CAWM.NET, 4127 Embassy Drive
Grand Rapids, MI 49456
Ph 616.264.3200 Fax 616.264.3201

Client (Child) Information Form

Date: _____

Identification

Client name:_____Date of birth:_____Age: ____
Nicknames or aliases: _____
Home street address:_____Apt.: _____
City:_____State:_____Zip: _____
Primary Phone:(__)___-_____ Cell Phone: (__) ___-_____Other Phone: (__)___-_____
E-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions:_____
Parent or legal guardian name(s):_____
Are you the legal guardian of this child? ❑ Yes ❑ No
Parents occupation(s): Mother:_____ Father: _____
Referral: Who referred you to us? Name:_____Phone: _____

May we have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you?

_____

Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name:_____Phone: (___) ____-_____
Address:_____City:_____State: ___ Zip Code: _____
If you enter into counseling with CAWM, may we inform and coordinate your treatment with your docter? ❑ Yes ❑ No
Religious and racial/ethnic identification: Current religious denomination/affiliation
❑ Protestant ❑ Catholic ❑ Jewish ❑ Buddhist ❑ Hindu ❑Other(specify):_____
Involvement: ❑ None ❑ Some/irregular ❑ Active
How important are spiritual concerns in your life?

_____

School

School Name:_____Phone: (___) ____-_____
Address: _____City:_____State:___Zip Code: _____
Grade/year in college:_____Teacher's name: _____
May we contact and coordinate care with school, please indicate any restrictions:

_____

Emergency information

If some kind of emergency arises whom should we call?
Name:_____Phone: (___) ____-_____ Relationship: _____
Address:_____City:_____State:___ Zip code:_____

Appointment, Fee & Consent for Treatment Information

Therapy Appointments: We often schedule several appointments in advance so that you can plan to make therapy sessions a priority in your busy schedule.

Fees: Cancelled appointments delay therapy work. The time we have reserved for you is very important for your care. Please try not to miss sessions if you can possibly help it. When you must cancel, please give at least 48 hours notice.

Late Fee: Cancellations made less than 24 hours of a business day in advance of your appointment will be billed as follows: ½ session charge for the first late cancel and a full session charge for the second and thereafter. Your insurance will not cover this charge.

Payment is expected at time of service. We accept cash, checks, credit and debit.

MASTERS-LEVEL LICENSED CERTIFIED SOCIAL WORKERS, THERAPISTS		**CPT Code**
Evaluation (50-55 minutes)	$180	90791
Therapy session (45-50 minutes)	$130	908343 434
Half Therapy session (20 minutes)	$ 70	90832
Session and a half (75-80 minutes)	$170	90808
Family session (45-50 minutes)	$150	90846, 90847
Professional services (phone consults, letters, treatment, etc.)	$130/hour prorated	
School Meetings	$ 130/hour including transportation time	
Court Consultations/Depositions	$150/$250/hour	

***Insurance rarely covers professional service fees, telephone consults or school meetings; these services are billed at the hourly rate, prorated over time. There is no charge for calls about appointments or similar business. Psychological testing: Testing fees include time spent with you, time for scoring and studying results, and time to write a report on the findings, if a report is desired. The amount of time depends on tests used and questions testing is intended to answer.

We assume you are a patient until you tell us in person, by phone, or mail that you wish to end treatment. You must pay for any services you receive before ending the relationship.

If you think you may have trouble paying your bills on time, please discuss this with your therapist. She will also raise the matter with you so you can arrive at a solution. If your unpaid balance reaches $200, you will be notified by mail. If it then remains unpaid, we must stop therapy with you. Patients who owe and fail to make arrangements to pay will be referred for collections.

_____Please Initial here when you have read this page

Health Insurance Coverage: Because we are licensed mental health providers, many insurance plans will help pay for our services. Every insurance plan is different. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. We will try our best to maintain the privacy as we bill your insurance, but please do not to hold CAWM responsible for accidents that may happen as a result.***There are certain insurance companies with whom we do not participate. In these cases, you may have coverage for our services, but we ask that you pay for your services in full up front and we will give you an invoice for the services you receive with the standard diagnostic and procedure codes, times met, charges, and payments. You can use this to apply for reimbursement. Please ask your counselor if they participate with your insurance carrier.

