HGCC CLIENT INFORMATION

FOR OFFICE USE ONLY

THX_____DX_____Rate_____

Healing Grace Counseling Center (HGCC) is a group of independently practicing mental health professionals who share office space, certain expenses and administrative functions. Each member independently provides clinical services and each is responsible for his or her clinical records. It is the policy of Healing Grace to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. No person shall be excluded from participation in, be denied the benefits of any service, or be subjected to discrimination because of race, color, nationality, religion, sex, sexual preference, age or disability.

CLIENT INFO

Client Name: _____

Address: _____

City/State: _____ Zip: _____

Date of Birth: ____ / ____ / _____ Gender: _____

SS#: _____

Parents/Guardians Names: _____

_____

Home #: _____

Cell #: _____

At which number may we leave a **confidential message?** (regarding scheduling, therapy information, billing, etc.)

☐ Home ☐ Cell

How did you hear about HGCC? _____

Would you like to receive HGCC updates, monthly newsletter, info about upcoming classes, etc. via email?

☐ Yes ☐ No

Email: _____

EMPLOYER & STATUS

I am:

☐ Employed
☐ Self-employed
☐ Retired
☐ Unemployed

☐ Single
☐ Married
☐ Divorced
☐ Widowed

Occupation: _____

Company: _____

Address: _____

City/State: _____ Zip: _____

How many people live in your household? _____

Children Names/Ages: _____

_____

_____

Spouse/Partner Name: _____

Spouse/Partner Occupation: _____

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Relationship to client: _____

HEALTH & MEDICAL

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications: _____

Turn Over

PAYMENT INFO

(✓ which applies)

☐ **Seeing Cash Rate Provider** ☐ **Using Insurance**

Primary Insurance Company: _____Policy Holder ID #: _____

Group #: _____ Policy Holder's Name: _____

Date of Birth: ____ / ____ / ____ SS#: _____ Relationship to Client: _____

Secondary Insurance Company: _____Policy Holder ID #: _____

Group #: _____ Policy Holder's Name: _____

Date of Birth: ____ / ____ / ____ SS#: _____ Relationship to Client: _____

INVOLVEMENT IN CARE

I hereby request the following person(s) to be allowed to participate in my care and/or payment decision-making process. I understand these person(s) may be given health or payment information about me.

NAME	**RELATIONSHIP**	**PHONE NUMBER**	**TYPE OF INFO** (Billing, Scheduling, Clinical, All)

HGCC will make a reasonable effort to provide only the necessary information for the person(s) to make an informed decision or to receive printed/verbal protected health information.

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding? Yes / No

Have you ever received counseling services from HGCC or any other organization? Yes / No If yes, where/when?

_____

The information I have given is true and correct. I am requesting services from Healing Grace and I understand that as a courtesy, HGCC will bill my insurance provider. Healing Grace does not know how your claims will be processed by your insurance company. QUOTES GIVEN ARE ESTIMATES ONLY AND YOU ARE FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES including but not limited to: Deductibles, co-pay/co-insurance, and non-covered services, etc. I also understand that HGCC has the right to discontinue services if my account balance becomes past due and/or excessively high. If an account balance is forwarded to the collection agency, I understand that I and/or any family members will NOT be accepted as a client in the future. All copays are due at the time of service.

Out of respect for your therapist AND to avoid a late cancellation/no show fee, please kindly give us 24 hours notice.

Client's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

HEALING GRACE CHILD INITIAL EVALUATION

Parents/Guardians, please complete this form for children under 16 years old and give it to your child's therapist at the time of your first appointment. This information will help your child's therapist identify problem areas and provide the best treatment possible.

