

**Child Intake Information & Outpatient Services Contract**  
*For clients 18 years of age or younger*

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

1. PARENT(S)/LEGAL GUARDIAN NAME(S) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

*(If different from above)*

2. PARENT(S)/LEGAL GUARDIAN NAME(S) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

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**INSURANCE INFORMATION**

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

SS# \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_

GROUP NO. \_\_\_\_\_ INSURED'S EMPLOYER \_\_\_\_\_

WORK NO. \_\_\_\_\_ REFERRAL SOURCE \_\_\_\_\_

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**Welcome to the Studio For Change®!**

This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between you and the Studio For Change.

**Psychological Services**

Psychotherapy with children is not easily described in general terms. It varies depending on the personality of both the therapist and the client, the age of the client and the problem being presented. Therapy with children is a slower process

than with adults because it takes a child longer to become comfortable in the environment and trusting of the therapist. There are a number of different approaches that can be utilized to focus on presenting problems.

For younger children, techniques of play therapy are often utilized. Play therapy allows children to speak in their most comfortable, effective language by using games, toys, creative arts, dolls and other play materials. Children can effectively convey their fears, wishes, anxieties and thought processes through play and behavioral management.

Older children have a higher capacity to express themselves verbally, but often also need support in mastering this skill. Typically for older children a combination of talk therapy and play therapy is utilized to best help them work through their problems and to effectively communicate their needs and feelings.

As with adults, psychotherapy with children has both risks and benefits. Risks often include the child experiencing uncomfortable feelings or a temporary increase in targeted negative behaviors. Psychotherapy with children has also been shown to have significant benefits including a reduction in feelings of distress, improved relationships, decrease in negative behaviors, and resolution of specific problems. However, there are no guarantees about what or when changes will occur.

The first few sessions may involve a combination of meetings with the parents and child both individually and as a family. By the end of the evaluation, your therapist will offer you impressions of what the work will include and an initial treatment plan. If you have questions about these procedures or the proposed treatment plan, you should discuss them with the therapist before moving forward with therapy.

### **Meetings**

The Studio For Change's best practice is to conduct an initial evaluation, which will last from two to four sessions. The therapist meets with the parent/s first to gather information regarding the child and the problems being presented. Once adequate information is obtained, the therapist schedules another session to meet with the child individually in order to observe the child, assess the presenting problem and determine if the child has the capacity to benefit from therapeutic services based on age and abilities. The final meeting is a feedback session with either the parents alone or with the child present. During this meeting the therapist will provide her/his assessment and make recommendations. Throughout this process, the parent, child and the therapist can decide whether the therapist is the best person to provide the needed services for the child in order to meet the treatment objectives. If psychotherapy is initiated, your Studio For Change therapist will schedule a session with the child. The duration of the session will be dependent on the child's needs and tolerance level.

Once therapeutic services are initiated for your child at the Studio for Change, a combination of individual and family therapy is utilized. It is important for the child, parents and therapist to work as a team and be comfortable flowing from one type of therapy to the other. It is also important that the child develops a sense of safety and trust in the therapist and the therapeutic environment. In therapy, children are provided the same confidentiality and respect as adults. Parents will be provided an overview of the progress and continued areas of focus for the child. As well, the child will be encouraged to share concerns and feelings with the parents through engagement in family therapy. However, specific information shared by the client during the therapeutic process will not be shared with the parent unless the therapist is concerned for the child's well-being or if it is believed that sharing the information will benefit the therapeutic process.

### **Cancellation & Rescheduling Policy**

The Studio For Change requires 24 hour notice for any cancelled appointments. Therapy appointments must be cancelled or rescheduled 24 hours before the scheduled date and time. Any same day cancellations or no call, no shows are subject to a cancellation fee of your full therapy fee. For such purposes we require a credit card number on file. *See the last page in this document to leave credit card information and to sign the client acknowledgement of this policy.*

### **Contacting Your Therapist**

To contact your therapist you can leave a confidential message on your therapist's Studio For Change voicemail. Your therapist will make every effort to return your call within 24 hours with the exception of weekends and holidays. If you cannot reach your therapist and you feel that it is imperative that you speak with someone, you should call your family physician, 911, or the emergency room at the nearest hospital and ask for the psychiatrist or psychologist on call.

### **Supervision**

In order to provide the best quality services, therapists often receive clinical supervision. As well, your Studio For Change therapist may be working towards a specific level of professional licensure. Your therapist's approved clinical supervisor will have access to your client file and information. You have the right to know and contact the licensed, clinical supervisor overseeing your case at any time. All approved supervisors are held to the same confidentiality requirements as your therapist.