If you have no health insurance coverage, or do not intend to use it, please check here and skip the next section ❑

If you will be using insurance, please complete the following:
Primary Insurance Company:_____
Name of subscriber (if not the patient):_____Subscriber's Date of Birth _____
Subscriber's SS#_____ID/policy #:_____Group or enrollment #: _____
Plan #/code or BS #:_____ Effective date: _____
Does your insurance require authorization for our services? ❑ Yes ❑ No
Is the CAWM provider you wish to see covered under this insurance plan? ❑ Yes ❑ No
Did you call to get authorization? (Priority Health Medicaid) ❑ Yes ❑ No
If yes, authorization #:_____
What is your deductible: $_____ What is your copay? $_____

Insurance release: I give CAWM permission to release any information obtained during treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. **Financial Responsibility:** I understand that I am responsible for all charges, regardless of insurance coverage. I also understand that if I do not give at least 24 hours of a business day notice that I will miss a scheduled appointment, my therapist reserves the right to charge me 50% of her hourly rate for the first missed appointment and 100% of her hourly rate thereafter. I am aware that my insurance company will not cover these charges.

Assignment of benefits: I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Counseling Associates of West Michigan. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____

Signature of Client (or parent/guardian's) **Printed Name** **Date**

indicating agreement to all of the statements above

Therapy Agreement/Consent for Treatment:

I,_____(or his/her guardian), understand I have the right not to sign this form. My signature below indicates I have read this agreement and had any questions answered; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned in this document can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this brochure, I can talk with my therapist about them, and s/he will do her best to answer them. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with my counselor before ending therapy.

- I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.
- I have read, or have had read to me, the issues and points in this brochure. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this brochure. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

_____

Signature of client (parent's or gaurdian's) **Printed Name** **Date**

Relationship to client: ❑ Self ❑ Legal guardian ❑ Custodial parent of minor (less than 14 years of age)

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Checklist and Developmental History

Date: _____

Child Name: _____**DOB**_____

Person Completing Form: _____

Relationship to Child: _____

Parents are currently: ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other:_____

Mother's (and step-father's name):_____

Father's (and step-mother's name):_____

Please check concerns:

- ❑ Affectionate
- ❑ Aggression, violence, cruelty to animals
- ❑ Argues, "talks back," smart-alecky, defiant
- ❑ Anxiety
- ❑ Bullying issues
- ❑ Cheats
- ❑ Cognitive/Developmental Impairment
- ❑ Conflicts with parents over (list):
- ❑ Complains
- ❑ Cries easily, feelings are easily hurt
- ❑ Dawdles, procrastinates, wastes time
- ❑ Difficulties with parent dating/new marriage/new family
- ❑ Dependent, immature
- ❑ Depressed
- ❑ Developmental delays
- ❑ Disrupts family activities
- ❑ Disobedient, noncompliant
- ❑ Distractible, inattentive, poor concentration
- ❑ Dropping out of school
- ❑ Drug or alcohol use
- ❑ Eating - appetite increase/decrease, overeats
- ❑ Exercise problems
- ❑ Extracurricular activities interfere with academics
- ❑ Failure in school
- ❑ Family changes, parental divorce or separation
- ❑ Fearful
- ❑ Fire setting
- ❑ Friendly, outgoing, social
  Deficit?___ Strength?___
- ❑ Friendship issues
- ❑ Complains of "sickness" frequently
- ❑ Immature
- ❑ Imaginary playmates, fantasy
- ❑ Inappropriate sexual behavior
- ❑ Independent
- ❑ Interrupts, talks out, yells
- ❑ Irresponsible
- ❑ Lacks motivation
- ❑ Lacks organization, unprepared
- ❑ Learning disability
- ❑ Legal problems:
- ❑ Likes to be alone, withdraws, isolates
- ❑ Lying
- ❑ Low frustration tolerance, irritability
- ❑ Moodyness
- ❑ Mute, refuses to speak
- ❑ Nail biting
- ❑ Nervous
- ❑ Nightmares
- ❑ Need for high degree of supervision
- ❑ Obedient
- ❑ Obesity
- ❑ Obsessive/Repeats words or behaviors
- ❑ Overactive, restless, hyperactive
- ❑ Oppositional, resists, negative
- ❑ Perfectionistic
- ❑ Prejudiced, insulting, name calling, intolerant
- ❑ Pouts
- ❑ Poor Social Skills; interpersonal relations
- ❑ Recent move, new school, loss of friends
- ❑ Relationships are poor
- ❑ Responsible
- ❑ Rocking or other repetitive movements
- ❑ Runs away
- ❑ Sad, unhappy
- ❑ Self-harming behaviors
- ❑ Speech difficulties
- ❑ Sexual problems
- ❑ Sleep issues/falling asleep or staying asleep
- ❑ Shy, timid
- ❑ Stubborn
- ❑ Suicide talk or attempt
- ❑ Swearing, foul language
- ❑ Temper tantrums, rages
- ❑ Thumb sucking, finger sucking, hair chewing
- ❑ Tics—involuntary rapid movements, noises, or words
- ❑ Teased, picked on, victimized, bullied
- ❑ Trauma history or trauma event
- ❑ Truant, school avoiding
- ❑ Underactive, slow-moving or slow-responding, lethargic
- ❑ Uncoordinated, accident-prone
- ❑ Wetting or soiling the bed or clothes
- ❑ Work problems
- ❑ Other:_____

