Client Name _____

Arrow Counseling Services, LLC

CONFIDENTIAL CHILD (12 yrs old and younger) CLIENT INTAKE FORM

Please bring this completed form to your first appointment. All information contained herein is confidential in accordance with the attached policies and procedures and in accordance with the HIPAA Privacy Act. This information is requested to obtain the best level of treatment and care possible.

Name: _____

Address: _____ Date of Birth _____

_____ Gender: Male Female (Circle One)

SS#: _____ Age:_____

How would you like me to contact you? May we leave a message at this contact number? (Please circle response)

Home:	yes or no	Phone:
Work:	yes or no	Phone:
Cell phone:	yes or no	Phone:
Email:	yes or no	Email address:
Other:		

Name of person completing form: _____

Relationship to person receiving services: _____

Special Needs

1. Do you have a need for Assistive Technology (interpreter, verbal instructions, etc.) in the Provision of Services? Yes No
   If yes, Describe:_____
2. Do you have any other disabilities, disorders or concerns in this area? Yes No

   If yes, Describe:__ _____

Presenting Problems

1. Please describe in detail the issues that have brought you to counseling:

_____
_____
_____

Client Name _____

PROBLEM BEHAVIORS

Please check any of the behaviors which occur **excessively** or **frequently** now and/or in the **past**.

Symptoms Experienced in the last **two (2) weeks**	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	If longer than 2 weeks please indicate the # of weeks, months, years
Accident prone						_____ W, M, Y
Argues						_____ W, M, Y
Bed wetting						_____ W, M, Y
Boredom						_____ W, M, Y
Bullies						_____ W, M, Y
Compulsive repetitive behaviors						_____ W, M, Y
Cruelty to animals						_____ W, M, Y
Crying						_____ W, M, Y
Decreased appetite						_____ W, M, Y
Defiant, oppositional						_____ W, M, Y
Depression						_____ W, M, Y
Destroys property						_____ W, M, Y
Disruptive behavior						_____ W, M, Y
Distractible						_____ W, M, Y
Disturbing thoughts						_____ W, M, Y
Fears						_____ W, M, Y
Fights						_____ W, M, Y
Frequent physical complaint						_____ W, M, Y
Hyperactive						_____ W, M, Y
Impulsive						_____ W, M, Y
Increased appetite						_____ W, M, Y
Insomnia						_____ W, M, Y
Irritable						_____ W, M, Y
Learning problems						_____ W, M, Y
Legal problems						_____ W, M, Y
Lies						_____ W, M, Y
Messy						_____ W, M, Y
Missing school due to illness						_____ W, M, Y
Mood swings						_____ W, M, Y
Night mares						_____ W, M, Y
Night terrors						_____ W, M, Y
Obsessive thoughts						_____ W, M, Y
Odd behaviors						_____ W, M, Y
Odd thoughts						_____ W, M, Y
Poor grades						_____ W, M, Y
Reckless/careless						_____ W, M, Y
Runs away from home						_____ W, M, Y
Sadness						_____ W, M, Y
Sexual activity						_____ W, M, Y

Short attention						_____ W, M, Y
Skipping classes, school						_____ W, M, Y
Sleepwalking						_____ W, M, Y
Speech problems						_____ W, M, Y
Steals						_____ W, M, Y
Tantrums, angry outbursts						_____ W, M, Y
Thumb sucking						_____ W, M, Y
Will not sleep alone						_____ W, M, Y
Withdrawn						_____ W, M, Y
Worries						_____ W, M, Y
						_____ W, M, Y

1. Any **history** of thoughts/plans/acts/ideation or intention of suicide? Yes No
If yes, circle all that apply: Passive Thoughts Single Attempt Multiple Attempts
If yes, explain: _____
_____

2. Do you **currently** have any thoughts/plans/acts/ideation or intention of suicide? Yes No
If yes, describe: _____
_____

3. Any **history** of thoughts/plans/acts/ideation or intention of homicide? Yes No
If yes, circle all that apply: Passive Thoughts Violence Towards Another
If yes, explain: _____
_____

4. Do you **currently** have any thoughts/plans/acts or intention of homicide? Yes No
If yes, describe: _____

If you answered yes to the above questions, what things happen that make you want to harm yourself or others?
_____
_____

Parent/ Guardian Family Information

PARENT 1: Mother

Name:_____ Date of Birth: _____

Address 1: _____ Home Phone/Cell Phone:_____

Address 2: _____ Work Phone:_____

Email Address:_____ Highest Grade Completed _____

Occupation: _____Place of Employment _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Date of Separation/ Divorce / Widowed (if applicable) _____

Military Experience

Have you ever served in the military? Yes No If Yes, Please describe your military experience:

_____

PARENT 2: Father

Name:_____ Date of Birth: _____

Address 1: _____ Home Phone/Cell Phone:_____

Address 2: _____ Work Phone:_____

Email Address:_____ Highest Grade Completed _____

Occupation: _____Place of Employment _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Date of Separation/ Divorce / Widowed (if applicable) _____

Military Experience

1. Have you ever served in the military? Yes No If Yes, Please describe your military experience:

_____

Sibling Information:

NAME	DATE OF BIRTH	RELATIONSHIP (full/half sib, foster, biological, adopted)	CURRENTLY LIVING (home, school, with other family)

Others Living in the Home

NAME	AGE	GENDER	RELATIONSHIP

With whom has the child lived in the past?