## ***Payments & Billing***

### **Professional Fee**

The Studio For Change bills at a rate of \$120-\$150 per hour. In addition to weekly therapy appointments, Studio For Change will charge for other professional services you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or school consultations, preparation of records or treatment summaries, or the time required to perform any other service that you may request. If you become involved in litigation that requires a therapist's participation, you will be expected to pay for the professional time required even if the therapist is compelled to testify by another party. Due to the complexity and difficulty of legal involvement, charges will be assessed with a possible increase in the hourly fee. In addition, any travel expenses incurred throughout legal proceedings will be billed to the client.

### **Overdue payments**

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, Studio For Change has the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. If this were to occur, the only information Studio For Change would release about a client's treatment would be the client's name, the nature of services provided and the amount due.

### **Insurance Reimbursement**

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Your therapist will provide you with the necessary assistance to facilitate the receipt of benefits including filling out any necessary forms. However, you are responsible for full payment of the fee that was agreed upon. All of the Studio For Change insurance billing is out-serviced through American Medical Billing (AMB) and invoices for claims not paid by insurance will be sent to clients directly from AMB.

It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that described mental health services. Any questions should be directed to your plan administrator. Studio For Change will provide any information your therapist can, based on our experience and will work with you to decipher the information received from your carrier. If necessary to resolve confusion, your therapist can call the carrier on your behalf.

The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits, which sometimes makes it difficult to determine exactly how much mental health coverage is available. "Managed Health care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented toward a short-term treatment approach designed to resolve specific problems that are interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In our experience, while quite a lot can be accomplished in short-term therapy, many clients feel that more services are necessary after insurance benefits expire.

You should also be aware that most insurance agreements require you to authorize your therapist to provide a clinical diagnosis and sometimes additional clinical information, such as a treatment plan, summary or in rare cases a copy of your entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, your therapist will have no control over what they do with it. In some cases they may share the information with a national medical information data bank. If you request it, your therapist can provide you with a copy of any reports submitted.

Once the Studio For Change has all of the insurance information, your therapist will discuss goals in relation to the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end your sessions.

**Paying Your Bill**

You will be expected to pay for each session at the time it is held, unless it is agreed otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to at the time these services are requested.

As a courtesy, the Studio For Change will bill your insurance company, HMO or responsible party if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event that you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds \$300.00, payments will be due at the time of service. After 60 days any unpaid balance may be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Lastly, we ask that every client authorize payment of medical benefits directly to the Studio For Change. We sincerely appreciate your cooperation and at any time if you have any questions regarding insurance, fees, balances or payments, please feel free to ask.

(Check **ONE** box for the payment option you choose to pay your bill and sign below)

I agree to use my **insurance to pay for services** understanding that I am responsible for all unpaid claims.

Signature \_\_\_\_\_ Date \_\_\_\_\_

OR

I am **not paying with insurance**, but I agree to pay \$\_\_\_\_\_ amount for each session.

Signature \_\_\_\_\_ Date \_\_\_\_\_

***Client Records and Confidentiality***

**Professional Records**

Your therapist is legally and ethically required to keep appropriate record of your work together such as dates seen and services performed. These records are kept in a locked file cabinet. At times, your therapist may record psychotherapy notes from your sessions. Because these records contain information that can be misinterpreted by someone who is not a mental health professional, it is our general policy that clients may not review them

**Confidentiality**

In general, the law protects the confidentiality of all communications between a client and a therapist. Your therapist can only release information about your work to others with your written permission. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent your therapist from providing information about your treatment. Yet, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require your therapist's testimony if s/he determines that resolution of the issues before him/her demands it.

There are some situations in which your therapist is legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. For example, if your therapist believes that a child, an elderly person, or a disable person is being abused, the Studio For Change is required to file a report with the appropriate state agency.

If your therapist believes that a client is threatening serious bodily harm to another, the Studio For Change is required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him or herself, your therapist may be required to seek hospitalization for the client or contact family members or others who can help provide protection.

The situations described above have rarely arisen in the Studio For Change. Should such a situation occur, your therapist would make every effort to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, your therapist will make every effort to avoid revealing the identity the client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your therapist will not tell you about these consultations unless it is believed that it is important to your therapeutic work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any question or concerns that you may have at the next meeting. The laws governing these issues are quite complex, and your therapist is not an attorney. While your Studio For Change therapist is happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, your therapist will provide you with the relevant portions or summaries of the applicable state laws governing these questions.