Presenting Issues: What are the main reasons you brought this child in for treatment?

Please give a brief history of these problems (when they began, attempted solutions, etcetera).

Medical: Does this child have any current medical problems? ❑ No ❑ Yes Please describe.

Does this child have a history of medical problems (starting with pregnancy)? ❑ No ❑Yes
Please describe.

Has the child ever received psychological, psychiatric, substance treatment before (mental health evaluations, testing or therapy)? ❑No ❑Yes Please describe.

Has the child ever taken medications for psychiatric or emotional problems? ❑No ❑Yes
If yes, please list medications current or past along with their dosages:

Who prescribes medication to your child? _____

Family: Please describe the following:
The child's parents' relationship with each other:

The child's relationship with each parent and with any other adults (step parents, teachers, etc.):

The child's relationship with brothers and sisters:

Family Psychiatric History:
Family of origin: has this child's mother, father, brothers or sisters ever experienced emotional problems?
❑ No ❑ Yes Please describe in detail.

Extended family: has this child's grandparents, aunts, uncles or cousins ever experienced emotional problems?
❑ No ❑ Yes Please describe in detail.

Child's education:
Does this child have any educational interventions at school (speech, 504 plan, IEP)? ❑ No ❑ Yes
Is this child having academic problems? ❑ No ❑ Yes
Please describe.

Describe this child's relationships with peers (friends, social difficulties, etc.):

Please list extracurricular activities/special talents/skills this child has been/is involved in:

Abuse history: ❑This child was not abused in any way. ❑This child was abused. *If abused please describe.*

Is there any other information you would like your therapist to know?

Chemical use: How many sodas/pop with caffeine does this child consume per day? _____
Has this child ever smoked or drank alcohol? ❑No ❑Yes Please describe:

Has this child ever used any other substances inappropriately? ❑No ❑Yes Please describe:

Legal History:
Are this child's parents involved in a legal dispute? ❑No ❑Yes If yes, please describe.

Is this child legally required to have this appointment? ❑ No ❑ Yes Please Describe.

Who is the legal guardian?_____

Custody Status: _____

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Notice of Privacy Practices (Brief Version)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ANDHOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy. Counseling Associates of West Michigan, LLC, is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the full, legally required notice of privacy practices. Please talk to our privacy officer (see end of form) about any questions or problems.

How we use and disclose your protected health information with your consent. We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form.

Disclosing your health information without your consent. There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or payment for your care, such as family and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, Who is Mary Lier, LMSW ACSW who can be reached at mlier@cawm.net or by calling 616.264.3200.

The effective date of this notice is 3/01/2014

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and us. When we use the words "you" and "your" below, this can mean you, your child, a relative, or other person as follows:_____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information"(PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.cawm.net, or by calling us at 616.264.3200.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

_____
Signature of authorized representative of this office or practice

Date of NPP: _____ ❑ Copy given to the client/parent/personal representative