DATES	TYPE OF PLACEMENT	NAMES OF CAREGIVERS	REASON FOR MOVE

***Type of placement: Birthparents, birth relatives, foster parents, adoptive parents, step parents, group home, residential treatment center, other.**

Custody Information

1. Who has legal custody of the child?
   _____

2. With whom is the child currently living?
   _____

3. If the child is adopted, what factors led to parent(s) decision to adopt?

_____

_____

_____

_____

4. Does the noncustodial parent:

Know of this Evaluation	YES	NO
Have Regular/Frequent Contact with Son/Daughter	YES	NO
Have Limited/Unpredictable Contact	YES	NO
Insure the Child/Adolescent	YES	NO

5. If the child/adolescent does not live with biologic or adoptive parent(s), please provide the following information regarding guardianship. Are you:

   ☐ Foster Parent(s)
   Foster Parent/Guardian's Name: _____

   Address: _____ Phone: (____)_____

   _____ Zip Code: _____

   ☐ A legal guardian(s) who is a biologic relative: State relationship _____

   ☐ A legal guardian(s) who is not a biologic relative

6. Please state why child/adolescent is in foster care or with a guardian

_____

_____

Client Name _____

Child/Adolescent Birth and Development History

1. Age of birthmother at time of child's birth: _____ Birthmother's total number of pregnancies _____
2. This child was pregnancy #_____ Miscarriages _____ Abortions: _____
3. Did Birthmother have prenatal care? _____ When? _____
4. Was mother depressed during the pregnancy?
   _____
5. Was mother ambivalent about the pregnancy? _____ If so, why?
   _____

Problems during pregnancy with this child/adolescent:

☐ None ☐ Unusual swelling ☐ Unusual weight gain If yes, how much? _____ ☐ Unusual weight loss If yes, how much? _____ ☐ High blood pressure ☐ Infections ☐ Bleeding ☐ Unusual vomiting ☐ Smoking during pregnancy ☐ Alcohol use ☐ Use of street drugs	☐ Medications taken during pregnancy (please list names and reason for taking) _____ _____ _____ ☐ Disease or exposure to contagious disease (please explain) _____ _____ _____ ☐ Persistent emotional stress, depression or anxiety (please explain) _____ _____ _____

6. Was father supportive during the pregnancy? _____.
   If not, why?
   _____
7. Did childbirth occur between 38 and 40 weeks? _____. Any complications during delivery? _
   _____
8. Was the infant diagnosed with in-utero alcohol exposure? _____.
9. Was the infant diagnosed with in utero drug exposure? _____. If yes, to which drugs?
   _____
10. Did examination at birth reveal any physical disorders? If so, please explain:

_____

_____

11. Mother's health after childbirth was good _____, poor _____. If poor, please explain:
    _____
12. On what day in the hospital did mother first see the baby? _____

13. Did mother hold the baby? _____. If so, on what day? _____

14. How long were mother and baby in the hospital before coming home? _____

15. Were there any problems with the child in the hospital before coming home?

    _____

16. How did the mother respond to the child's fussiness?

    _____

During infancy, were any of the following present?

☐ Weak crying response ☐ Constant whining ☐ Rageful crying ☐ Extremely sensitive to touch ☐ Extremely resistant to cuddling ☐ Limp when held ☐ Stiff when held ☐ Arched back and resisted to being held ☐ Poor sucking response	☐ Poor eye contact, lack of tracking with eyes ☐ No reciprocal smile response ☐ Indifference to others ☐ Choked easily ☐ Vomited or spit up frequently ☐ Unusually nervous or jittery ☐ Child had colic till age: _____	☐ Difficulty chewing ☐ Held breath for long periods of time ☐ Had allergic reactions to: _____ _____ ☐ Other: _____ _____ _____ _____

At what age did the following occur?

Smiling: _____ Sat without support: _____ Walked alone: _____ Spoke first word: _____ Used 2 or 3 word sentences: _____ Was completely weaned: _____	Started toilet training: _____ Completed toilet training: (bladder)_____ Completed toilet training: (bowel) _____ Relapses of bladder or bowel control: _____ Completely dressed him/herself:_____ Tied shoes: _____

17. Was the above information from your baby book, diary, reports or memory?

    _____

18. If child was abused, neglected, or institutionalized, please describe the child's experiences (if known):

_____

_____

Physical Development

1. **Please describe the child's large muscle development (e.g. walking, hopping, skipping, riding a bicycle):**

_____

_____

2. **Please describe the child's small muscle development (e.g. using a pencil, doing puzzles):**

_____

_____

3. **Which hand does the child prefer to use? _____ Is preference consistent? _____**
4. **Is the child's speech normal? _____ If not, please describe:**

   _____
5. **Has the child ever had speech therapy? _____. If so, please describe:**

   _____
6. **Is the child's hearing normal? _____ If, not please describe:**

   _____
7. **Has the child received vision therapy? _____ If so, please describe:**

   _____

SUBSTANCE USE

1. Has your child/adolescent ever used any substances? Please check all that apply:

Drugs, Alcohol, or Substances:

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								

If yes to any of the above, please explain _____

Client Name _____

Medical Information

	Name	Phone number		
Primary Care Physician			Yes	No
Psychiatrist			Yes	No
Caseworker			Yes	No
Case Manager			Yes	No
Other MH Therapist			Yes	No

1. Please list all other Health Care Providers: May we contact them to coordinate care?

2. Please list the child's medications below: (Beginning with current medications and working backwards):

Dates	Name of Medication	Amount (ex 10 mg)	Taken When:	Prescribed by:	Side Effects/Reactions

3. Weight _____lbs Height_____ BMI_____

4. Any allergies or special precautions? Yes No Unknown

If yes, *circle all that apply*:
Seasonal Medications Food Latex Animals Other
If yes, specify: _____
_____

Social Adjustments

1. How would you describe your child's interactions with others (parents, teachers, peers, siblings, relatives)

_____

_____

_____

_____

Client Name _____

	Gets along well	Avoids	Aggressive	Clings	Other
Parents					
Mom					
Dad					
Siblings					
Teachers					
Relatives					
Peers					

Education

1. Please list all schools attended beginning with current school:

Dates & Grades Attended	Name of School	Address/Telephone Number	Behavior Problems (If any)

2. Does your child enjoy being in school? Specific likes and dislikes:

_____

_____

3. Has your child been diagnosed with learning disabilities? If so, please indicate:

_____

_____

Client Name _____

Cultural, Gender and Spiritual Information

1. Primary cultural/ethnic group?

   Caucasian Hispanic/Latino African American Asian Jewish
   Middle Eastern Native American Arab European
   Other- _____

2. Any Gender and/or Sexual Orientation Issues? Yes No
   If yes, describe issues: _____
   _____

3. Primary Religious Affiliation *Circle any that apply:*
   Baptist Buddhist Catholic Episcopalian Hindu
   Lutheran Methodist Muslim Non-denominational Protestant
   Jewish Other Non-Christian None Other-Christian
   Other: _____

4. What are your spiritual beliefs and practices?
   _____
   _____

5. How often are you involved in religious or spiritual practices? *Circle all that apply*
   Regular Involvement Occasional Involvement
   Special Celebrations/Holiday Involvement No Involvement

6. Do you have spiritual strengths? No Yes Please describe_____

_____

7. Do you have spiritual problems? No Yes Please describe_____

_____

Treatment History

Professional Counseling or Therapy	Dates	Therapist's Name/Address & Phone	Type (Individual. Family)	Results

5. Did you have a positive experience in your previous treatment? Yes No

6. Were you compliant with previous treatment? Yes No

Client Name _____

Trauma

1. **Has your child/adolescent witnessed any Domestic Violence?** ☐ **NO** ☐ **Yes, if so: Please explain:**

_____

_____

2. **Has your child experienced any trauma? (Ex. Domestic violence, sexual abuse, physical abuse, witnessed a car accident, parent die, ect.)** ☐ **No** ☐ **Yes If so, please explain:**

_____

_____

3. **What was your child's reaction to the trauma? Please explain:**

_____

_____

4. **Did your child receive any treatment to address the effects of the trauma? If so, please explain:**

_____

Legal and Military History

1. Has your child/adolescent ever had a history of legal charges? Yes No
   If yes, please explain _____
   _____
2. Is your child/adolescent currently on probation? Yes No
   If yes, please explain terms of probation _____
   _____
3. Has your child/adolescent been involved with the military? Yes No
   If yes, please explain _____

STRENGTHS/WEAKNESSES/ BARRIERS TO TREATMENT

1. Please list your strengths: *Circle all that apply*:

Affectionate	Ambitious	Artistic	Athletic	Brave	Calm
Cheerful	Considerate	Creative	Dependable	Drug-free	Easy-Going
Efficient	Energetic	Forgiving	Humorous	Hardworking	Insightful
Honest	Humble	Independent	Intelligent	Kind	Likeable
Loyal	Mature	Open-minded	Organized	Outgoing	Patient
Active	Attractive	Healthy	Strong	Tough	Prayerful
Professional	Reflective	Relaxed	Religious	Reserved	Resourceful
Responsible	Sensitive	Serious	Stable	Sympathetic	Tactful
Adventurous	Tolerant	Trustworthy	Warm	Wholesome	Wise

Other:_____

2. Describe any leisure activities or hobbies: *Circle all that apply*

Hunting/Fishing	Spending Time with Family	Playing on the Computer	Church Activities
Reading	Cooking	Working Outside	Playing with Friends
Exercising	Sports	Water Activities	Other

Comments:_____ _____
_____
_____

3. Who makes up your current support system? *Circle all that apply:*

Boy/Girlfriend	Parents	Classmates	Extended Family
Friends	Siblings	None	Religious Organization
Self-help Group	Social Service Group	Teachers	Other:_____

4. How do you cope with life events and daily stress? Please check all that apply

☐ Talk to family	☐ Talk to support group	☐ Other _____
☐ Talk to friends	☐ Resources on internet	☐ Other _____
☐ Pray	☐ Journal	☐ Other _____
☐ Talk with professional	☐ Yoga/Exercise	☐ Other _____

5. Are there any **barriers or challenges** to treatment and to change? Yes No
If yes, *circle all that apply*

Anger	Aggression	Childcare	Cultural Beliefs
Family Members	High Anxiety	Unstable Living Conditions	Medical Complications
Memory Impairment	Pregnancy	Past Treatment Experience	Religious Beliefs
Severe Depression	Substance Use	Medication Side Effects	Transportation
Work Schedule	Other: _____		

Explain: _____
_____

Initial Goals for Treatment:

1. _____
2. _____
3. _____

I have answered truthfully and to the best of my ability regarding all of the information contained in this Child/Adolescent Intake Assessment.