**Confidentiality and Emergency Situations**

Your verbal communication and clinical records are strictly confidential except for: a) information you and your child or children report about physical or sexual abuse, by Illinois State Law and the Mandated Reporter Act, your therapist is obligated to report this information to the Illinois Department of Children and Family Services, b) information shared with your insurance company to process your claims, c) where you sign a release to have specific information shared, d) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact the emergency services in the community for those services. Your Studio For Change therapist will follow those emergency services with standard counseling and support to the client or the client's family.

I have read and understand my child's and my own confidentially rights

Signature \_\_\_\_\_ Date \_\_\_\_\_

***Consents for Treatment***

**Minors**

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. For those who are between 12 and 18 years of age, it is the Studio For Change policy to request an agreement from parents that they consent to give up access to your records. If they agree, your therapist will provide them only with general information about your work together unless your therapist feels that there is a high risk that you will seriously harm yourself or another, in which case your therapist will then notify them of concern. Your therapist will also provide them with a summary of your treatment when it is complete if they have opted to let our work be confidential. Before giving parent/s any information your therapist will discuss the matter with you, if possible, and will do the best to resolve any objections you may have about what may be discussed.

**Signed Consent To Services**

Your signature below indicates that you have read the information in this document and when applicable, reviewed it with your child, and agree to abide by its terms during our professional relationship.

Child Signature (13 years or older) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent for Treatment of Children and Adolescents**

I/We consent that \_\_\_\_\_ (name of child) may be treated as a client or clients by a Studio For Change therapist.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Audio/Visual Consent**

As a learning tool, your Studio For Change therapist may sometimes utilize audio and/or video recording devices during a therapy session. The purposes of these tapes are for supervision and learning only. The tapes will only be viewed by your therapist and their approved, licensed supervisor. You will never be recorded in any manner without your acknowledgement or consent, nor will there ever be any secret recordings of you in a therapy session. If deemed appropriate for the therapy, the video and/or audiotape may be played in a therapy session for you (the client) and your therapist to review. All audio and video recordings are stored confidentially in the same manner as your treatment records and destroyed at the time of therapy termination.

Please circle the appropriate consent: I consent to allow my therapist to **AUDIO TAPE AND/OR VIDEO TAPE** our therapy sessions as deemed appropriate for my therapy. I understand that I have the right to ask the therapist to stop recording at any point in time and know that any information shared on the tape will be managed in a confidential manner as indicated above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Additional Client(s) Receiving Services from Studio For Change**

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

*Pediatric Intake Questionnaire*

**Background Information**

1. Child/Adolescent's preferred name to be called: \_\_\_\_\_
2. Gender Identity (circle): Male Female
3. Who should be called regarding scheduling and messages for child? \_\_\_\_\_
4. Is it OK to leave voice messages on any of the following numbers? (Please check all that apply and provide the preferred phone numbers):
  - a.  Home #: \_\_\_\_\_
  - b.  Work #: \_\_\_\_\_
  - c.  Cell #: \_\_\_\_\_
  - d.  Other #: \_\_\_\_\_
5. Ethnic Identity: \_\_\_\_\_
6. Primary Language Spoken in the Home: \_\_\_\_\_
7. Primary Language Spoken by Client: \_\_\_\_\_
8. Why are you seeking psychotherapy for your child at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. How would you currently rate your child's problem(s) that you are seeking help with at this time? (On a scale from 1-10 with 1=mild and 10=severe) \_\_\_\_\_
10. How long has the current problem(s) been occurring? \_\_\_\_\_
11. Please list your child's current coping strategies in dealing with the problem(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. What are your child's strengths? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Is your child currently receiving other services to address the problem (counseling, physical therapy, occupational therapy, services at school, etc)? **Yes No** (circle one)  
If yes, what services, where and how often? \_\_\_\_\_

14. Has your child ever received therapeutic services before? **Yes No** (circle one)  
If yes, for what purpose? \_\_\_\_\_  
What services were helpful and why? \_\_\_\_\_  
\_\_\_\_\_  
What services were not helpful and why? \_\_\_\_\_  
\_\_\_\_\_

