sliding Scale Fee (w/ confirmation of W-2)
____ Sponsorship (Sponsorship agreement form required from sponsor)
____$300 includes Prepare & Enrich assessment plus three (3) sessions*
____$150 includes Prepare & Enrich assessment plus one (1) session*

I have read, understand, and agree to the above financial policies.

_____ _____
Parent/Guardian Signature Date

*Good Faith Estimate: Due to not using insurance to pay for services, this estimate is given to show the costs of projected services to meet state and federal requirements. A quarterly estimate at the standard rate of $90 for 4-12 sessions would range from $360-$1080.. Ultimately, you and your counselor will determine duration and frequency of services and a possible unofficial diagnosis may be given for treatment.

**A minimum of ½ the cost of the Prepare-Enrich package is due for sessions scheduled (non-refundable), as some preliminary work is required of the counselor.

Client Name: _____

INFORMED CONSENT

The following information is for your benefit so you can enter a cooperative counseling partnership in an informed manner. Counseling is a helping relationship for which you are voluntarily entering for assistance with specific and stated problems. It is expected that you will benefit from your counselor relationship, but there are no guarantees that you will. Keep in mind that it is common to feel worse before feeling better. It is also expected that the counseling relationship should end through mutual agreement once desired goals have been reached; however, you have the right to terminate counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

By law, the counselor considers all information and issues presented in the course of counseling as privileged and confidential. Confidential information may be released only with the written consent of the person being treated or that person's legal guardian. State law also requires the release of confidential information under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under age 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may require court-ordered counseling records, a deposition or testimony from a counselor. The contemplation, commission of a crime or harmful act is not considered confidential communication.

Consultation and Professional Training

In accordance with ethical standards, the counselor is required to participate in direct supervision. The counselor requires your consent to obtain professional supervision or collegial consultation outside our ministry when he/she feels it will facilitate the work with you/your family. Your name and any uniquely identifying information about you/your family will be deleted or changed to protect your identity. **Your signature on this form indicates your consent. Please let your counselor know if you are withholding consent.**

Professional Records

The laws and standards of counseling require the keeping of case records. Records are electronically secure and HIPPA compliant. You are entitled to receive a copy of your records or a summary of your care if you make a written requestThese request forms for the summary of your care are available to you. Please note that these are professionally held records and can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records it is recommended that you review them with your counselor so that the contents can be discussed. You have the right to amend your record, if you find something disagreeable or concerning. Your record will NOT be disclosed to others unless you ask the counselor to do so in writing, or unless the law compels the counselor to do so. Communications between the counselor and client will otherwise be deemed privileged and confidential as stated under the laws of this state. You will be charged an appropriate fee for any professional time spent in responding to your request for information. Meetings will be scheduled at mutually convenient times.

Client Name: _____

AUTHORIZATION TO TREAT

Authorization for Treatment

My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my counseling for specific and stated problems.

_____ _____

Client Name Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Counselor Signature and Credentials Date

Client Name: _____

New Life Counseling
800-678-0648
Video Counseling Consent

New Life Counseling will be offering the option of receiving counseling through video-based services Video counseling will also provide access to counseling services for those who lack accessibility due to transportation and location issues.
Clients will be invited via email to the virtual platform on the day of their appointment by the counselor

Participating in Video Counseling services requires that the client agree to the following:

- The client will provide their own technology (including a secure strong internet connection, video/webcam, microphone and audio). Earphones are recommended.
- The client agrees to participate in their appointment from a non-public location that allows privacy and minimizes the ability of the appointment being overheard.
- The client needs to uphold the expectation of providing a safe and confidential space, otherwise the appointment will be ended, and the client will be responsible for fees associated with appointment cancellation.
-

Consent for Video Counseling Services

1. I understand that my counselor has offered me Video Counseling Services, that I can ask questions about video services, and that the information transmitted during Video Counseling will not be recorded.
2. I understand that Video Counseling services have the potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
3. I understand that there are potential risks to Video Counseling including interruptions, unauthorized access, and technical difficulties. This includes confidentiality risks in electronic communication.
4. I understand that if there is a service disruption due to technology failure, that my counselor will call me by telephone to continue the appointment in this format.
5. I understand that the counselor or I can request to discontinue the Video Counseling services if it is agreed that the video-conferencing connections are not adequate for this situation or that the client would be better served by another form of intervention or other referrals will be made.
6. Any videoconferencing platform is not an emergency service. In the event of an emergency, I will call 9-1-1

By signing this I certify that:

1. I have read the video counseling consent form or had the form read and/or explained to me.
2. I fully understand its contents including the risks and benefits of receiving counseling through videoconferencing.
3. I have been given ample opportunity to ask questions and that they have been answered.
4. I agree to provide the environmental conditions outlined above to ensure a safe and confidential environment.

Client Name (printed)_____

Client/Parent Signature _____Date_____

Client Name: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Presented to: _____
Client Printed Name

For: _____
Client Printed Name

Presented by: _____
New Life Staff Printed Name

I, _____, hereby acknowledge that I have received and read the Notice of Privacy Practices for Arizona Baptist Children's Services and that their staff was available to answer any questions I had and to offer further clarification of the contents of the Notice. * *You may refuse to sign this acknowledgment**

Signature: _____ **Date:** _____
Client Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining the acknowledgement

____ Other (Please Specify) _____

Arizona Baptist Children's Services Staff Signature: _____

Arizona Baptist Children's Services
1779 N. Alvernon Way
Tucson, AZ 85712

Phone 520.795.7541
Fax 520.795.7581
Web www.abcs.org

Client Name: _____