Patient Signature_____ Date _____

Parent Signature_____ Date _____

Parent Signature_____ Date _____

Therapist Signature _____ Date _____

We are required to have a safety plan in place, in the event that a Crisis takes place during treatment. Please fill out the following Crisis Safety Plan to the best of your ability.

Thank you.

Client Name _____

MY CRISIS & SAFETY PLAN

_____

Name

Things that really upset me!

1. _____
2. _____
3. _____

People I can ask for help from:

1) _____
2) _____
3) _____

Things that help me to calm down when I'm upset:

1. _____
2. _____
3. _____

Places I can go that will help me to calm down:

1) _____
2) _____
3) _____

If I am unable to feel safe after I try all the things I listed above I will:

1. Call My Therapist(s) or Caseworker:

_____ Phone: _____
Name

_____ Phone: _____
Name

_____ Phone: _____
Name

2. I will or have my parent/guardian call Crisis **717-851-5320**
3. I will or have my parent or guardian call **911**
4. I will have my parent or guardian take me to the nearest hospital
   York Hospital 1001 S. George Street York Pa OR Memorial Hospital 325 S. Belmont Street York

Things I or my parent needs to do to make my home/school safe:

1. _____
2. _____

Medications I can take when I'm in a crisis

Name	How Much	How Often	Prescribed by:

I promise that I will not hurt myself or anyone else but will follow this plan and ask for help during a crisis.

Client Signature: _____ Date_____

Therapist Signature: _____ Date_____

Client Name _____

Mental Status Exam (For Clinician Use Only) Patient _____

Appearance
- ☐ Well Groomed
- ☐ Disheveled
- ☐ Bizarre
- ☐ Body Odor

Mood
- ☐ Normal
- ☐ Depressed
- ☐ Anxious
- ☐ Euphoric
- ☐ Irritable

Attitude
- ☐ Cooperative
- ☐ Uncooperative
- ☐ Suspicious
- ☐ Guarded
- ☐ Belligerent/Hostile

Motor Activity
- ☐ Calm
- ☐ Hyperactive
- ☐ Agitated
- ☐ Tremor/Tics
- ☐ Lethargic

Affect
- ☐ Appropriate
- ☐ Sad
- ☐ Flat
- ☐ Anxious
- ☐ Inappropriate
- ☐ Angry
- ☐ Constricted
- ☐ Labile

Thought Content
- ☐ Normal
- ☐ Morbid
- ☐ Somatic complaints
- ☐ Aggressive
- ☐ Paranoid
- ☐ Phobias
- ☐ Obsessive
- ☐

Hallucinations
- ☐ Auditory
- ☐ Visual
- ☐ Denies

Delusional Beliefs
- ☐ Religious
- ☐ Somatic
- ☐ Persecutory
- ☐ Grandiosity
- ☐ Being controlled
- ☐ Ideas of reference
- ☐ Denies

Bizarre Delusions
- ☐ Thought Broadcasting
- ☐ Thought Insertion
- ☐ Thought Withdrawal
- ☐ Denies

Orientation
- ☐ Person
- ☐ Place
- ☐ Time
- ☐ Responds to name
- ☐ Knows familiar faces or places
- ☐ Knows own daily schedule

Thought Process
- ☐ Intact
- ☐ Tangential
- ☐ Circumstantial
- ☐ Loose Associations
- ☐ Flight of ideas
- ☐ concrete thinking
- ☐ Inability to abstract
- ☐ Follow 1-step directions

Speech
- ☐ Normal
- ☐ Soft
- ☐ Loud
- ☐ Pressured
- ☐ Halting
- ☐ Incoherent
- ☐ Slurred
- ☐ Nonverbal
- ☐ Limited communication skills
- ☐ Uses yes/no only
- ☐ Uses a picture board

Insight
- ☐ Good
- ☐ Fair
- ☐ Poor

Judgment
- ☐ Intact
- ☐ Impaired

Command Hallucinations
- ☐ Harm to self
- ☐ Harm to others
- ☐ Can resist commands
- ☐ Denies

_____ _____

Therapist Signature Date

Client Name _____

Arrow Counseling Services, LLC

CONSENT FOR TREATMENT OF MINOR/CHILD ASSENT FORM

This is an authorization for _____ to provide treatment and/or diagnostic services
Therapist Name

to my child/adolescent _____.
Child Name

By signing this Consent for Treatment, I certify that I have legal custody or joint legal custody of my son or daughter and thus, can legally consent for treatment of my child. (Please provide documents such as court order or custody agreement)

_____ _____
Parent or Legal Guardian Date

_____ _____
Parent or Legal Guardian Date

CHILD ASSENT

I understand that my parent or guardian may consent for my treatment; however, I have also been asked to give my assent for my own treatment. By signing below, I realize that the therapist listed above has elicited my own assent for treatment.

