CUMBERLAND VALLEY COUNSELING ASSOCIATES

INITIAL CONTACT FORM

NAME: _____ **Birth Date:** _____ **Date:** _____

ADDRESS: _____
Street Town State Zip

CIRCLE PREFERRED METHOD OF CONTACT

TELEPHONE: _____
Home Work Cell

EMAIL ADDRESS: _____

REASON WHY YOU CALLED: _____

EMERGENCY CONTACT PERSON: _____
Name Relationship Telephone Number

INSURANCE:

Primary: _____
Insurance Company Policy Holder or Relation to Holder ID Number

Secondary: _____
Insurance Company Policy Holder or Relation to Holder ID Number

Primary Insured _____
Name Date of Birth SSN#

EMPLOYER OF POLICY HOLDER: _____

How did you hear about our company? _____

Modified: December 3, 2008; June 23, 2010; October 9, 2013

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CHILD/ADOLESCENT INITIAL INTAKE FORM

CHILD'S NAME: _____ **ID:** _____ **Date:** _____

PERSON Providing Information: _____
Name Relationship to Child

LEGAL GUARDIAN(S): _____
Names Relationship to Child

ADDRESS of Child: _____
Street Town State Zip

TELEPHONE: _____
Home Work Cell

EMERGENCY CONTACT PERSON: _____
Name Relationship Telephone Number

PRESENTING ISSUE:

I/We brought my child to counseling because: _____

_____

_____

DESCRIBE YOUR CHILD: _____

_____

_____

FAMILY STRUCTURE: Identify adults living at home and relationship to child: _____

_____

OTHER CHILDREN LIVING IN HOME:

CHILDREN: Name(s), Ages	How does your child get along with each one?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY OF ORIGIN OF CHILD IF NOT DESCRIBED ABOVE:

	Ages	How does your child get along with each?	Any mental health/drug/alcohol issues?
MOTHER:			
FATHER:			
BROTHER:			
BROTHER:			
BROTHER:			
SISTER:			
SISTER:			
SISTER:			

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CHILD/ADOLESCENT INITIAL INTAKE FORM

CHILD'S NAME: _____ **ID#** _____ **Date:** _____

ABUSE HISTORY: Has the child ever been abused – verbally, mentally, emotionally, physically, sexually?
_____ No; _____ Yes: Describe, if you are comfortable: when, by whom, what happened: _____

_____

DEVELOPMENTAL HISTORY OF CHILD:

MOTOR DEVELOPMENT: Coordination, gait, balance, posture, gestures, tics, athletic:

_____ Normal _____ Delay _____ Advanced: Describe: _____

_____

_____

LANGUAGE DEVELOPMENT: Use of single words, sentences: _____ Normal _____ Delay _____ Advanced:

Describe: _____

_____

_____

SENSORY DEVELOPMENT: Vision, hearing, touch, smell, heightened reactions to sensory stimulation:
_____ Normal _____ Delay _____ Advanced:

Describe: _____

_____

_____

EMOTIONAL DEVELOPMENT: Stable, easygoing, joyful, overreacts, mood swings, angry, worries, rigid, change is not easy: _____ Normal _____ Delay _____ Advanced:

Describe: _____

_____

_____

THINKING: Smart, good memory, problem solving, odd ideas, preoccupations, fixations, unusual fantasies, speaks in incomplete or incoherent thoughts, hallucinations, delusions:

_____ Normal _____ Delay _____ Advanced:

Describe: _____

_____

_____

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CHILD/ADOLESCENT INITIAL INTAKE FORM

CHILD'S NAME: _____ **ID#** _____ **Date:** _____

SOCIAL BEHAVIORS: Plays well alone or with others, has friends, aggressive, rejected, bullies or is bullied, withdrawn, shy, anxious around others, does not seem to want/need friends:
_____ Normal _____ Delay _____ Advanced:

Describe: _____

_____

_____

INTELLECT/ACADEMIC SKILLS: Math, reading, writing, memory, speech, etc
____ Normal _____ Delay _____ Advanced:

Describe: _____

_____

SCHOOL: In general, how does your child do at school: ____ OK ____ Issues

Describe: _____

_____

Does your child have an Individualized Education Plan? _____ Yes _____ No
Does your child receive any special education services? _____ Yes _____ No
If "Yes", Please describe: _____

_____

SOCIAL HISTORY: Have the child describe him/her self: _____

_____

What do you (child) like about yourself: _____

_____

Write about or tell about a time when you (child) felt proud, good about yourself:

_____

_____

How do you see the people around you (child)? _____

_____

What would you (child) like to change in your life? or, If you (child) woke up one day and everything was better, what would have changed?