CHILD'S NAME _____ **DATE** _____

A. PARENT QUESTIONS:

1. Are the parents of this child divorced/separated/never married? ☐ Yes ☐ No
   If yes, what are the custody arrangements? (circle) Joint Sole Other _____
   If joint custody exists, are both parents aware of the child's involvement in counseling? ☐ Yes ☐ No
2. Was this child adopted? ☐ Yes ☐ No
3. Feelings related to parenting (circle one for each statement): **1=Never 2=Somewhat 3=Often 4=Always**

I am worried about my child.	1	2	3	4
I am confident in childrearing.	1	2	3	4
I have conflict with others related to how I discipline my child.	1	2	3	4

C. FAMILY HISTORY: Specify whom (parent, sibling, aunt/uncle, grandparent, etc.)

1. Psychiatric problems _____
2. Depression or Anxiety _____
3. Abuse of alcohol or drugs _____
4. Suicidal behavior _____
5. Physical violence _____
6. Health conditions (or deceased) _____

D. DEVELOPMENT HISTORY:

1. Did this child's biological mother use alcohol or drugs during her pregnancy? ☐ Yes ☐ No
   If yes, what substances? _____
2. Did the biological mother experience unusual stress or health complications during this child's pregnancy?
   ☐ Yes ☐ No If yes, describe: _____
3. Did the child experience any trauma at birth (anoxia, etc.)? ☐ Yes ☐ No
   If yes, explain: _____
4. Were the child's developmental milestones (walk, talk, toilet training, etc.) within normal limits?
   ☐ Yes ☐ No If no, explain: _____

E. EMOTIONAL & BEHAVIORAL HISTORY: Child and Family

1. Has your child ever seen a counselor/therapist before? ☐ Yes ☐ No
2. Has your child ever been hospitalized for emotional/behavioral reasons? ☐ Yes ☐ No
3. Has your child taken medications for emotional or behavior problems? ☐ Yes ☐ No
   If yes, specify drug name: _____
4. Has your child ever received psychological testing (WISC-III, etc.)? ☐ Yes ☐ No
   If yes, describe: _____
5. Has your child ever witnessed violence (domestic, homicide)? ☐ Yes ☐ No ☐ Unsure

OVER PLEASE

6. Has your child ever suffered from physical abuse or neglect? ☐ Yes ☐ No ☐ Unsure
7. Has your child ever been a victim of sexual abuse? ☐ Yes ☐ No ☐ Unsure

F. MEDICAL:

1. Please list **all** prescription and over the counter medications/supplements your child is currently taking (include doctor's name):_____

_____

2. Identify health problems your child has had (P) or has now (C).

___Allergies	___Asthma	___Headaches
___Seizures	___Head Injury	___Encephalitis
___Meningitis	___Unconsciousness	___Concussions
___Cancer	___Heart Problems	___Sinus Problems
___Hearing Problems	___Vision Problems	___Other serious illnesses

G. SCHOOL FUNCTIONING:

1. If your child is school age, please state the grade and school your child attends: _____

_____

2. Does your child appear motivated for school? ☐ Yes ☐ No ☐ Unsure
3. Has your child ever been suspended or expelled from school? ☐ Yes ☐ No
4. Has your child ever been diagnosed with a learning disability or attention deficit? ☐ Yes ☐ No
   If yes, describe: _____
5. Does your child have difficulty making friends or getting along with peers? ☐ Yes ☐ No ☐ Unsure

H. CURRENT SYMPTOMS:

Please **circle** all words or phrases below that describe what your child is experiencing. Also, identify the frequency of each symptom by placing a number from the following scale in the blank.

1=Sometimes (1-2 days/week)**2=Often** (3-4 days/week)**3-Most days** (5-6 days/week)**4=Always** (7 days/week)

Very Unhappy		Irritable		Temper Tantrums		Withdrawn		Daydreaming	
Fearful		Phobic		Sluggish		Distractible		Impulsive	
Peer Conflict		Disobedient		Argumentative		Regressed		Destructive	
Animal Cruelty		Cutting Self		Sibling Violence		Overactive		Legal Trouble	
Running Away		Stomachaches		Head Banging		Rocking Self		Bed Wetting	
Soiled Pants		Fire Setting		Hallucinations		Mute		Stealing	
Suicide Talk		Failing Grades		School Refusal		Drug Use		Alcohol Use	
Insomnia		Overeating		Poor Appetite		Bullying			

I verify that I have completed this form to the best of my knowledge.