_____ _____
Child's Name Date

_____ _____
Therapist Name Date

Client Name _____

Arrow Counseling Services, LLC

CHILD/ADOLESCENT RELEASE OF INFORMATION

I, _____ , parent of _____

whose date of birth is _____/_____/_____ hereby authorize:

_____ to disclose, when requested to do so
(Name of Organization and/or Person to Release the Information)

by Arrow Counseling Services, LLC., any and all information concerning myself with respect to any illness or injury, medical history, prescription or treatment, legal history, counseling or consultation, or psychological testing and evaluation, and written copies of any medical, counseling, or social service records.
I also authorize Arrow Counseling Services, LLC to disclose any and all information to the above organization and/or person. The only purpose(s) for the disclosure of such information is to: facilitate client's treatment, coordinate treatment services with the above named provider, or obtain corroboration of client's report of history and current behavior. I may cancel this consent of information release at any time. This document will automatically be null and void 60 days after termination of treatment with Arrow Counseling Services, LLC.A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ Date_____
Client Signature

_____ Date_____
Signature of Parent or Legal Guardian

_____ Date_____
Counselor SignatureSignature of Parent or Legal Guardian

_____ Date_____

Counselor Signature

Client Name _____

Arrow Counseling Services, LLC

Parental Waiver of Rights to Child's Records

I _____, parent of _____ whose date of birth is _____, understand that due to privacy in psychotherapy being essential to successful progress in treatment, I consent to waive my rights to my child's records. I further understand that at scheduled appointments that I will be provided with general information regarding the progress of my child's treatment. Further, I understand that a summary of my child's treatment will be provided to me at the conclusion of treatment. I understand that any other communication will require my child's consent, unless the therapist feels that my child is in danger or is a danger to someone else, in which case, the therapist agrees to and will notify me immediately.

Parent Signature: _____ Date:_____

Child/Adolescent Signature:_____ Date:_____

Therapist Signature: _____ Date:_____

Client Name _____

Arrow Counseling Services, LLC
POLICIES & PROCEDURES

Welcome and thank you for choosing Arrow Counseling Services. Our desire is to provide professional counseling services to children, families, adolescents and adults. Please read the following information carefully and sign/initial where indicated. Your signature will provide us with your understanding of office policy and procedures as well as your consent for treatment.

INFORMED CONSENT, CONFIDENTIALITY & RELEASE OF INFORMATION

Information provided during therapy sessions is held in the strictest of confidence. Case notes will not be provided to a third party without written authorization from you. However, there are limits to confidentiality. These limits include:

*** Duty to Warn & Protect** - When a client discloses intentions or a plan to harm another person, the mental health professional is required warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

*** Abuse of Children & Vulnerable Adults** - When there is suspicion of abuse or neglect of a child, elderly person or disabled person, the mental health professional is required to report this information to the appropriate social service agency and/or legal authority.

*** When a court order exists to release information**

*** Supervision and Treatment Purposes** - As Owner of Arrow Counseling Services, Carla Arrow will have access to all medical treatment records, for the sole purpose of clinical consultation and administrative audits. No information in the records will be released without prior written authorization

PARENTS & MINORS

* For parents of minors, please understand that therapy being provided is not for custody purposes or disputes. Therefore, you knowingly and freely waive your right to request the release of information to your attorney or any other officer of the court/or custody purposes. Please be aware that we are not custody experts.

* Patients under the age of 18 who are not emancipated from their parents should be aware that the law may allow parents to review their child's treatment record. Due to privacy in psychotherapy being essential to successful progress especially with teenagers, it is at times, our policy to request an agreement from parents that they provide consent to waive access to their child's records. If agreed, at scheduled appointments parents will only be provided with general information regarding the progress of the child's treatment. A summary of the child's treatment will also be provided at the conclusion of the child's treatment. Any other communication will require the child's consent, unless the therapist feels that the child is in danger or is a danger to someone else, in which you as the parent would be immediately contacted. Prior to communicating any information with parents, we will discuss the matter with the child and handle any objections as appropriate.

PROVISION FOR CRISIS MANAGEMENT

* When crises occur that require hospitalization and stabilization of an extreme nature or of extreme distress, sessions may run longer than the normal 50-60 minutes. A provision has been established that after the first 60 minutes of crisis therapy additional sessions can be added on in 30 minute increments. This would typically be used when immediate hospitalization is required, or following a traumatic event that has destabilized the family or client. This is a provision by the insurance companies to reimburse for these unexpected crises. Billing will be processed according to each individual's insurance carrier's procedure.

* After hour emergency phone calls can be directed to our on-call emergency phone line at 717-758-8075. This phone number should only be used after normal business hours (M-F 8am-8pm) for emergencies that are not life threatening and do not require medical or crisis management. This phone number should not be used to reschedule appointments or contact your therapist to discuss matters that can be handled during the next business day.

Client Name _____

TELEPHONE CALLS

* Occasionally the need to talk to your therapist may arise between normally scheduled sessions. Your therapist will respond to your call within 48 hours during his or her normal business hours. If you require more than a brief (e.g., 5 minute) conversation and you decide your issue or concern cannot wait until your next scheduled session, you will be billed $1.00/minute.