_____

_____

Adopted: February 2012

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CHILD/ADOLESCENT INITIAL INTAKE FORM

CHILD'S NAME: _____ **ID#** _____ **Date:** _____

I (child) have close friends/close family members: none a few some many a lot

For fun after school, I (child) _____

Describe your (child) after school activities: _____

_____

In a day: Normally: How much time watching TV: _____**; playing video/computer games:** _____

In a day: Normally what does your child eat? Breakfast: _____

Lunch: _____ **Supper:** _____

Snacks: How much/What: _____

In a day, normally, how much time does your child exercise, physically play: _____

PREGNANCY AND DELIVERY:

1. **Length of pregnancy: full term, 40 weeks, 32 weeks, etc.** _____
2. **Length of delivery: Number of hours from initial labor pains to birth:** _____
3. **Mother's age when child was born:** _____
4. **Child's birth weight:** _____

DID ANY OF THE FOLLOWING CONDITIONS OCCUR DURING PREGNANCY/DELIVERY

1. **Bleeding:** _____ No _____Yes
2. **Weight gain-number of lbs:** _____
3. **Toxemia/preeclampsia** _____ No _____Yes
4. **Rh factor incompatibility** _____ No _____Yes
5. **Frequent nausea or vomiting** _____ No _____Yes
6. **Used alcoholic drinks:** _____ No _____Yes
   a) **If yes, how many a week** _____
7. **Had a cesarean section** _____ No _____Yes
8. **Took illegal drugs** _____ No _____Yes
9. **Delivery was induced** _____ No _____Yes
10. **Forceps use in delivery** _____ No _____Yes
11. **Had a breech delivery** _____ No _____Yes
12. **Serious illness or injury** _____ No _____Yes
13. **Smoked cigarettes: If yes, how many a day:** _____
14. **Given medication to ease pain: If Yes: Name of Meds:** _____
15. **Took prescription medication: If Yes, name/dosage:** _____

OTHER PROBLEMS – DESCRIBE: _____

Did any of the following affect your child during delivery or within the first few days after birth:

a) **Injury during delivery** _____ No _____Yes
b) **Cardiopulmonary distress during delivery** _____ No _____Yes
c) **Delivered with cord around neck** _____ No _____Yes
d) **Had trouble breathing following delivery** _____ No _____Yes
e) **Needed oxygen** _____ No _____Yes
f) **Was cyanotic, turned blue** _____ No _____Yes
g) **Was jaundiced, turned yellow** _____ No _____Yes
h) **Had an infection** _____ No _____Yes
i) **Had seizures** _____ No _____Yes
j) **Was given medications** _____ No _____Yes
k) **Born with a congenital defect** _____ No _____Yes

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CHILD/ADOLESCENT INITIAL INTAKE FORM

CHILD'S NAME: _____ **ID#** _____ **Date:** _____

INFANT HEALTH AND TEMPERAMENT:

During the first 12 months, was your child:

a)	Difficult to feed	_____ No _____Yes	g)	Cheerful	_____ No _____Yes
b)	Difficult to get to sleep	_____ No _____Yes	h)	Affectionate	_____ No _____Yes
c)	Difficult to put on schedule	_____ No _____Yes	i)	Sociable	_____ No _____Yes
d)	Colicky	_____ No _____Yes	j)	Easy to Comfort	_____ No _____Yes
e)	Alert	_____ No _____Yes	k)	Difficult to keep busy	_____ No _____Yes
f)	Overactive/constant motion	_____ No _____Yes	l)	Stubborn, challenging	_____ No _____Yes

Hospitalized: _____ No _____ Yes: How many times? _____ For what? _____

COMMENTS: _____

_____

EARLY DEVELOPMENTAL MILESTONES:

When did your child first accomplish the following:

a)	Sitting without help	Early	Average	Late
b)	Crawling	Early	Average	Late
c)	Walking alone, without assistance	Early	Average	Late
d)	Using single words: "Mama", "Dada", "ball", etc	Early	Average	Late
e)	Putting two or more words together: "Mama up"	Early	Average	Late
f)	Bowel training, day and night	Early	Average	Late
g)	Bladder training, day and night	Early	Average	Late

COMMENTS: _____

_____

HEALTH HISTORY:

Physician/Practice _____ **Phone number** _____ **Date of last physical exam:** _____

Results: _____

Child's Height: _____ **Weight:** _____

At any time has your child had the following:

a)	Asthma	Never	Past	Present
b)	Allergies	Never	Past	Present
c)	Diabetes, arthritis, chronic illnesses	Never	Past	Present
d)	Epilepsy or seizure disorder	Never	Past	Present
e)	Febrile seizures	Never	Past	Present
f)	Chicken pox/common childhood illnesses	Never	Past	Present
g)	Heart or blood pressure problems	Never	Past	Present
h)	High fevers - over 103	Never	Past	Present
i)	Broken bones	Never	Past	Present
j)	Severe cuts requiring stitches	Never	Past	Present

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CHILD/ADOLESCENT INITIAL INTAKE FORM

CHILD'S NAME: _____ ID# _____ Date: _____

k) Head injury with loss of consciousness	Never	Past	Present
l) Lead poisoning	Never	Past	Present
m) Surgery	Never	Past	Present
n) Lengthy hospitalization	Never	Past	Present
o) Speech or language difficulties	Never	Past	Present
p) Chronic ear infections	Never	Past	Present
q) Hearing difficulties	Never	Past	Present
r) Eye or vision difficulties	Never	Past	Present
s) Fine motor/handwriting difficulties	Never	Past	Present
t) Gross motor difficulties, clumsiness	Never	Past	Present
u) Appetite problems – over or under eating	Never	Past	Present
v) Sleep problems – falling asleep, staying asleep	Never	Past	Present
w) Soiling problems	Never	Past	Present
x) Wetting problems	Never	Past	Present

OTHER HEALTH DIFFICULTIES: DESCRIBE: _____

_____

PAST PSYCHOLOGICAL/PSYCHIATRIC HISTORY:

Dates	Hospital/Agency	Problem	Helpful or Not

OTHER MENTAL HEALTH PROVIDERS:
Is your child currently being treated, seen, by any other mental health provider?

Counselor: ___ No ___ Yes: If YES: Name: _____ Ph #: _____
Psychiatrist: ___ No ___ Yes: If YES: Name: _____ Ph #: _____

MEDICATIONS: ONLY FROM CHILD'S PSYCHIATRIST: Please list all medications from child's psychiatrist that he/she is currently taking: OR BRING IN A LIST THOSE MEDICATIONS WITH THE FOLLOWING INFORMATION.

NAME OF MEDICATIONS	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR

MEDICATIONS: FROM YOUR CHILD'S DOCTOR/SPECIALISTS: Please list all medications that your child is currently taking: OR YOU CAN BRING IN A LIST OF ALL MEDICATIONS WITH THE FOLLOWING INFORMATION.

NAME	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR

List any over the counter medications/dietary supplements/herbal/etc that your child takes daily:

_____

_____
Parent Signature Date

Adopted: February 2012

CUMBERLAND VALLEY COUNSELING ACCOCIATES
PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

OUR LEGAL DUTIES:
State and Federal laws require that CVCA keeps your medical records private. CVCA has the right to change polices only if the changes comply with all pertinent laws. Information given to the therapist during treatment – intake, evaluation, counseling sessions – are covered by these laws as private information. CVCA respects your privacy and abides by ethical and legal requirements regarding confidentiality of records.

USE OF INFORMATION:

Information that you provide to CVCA is used for diagnosis, treatment planning, treatment and continuity of care. With your written permission, pertinent information will be disclosed to your insurance company, your family physician and to any other person that you give written permission permitting the release of information.

CVCA will not release information about you **without** your written permission. However, certain laws require CVCA to release information with or without your permission. The following lists many of these situations but is not intended as an exclusive list as laws may change.