_____ _____

Signature Date

CHILD INITIAL EVALUATION CONTINUED

PRESENTING PROBLEM:

1. Please describe the problem(s) that prompted you to seek help for your child/family:
2. When did these symptoms/problems begin? (Approximate date):
3. Please describe any changes that might have contributed to development of the problem:

PARENT QUESTIONS:

If your child is adopted, please describe when and why:

EMOTIONAL & BEHAVIORAL HISTORY: (Child and Family)

1. If your child has seen a counselor/therapist before, please describe and list the provider's name:
2. If your child has ever been hospitalized for emotional/behavioral reasons, please describe:
3. If you child ever witnessed violence (domestic, homicide), please describe:
4. If your child ever suffered from physical abuse or neglect, please describe:
5. If your child has ever been a victim of sexual abuse, please describe:

SCHOOL FUNCTIONING:

If your child has ever been suspended or expelled from school, please describe:

THERAPY GOALS:

What would you like to accomplish in child/family therapy?

Healing Grace Counseling Center
Consent for Treatment

We are committed to providing you with the best possible care. Please read and initial each item:

_____ 1. Therapy
I understand there are no guarantees made to me regarding therapy treatment. There are many kinds of treatment alternatives, and I may discuss them with my therapist. I consent to the evaluation and treatment process. Christian counseling is available, and I will advise my therapist if I am interested.

_____ 2. Client Discharge
I understand that I may discontinue service at any time. HGCC may also discontinue service at any time with or without my consent for non-compliance, non-payment, excessively high balance, etc. I will be given a referral for another provider. Accounts are sent to collections when no response or payment is received for 90 days after discharge. If an account balance is forwarded to a collection agency, I understand that I and/or my immediate family members will not be accepted as a client in the future.

_____ 3. Release of information
I authorize the release of any medical or other information necessary to process claims, or otherwise collect payment on my account. In addition, I authorize my insurance carrier to pay HGCC for billed services. All medical records requests require a separate release form. There is a fee for copies and handling, not covered by insurance plans.

_____ 4. Confidentiality
All information shared in session is confidential except in circumstances governed by the law, including the mandatory reporting of alleged harm to self or others, particularly in the case of child, disabled person, or elder abuse.

_____ 5. Minor Children
Clients under the age of 18 may not cancel or change appointments. If a parent/guardian seeks treatment for a minor, we require that both parents or guardians sign this form. In some cases, guardianship/adoption documents will be required. Divorced Parents: If joint custody, we require that both parents sign this form, and provide copy of the most current court records. If parent has full custody, we require that the custodial parent sign this form and provide copy of the most current court records. Note: Although discouraged, either parent/guardian has the right to request copies of session/s documentation.

_____ 6. No Suicide Agreement
I agree not to attempt or otherwise engage in self harm and/or harm to others. I agree to seek hospital/emergent care in the event I might violate this agreement. For non life-threatening, clinical emergencies, please (816) 246-4465 and leave a message on your therapist's voicemail box.

_____ 7. Services <u>not</u> provided
HGCC therapists are not qualified as legal experts in court cases. HGCC does not provide custody evaluations, sexual abuse investigations, or anything related to such matters.

_____ 8. Privacy Practices
I acknowledge that I have been offered a copy of the Healing Grace Notice of Privacy Practices.

_____

Print Client Name | Date of Birth

_____

Client/Legal Representative Signature | Date | Therapist/Witness Signature | Date

_____

Client/Legal Representative Signature | Date | (Both signatures required for divorced parents having joint custody)

Healing Grace Counseling Center
Credit/Debit Card Authorization Form

Please print clearly

Client Name_____ Phone_____

Cardholder's Name (As Shown On Card)_____

Billing Address_____
Street City State Zip Code

Credit/Debit Card Number_____
We accept Visa, MasterCard, Discover, & American Express

Expiration Date_____ CVV_____

PLEASE READ AND SIGN BELOW

By signing below, I authorize Healing Grace billing department to keep my signature on file and charge my credit/debit card account for any outstanding balances, including, but not limited to: deductible, co-pay, co-insurance, and private pay fees; missed appointment or late cancellation fees; along with any other outstanding balances.

I acknowledge that Healing Grace does not need any further authorization, such as phone calls or emails, prior to charging my card.

Cardholder Signature_____

Email receipt sent to:_____

All information entered on this form will be kept strictly confidential by Healing Grace Counseling Center.

If you have any further questions, please feel free to contact our billing staff at 816-944-3251.

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