LENGTH OF SESSIONS

* Psychotherapy sessions are 54 minutes in length beginning at your appointed time and concluding after 54 minutes. Since your therapist has sessions scheduled after yours, the sessions must end at the appoint time regardless of when you arrive, and the full session fee will be charged. Therefore, it is to your benefit to be on time. Additionally, due to the nature of the work we do, there may be times when crisis arises and may result in the need to reschedule your appointment. We will make every effort to reschedule your appointment at a mutually agreed upon time. We ask your understanding when these rare occasions occur.

FEES

All services are billed at a per session rate. All co-payments, co-insurance payments, or private payments are due at the time of services. The current fee schedule is as follows:

* Initial Assessment Session: $200
* Individual Session (60 minutes): $150
* Couple or family session $150
* A sliding scale is available for those with financial difficulties, who do not have insurance (based on gross income and number of household members)
* No Show or late cancellation fee is $70 per session missed.
* Emergency cancellations less than 24 hours in advance will result in a $70 cancellation fee.
* Phone Calls from a client regarding clinical treatment content will be $1 a minute.
* For copies of medical records that are not able to be sent electronically via secure email fees will be: $.05 per one sided page and $1 per minute records preparation fee. The therapist will inform the client of the amount due for copies of medical records and payment will need to be received before copies of records are released.
* Any forms such as Disability, FMLA, etc., that are not filled out during the client's session will be charged at $1 a minute. The therapist will inform the client of how long it took to fill out the forms and payment will need to be received before forms are released.
* Court appearances are billed at $150 per hour that the therapist is required to be present.
* If the court hearing is outside of the York County Court area, the therapist's time to travel to the court hearing will be paid at $30 per hour. Any mileage over the amount that it would take the therapist to get from their home to Arrow Counseling Services will be paid at $.56 a mile.
* Any letters outside of coordination of care will be billed at $1 minute.

***NOTE:** When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. Please note that most insurance carriers do not reimburse fees for cancellations or missed appointments. Therefore, it will be the client's financial responsibility to make late cancel or no show fee payments.

SCHEDULING POLICY

In most cases, issues are not resolved in one therapy session. At the time of the initial appointment the therapist will usually establish the next appointment within one week. Appointment frequency is based on the therapist's assessment of what will be most effective and productive for you. During the initial phase of therapy, ongoing appointments are generally scheduled weekly or bi-weekly. Please note:

*If you cancel two appointments within a 6 month period, we will only be able to schedule one appointment at a time.

*If you late cancel or no show 2 or more times within a 6 month period, you will not be able to schedule in advance and you may be discharged from services. You will be placed on a cancellation list and will be called when your therapist has openings in his or her schedule.

If you cancel any appointment with less than 24 hours notice, the cancellation fee always applies.

BILLING & FINANIAL RESPONSIBILITY

* For health insurance holders, Arrow Counseling Services participates with a number of insurance providers. Please contact your insurance carrier prior to your first appointment to verify the following information:

* ls my Arrow Counseling Services therapist a participating in network provider?
* Does my insurance policy provide mental health benefits?
* Do I have a co-pay or co-insurance?
* Do I have a deductible that needs to be met?
* Do I need pre-authorization for services?

Please be able to provide this information prior to your first appointment. If your insurance requires a preauthorization, please bring the authorization number to your first appointment.

INSURANCE BILLING

* We will bill your provided healthcare insurance company and follow the contractual obligations that exist between your healthcare insurance company and our agency. Our office will only file an insurance claim if our office is a participating provider. Otherwise, it will be your responsibility to seek reimbursement from your insurance company, and you will be responsible for payment in full to Arrow Counseling Services. You have a responsibility to be aware and understand the provisions of your healthcare insurance policy. Please remember that insurance and behavioral health plans are a method of reimbursement for services, and not a substitute or guarantee of payment. Please understand that insurance is a contract between you and your insurance carrier. Therefore, in the event that your insurance company does not reimburse for services rendered as anticipated, you will be responsible for all incurred fees and expenses and will be billed accordingly.

* For self-pay clients, or those with non-participating or out-of-network plans, full payment is expected at the time of service. Our office will be glad to provide you with an invoice to potentially obtain reimbursement.

* Payment for services may be made by cash, check, credit card or HSA account cards. Please make all checks payable to Arrow Counseling Services, and provide payment to the office manager before your session starts. If the office manager is not on site, please have your check written ahead of time so that your full session time can be designated for therapy. Please make every attempt to have exact amount for cash payments. Change may not be able to be provided. Returned checks will result in a charge of $35.00 to cover bank charges and processing fees.

***NOTE:** Again, all payments are expected at the time of service. If you do not have your payment on the date of service, we reserve the right to reschedule your appointment.

EMERGENCY TREATMENT

* In the event of a psychiatric emergency, do not phone your therapist or Arrow Counseling Services office. Instead, call 911 or go immediately to your local emergency room. Then you should call your therapist. If your therapist is unable to be reached, please leave a message and your therapist will contact you as quickly as possible.

*In case of an emergency during a therapy session, if you become unable to communicate or need medical assistance, the person you have indicated as your emergency contact on your Intake Form will be contacted, and by signing this form, you authorize me to do so.