1. **Duty to Warn and Protect:**

When a client discloses intention or plan to harm another person(s), CVCA is required to warn the intended victim and report this information to legal authorities. When a client discloses or implies intent and plan for suicide and has the means to carry out the plan, CVCA is required to notify legal authorities and make reasonable attempts to notify the family of the client.

2. **Public Safety:**

A client's record, or portions, may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military and when complying with worker's compensation laws.

3. **Abuse:**

If a client states or suggests that he/she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, CVCA is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence or a crime victim, and their safety appears to be at risk, CVCA may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

4. **Professional Misconduct:**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is held, related records may be requested in order to substantiate disciplinary concerns.

5. **Judicial or Administrative Proceedings:**

Health care professionals are required to release records of clients when a court order has been placed.

6. **Minors/Guardianship:**

Parents/legal guardians of non-emancipated minor clients have the right to access the minor's records.

CUMBERLAND VALLEY COUNSELING ASSOCIATES
CLIENT RIGHTS NOTIFICATION

As a recipient of services at our facility, we would like to inform you of your rights as a client and the process for reporting a violation of your rights.

Your rights as a client include the right to:

1. be treated with respect and dignity
2. make complaints and have your complaints heard
3. make suggestions about the services that are provided
4. have your civil rights protected by federal and state laws
5. receive attention to and care for cultural/spiritual/gender needs and receive this care by a therapist with specific training or experiences to meet these needs. If these services are not available at CVCA, we will help you in the referral process
6. receive appropriate treatment and take part in formulating your treatment plan
7. refuse any therapies or services that may be recommended by your therapist
8. be apprised of treatment benefits and risks
9. request restricted use of your protected health records
10. obtain a copy and/or inspect your protected health information; however, CVCA may deny access to certain records, in which case CVCA will discuss this decision with you
11. request an amendment in your records; however, this request may be denied. If denied, your request will be kept in the records.
12. discuss your treatment with your doctor or attorney
13. receive an accounting of disclosures of your protected health information that you have not authorized

You have the right to receive information about:

1. cost of services that CVCA provides
2. what behaviors or violations could lead to termination of services at CVCA
3. confidentiality and the extent and limits of your protected health information and how it will be used
4. any policy changes that affect your treatment or services.

Our ethical obligations to you include:

1. CVCA is dedicated to serving the best interest of each client
2. CVCA will not discriminate among clients or professionals based on age, race, creed, gender, orientation, disabilities, handicaps, preferences or other personal concerns
3. CVCA maintains an objective and professional relationship with each client
4. CVCA respects the rights and views of other professionals
5. CVCA will end services or refer clients to other programs when appropriate
6. CVCA therapists engage in ongoing activities, including continuing education and clinical and peer supervision, in order to increase professional growth and effectiveness
7. CVCA holds respect for various institutional and managerial policies, but will review and amend such policies in the best interests of the practice and CVCA clientele

Your responsibilities as a client include:

1. to fulfill your financial obligations to CVCA as outlined in the ***Payment Contract for Services***
2. to follow the policies of CVCA
3. to treat staff and fellow clients in a respectful, cordial manner so that their rights are not violated
4. to provide accurate information about yourself

IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED, PLEASE CONTACT THE PRESIDENT OF THE BOARD OF CVCA.
Office staff can provide you with the president's contact information.

Modified: December 3, 2008; June 23, 2010; October 9, 2013

CUMBERLAND VALLEY COUNSELING ASSOCIATES

FINANCIAL POLICY

Payment is expected at the time of service for any service that will not be covered by your insurance company. We accept cash, check, or major credit cards.

Patient Responsibility

- Provide current and accurate billing and insurance information. Insurance card **must** be presented at first visit.
- Provide accurate insurance subscriber information(name, date of birth, and SSN)
- Pay at time of service any amount that is your responsibility - a $15 fee will be assessed for any checks returned for insufficient funds.

Billing Process

Effective on July 1, 2013 insurance claims and billing for services provided by Cumberland Valley Counseling Associates will be done through **Medigistics**, our billing company. Questions about billing or invoices received should be directed to **Medigistics** at **1-800-282-0738 ext. 5707**

Modified: December 3, 2008; June 23, 2010; October 9, 2013