TERMINATION

* In the event you choose to terminate counseling with ACS it is our policy to consider anyone terminated if, the therapist or the office has not had any contact with you by phone, email or written correspondence and you have not continued with the therapy process for 30 calendar days after your last scheduled appointment. If after the 30 days you would like to schedule a follow up appointment, please call the office.

*If we do not hear from you by the end of the 60 day period as prescribed, we will assume that you are not interested in pursuing counseling at this time and we will close your file.

*If after file closure, your circumstances change and you wish to pursue counseling, we would welcome the opportunity to work with you. However, once your file is closed, you will have to go through the intake process again in order to schedule an appointment.

Community Resource Guide and Re-engagement with Services if needed

* The Community Resource Guide is a handout that each client receives which helps give them other options for support within the community. You are able to access these resources and opportunities at any time during and after treatment. Specific instructions are also given on how to reengage in services at Arrow Counseling Services LLC if needed. By signing this form, you are signifying that you were given a Community Resource Guide with instructions on how to reengage in services if needed.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HAW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

l. My Duties

* The privacy and confidentiality of your health information is very important and I am committed to protecting it to the extent that I can, consistent with law and ethical standards. Your health information includes records that I create and obtain in order to provide care to you. For example, it includes a record of your symptoms, examination and test results if applicable, diagnoses, summary of treatment and referrals. Bills, insurance claims and other payment information is also included in the record of your health information.

* This Notice tells you about the different ways I may use and disclose your health information. lt also describes your rights and my obligations. I am required to: maintain the privacy of your protected health information as required by law; provide you with this Notice of my legal duties and privacy practices with respect to your health information that I collect and maintain; and follow the terms of my Notice that is currently in effect.

ll. Uses and Disclosures of Protected Health Information - Payment, Treatment and Health Care Operations

* Under federal law, I am permitted to use and disclose personal health information without authorization for treatment, payment and health care operations. However, state law or the ACA's Code of Ethics may require me to obtain your express authorization before disclosing certain portions of your record and protected health information. I may also choose to require your release of information in certain circumstances. Treatment: For example, I may discuss certain aspects of your counseling with your psychiatrist in order to provide the best treatment and medication for you. Likewise, your psychiatrist may discuss certain medication management issues with me so I can collaborate in treatment. Payment: If your health insurance company needs more information for payment than what is printed on your receipt, I will provide only the minimum amount of information necessary for the insurance company to process the claim. This may include the diagnosis and explanation of care provided.

III. Other Uses and Disclosures of Protected Health Information

Besides use and disclosure for treatment, payment and health care operations, I may use and disclose your personal health information without authorization for the following purposes:

* **Abuse, Neglect or Domestic Violence**: I may disclose protected health information about you to a state or federal agency if I am required or permitted by law to report child or vulnerable adult abuse or neglect or domestic violence. When possible, and as consistent with my professional judgment in order to avoid harm to you or others, I will inform you of the need to make such a disclosure.

* **Judicial or Administrative Proceedings:** I may disclose health information about you in the course of a judicial or, administrative proceeding as required by law. For example, if a court orders me to release information, I must generally comply with the order. In some circumstances, I may be required to turn over information in response to a subpoena. If I receive a subpoena for your records, I will attempt to contact you and/or your attorney if that is feasible. Your attorney may be able to file a motion which will lead to a court order.

* **Law Enforcement:** If authorized or required by law, I may release health information to law enforcement officials. For example, I may release information to help identify a suspect or fugitive or report a crime related to a medical emergency.

* **Health Oversight Activities:** I may disclose health information about you to governmental, licensing, auditing or health care accrediting agencies where authorized or required by law. For example, information may be released to the state licensure board if a complaint is filed against me.

* **Appointment Reminders and other Health Services:** I may contact you to remind you of appointments or to inform you of treatment alternatives or other options and services that may be of interest to you.

* **Prevention of Serious Threat to Public Health or Safety:** In accordance with law and ethics, I may use and disclose health information about you to prevent or minimize the risk of a serious and imminent threat to your health and safety or to the health and safety of another person or the public.

* **Minors:** If you are an unemancipated minor under the law of the state of Pennsylvania, I may, in certain circumstances, disclose health information about you to a parent, guardian or other authorized person, in accordance with law and ethics.

*** Parents:** If you are the parent of an unemancipated minor, I may disclose health information about your child to you in certain circumstances. For example, if I must legally obtain your consent in order to treat your child, when you are acting as your child's "personal representative" under law, I may disclose health information about your child to you. In other circumstances, such as when your child is legally authorized to consent to treatment without a separate consent from you, and where the child does not request that you act as his/her "personal representative", I may not disclose health/mental health information about your child to you without your child's authorization.

*** Personal Representative:** If you are an adult or emancipated minor, I may disclose health information about you to a "personal representative" authorized to act on your behalf in making health care decisions.

*** Research and Related Activities:** I may disclose health information about you for research purposes in accordance with my legal and ethical obligations. Additionally, federal law allows us to create a "limited data set" which does not include information such as your name, address, Social Security number. This limited data set may be shared with those who have signed a contract promising to protect the privacy of the information and to use it only for research, health care oversight and health care operations.

*** Worker's Compensation/ Employee Assistance Program:** I may disclose health information about you for worker's compensation or employee assistance program as authorized or required by law. These programs provide benefits for certain work-related illnesses and injuries or employee related mental health issues.

*** Required by Law:** I may disclose information about you when required to do so by federal, state or other applicable law.

*** Authorization Required for Other Uses or Disclosures:** I will obtain your written authorization for any other use or disclosure of your protected health information. You have the right to revoke any authorization, in writing and in accordance with this Notice, to the extent that action has not been taken in reliance on the authorization. Psychotherapy notes are not among the records that you may, by law, review or copy unless I believe it is in your best interests to access them. I will be happy to discuss the issue of psychotherapy notes with you if you have any questions.

IV. Your Rights Regarding Health Information

You have certain rights regarding health information that I create and maintain about you. These rights include:

*** Right to Inspect and Copy**. With certain exceptions (such as psychotherapy notes as described above, information collected for certain legal proceedings and health information restricted by law), you have the right to inspect and/or receive a copy of your records. If I am unable to accommodate your request, I will inform you in writing of the reason for the denial and your right if any, to request a review of the denial. I may charge you a reasonable fee for copying your records.

*** Right to Request Communication by Alternative Means**. If you would like me to communicate with you in a certain way (e.g., by leaving a message on your office phone number) or at a certain location (e.g., home only), I will make efforts to accommodate such requests for confidential communications as long as they are

reasonable. I may request that you give me an alternative means to reach you if there is an emergency. If I am unable to contact you using your requested means, I may contact you using any information I have.

*** Right to Request Restrictions.** You have the right to request that I restrict or limit certain uses and disclosures of information. You may be asked to submit this request in writing. However, I am not required to agree to your request. I will let you know whether I am able to honor your request.

***Right to Receive a Paper Copy of this Notice**. You have the right to request a paper copy of this Notice at any time, even if you have agreed to receive it electronically.

In order to make any requests or exercise any rights set forth above, you must submit your request in writing to:

Carla V. Arrow, MS LPC NCC
1427 East Market Street
York, PA 174O3

You may also contact Carla Arrow by phone or e-mail during normal office hours.

717-755-O011 (ph) or Carrow@ArrowCounselingServices.com (email)

V. Questions or Complaints

* If you believe that your privacy rights have been violated, you may file a written complaint and address it to Carla V. Arrow (listed in section IV above). If that does not satisfy your concern, you may complain to the Secretary of Health and Human Services (HHS). Instructions for filing a complaint with the appropriate office for your region can be found at http://www.hhs.gov/ocr/howtofileprivary.pdf. Alternatively, you may call 1-800-368-1019 and request instructions for filing a complaint. There will be no retaliation for filing a complaint.

VI. Future Changes to this Notice and My Privacy Practices

* I reserve the right to amend the terms of my privacy practices and policies and this Notice. If this Notice is revised, the changed terms will apply to all health information about you, including information obtained before the effective date of the revised Notice. Any materially revised Notice will be distributed to all clients, posted in my waiting area and posted on my website.

CLIENT RIGHTS AND RESPONSIBILITTES

As a client of Arrow Counseling Services, you have the following rights:

* To be treated with dignity and respect at all times. You will not be subjected to harsh or unusual treatment or be deprived of any civil rights while a client at Arrow Counseling Services;
* To expect that a licensee has met the minimal qualifications of training and experience required by state law;
* To examine public records maintained by the Board and to have the Board confirm credentials of a license.
* To obtain a copy of the Code of Ethics;
* To report complaints to the Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors;
* To be informed of the cost of professional services before receiving the services;
* To be assured of privacy and confidentiality while receiving services as defined by rule and law, excluding the following exceptions:
* A Reporting suspected child abuse;
* Reporting imminent danger to client or others;
* Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
* Providing information concerning licensee case consultation or supervision; and
* Defending claims brought by client against licensee;
* To be free from being the object of discrimination on the basis of race, religion, gender; or other unlawful category while receiving services.

As a client of Arrow Counseling Services, you have the following responsibilities:

* To provide accurate and complete information concerning your present complaints, present/past medical/personal history and other matters relating to your current condition and life circumstances.

* To make it known to the therapist whether he/she comprehends clearly the course of treatment and what is expected from him/her.
* To read all handouts: Policies & Procedures, Client Notice of Privacy Practices, Client Rights and Responsibilities, and Client Release of Information Forms.
* To keep appointments and notifying the therapist at least 24 hours in advance if you are unable to make your appointment.
* To adhere to treatment recommendations. While entering into therapy is voluntary during the course of your care, your therapist will make recommendations that are specific to your presenting problem and circumstance. While there are benefits to following these recommendations, choosing not to adhere to them could result in consequences. Those consequences will be discussed in greater detail during the session.
* To pay all fees incurred for treatment services at the time of service.

Our desire is that your experience with Arrow Counseling Services will be helpful and productive for you. If you have any questions regarding these policies and procedures or other aspects of your relationship with us, please discuss them with your therapist or call the office at 717-755-0011.

As a client of Arrow Counseling Services, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Arrow Counseling Services. I also acknowledge that I have read and have been given a copy of all Policies and Procedures including my consent for treatment by Arrow Counseling Services.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

This Notice is effective 11/1/2007 and updated 06/16/2018.