**Mental Health Information**

1. Is your child currently experiencing or has ever experienced suicidal thoughts? **Yes No** (circle one)  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
2. Has your child ever intentionally inflicted harm on him/herself or someone else? **Yes No** (circle one)  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
3. Has your child ever been hospitalized for mental health issues? **Yes No** (circle one)  
If yes, please provide when, where and reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Is your child currently seen by a mental health professional? **Yes No** (circle one)  
If yes, please provide name/address/phone # of psychiatrist: \_\_\_\_\_  
\_\_\_\_\_
5. Does your child currently take any medication? **Yes No** (circle one)  
If yes, please list medication with dosage: \_\_\_\_\_  
\_\_\_\_\_
6. Does your child currently have a formal Mental Health diagnosis? **Yes No** (circle one)  
If yes, what diagnosis: \_\_\_\_\_  
Who was the diagnosing practitioner? \_\_\_\_\_

**Developmental/Medical Health**

1. Please describe any developmental history or concerns you have or had with your child (pregnancy, milestones, motor skills, speech and language): \_\_\_\_\_  
\_\_\_\_\_

2. Does your child have any major illnesses or long-term medical problems? **Yes No** (circle one)  
Please explain: \_\_\_\_\_  
\_\_\_\_\_
3. Does your child require assistance in daily living activities (i.e. getting dressed, eating, toileting, walking, etc)?  
**Yes No** (circle one)  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. Does your child have any difficulties with sleep? **Yes No** (circle one)  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
5. Does your child have any issues related to eating? **Yes No** (circle one)  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
6. Does your child have consistent weekly activity? **Yes No** (circle one)  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
7. Who is your child's physician (please provide name/address/phone #)? \_\_\_\_\_  
\_\_\_\_\_

**Social History**

1. Does your child attend school? **Yes No** (circle one)  
If yes, please provide school name, address, phone #: \_\_\_\_\_  
\_\_\_\_\_
- What grade is your child in? \_\_\_\_\_
- Is your child in a full-time regular classroom? \_\_\_\_\_
- Does your child receive supportive services from school? **Yes No** (circle one)  
If yes, what services and how often? \_\_\_\_\_  
\_\_\_\_\_
2. Does your child have any learning issues or disabilities? **Yes No** (circle one)  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
3. Does your child have any issues related to socialization (i.e. difficulty making/maintaining friends, lack of significant peer group, exhibit anti-social behaviors)? **Yes No** (circle one)  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

4. Please list your child's participation in extra-curricular activities: \_\_\_\_\_  
 \_\_\_\_\_
5. Please list your child's hobbies or areas of interest: \_\_\_\_\_  
 \_\_\_\_\_
6. Please list all of your child's volunteer positions or jobs (i.e. babysitting, dog walking, paper route, etc)?  
 \_\_\_\_\_

**Substance Use**

1. Does your child smoke cigarettes? **Yes No** (circle one)
2. Does your child drink alcohol or take any recreational drugs? **Yes No** (circle one)  
 If yes, please describe: \_\_\_\_\_
3. Do you have any concerns related to your child and substance abuse? **Yes No** (circle one)  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
4. Does anyone in your child's family currently have or has had in the past a substance abuse problem?  
**Yes No** (circle one)  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Family Background**

1. Please list current members of your family:

Name	Age or Date of Birth	Occupation or Year in School	Currently living with Client? (yes or no)

2. Please list any information about your child's family and relationships (i.e. divorce, extended family, past abuse experienced or witnessed by child, etc.): \_\_\_\_\_  
\_\_\_\_\_
3. Have any family members experienced and/or been diagnosed with a Mental Health Disorder?  
**Yes No** (circle one)  
If yes, please explain: \_\_\_\_\_
4. Have any family members experienced and/or been diagnosed with any learning issues or disabilities?  
**Yes No** (circle one)  
If yes, please explain: \_\_\_\_\_

**Legal Concerns**

1. Is your child or any immediate family members currently involved in any court case? **Yes No** (circle one)  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
2. Are you currently involved in divorce mediation or a custody case? **Yes No** (circle one)  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
3. Is there currently a custody agreement in place? **Yes No** (circle one)  
If yes, please describe agreement (please note: the Studio For Change needs a copy of the custody agreement for your child's file): \_\_\_\_\_  
\_\_\_\_\_

**Please list anything else you would like your Studio For Change therapist to know about your child or family before you initiate therapy:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***Studio For Change® Cancellation & Rescheduling Policy***

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Type of Card (check one):  Visa  MasterCard  Discover

Name on Card (please print) \_\_\_\_\_

Credit Card number \_\_\_\_\_ Expiration Date # \_\_\_\_\_

3 Digit Code on back \_\_\_\_\_

Card Holder's Billing Address \_\_\_\_\_ Apartment, Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

By my signature below, I certify that I understand that this credit card information is to remain on secure file with Studio For Change until the termination of treatment; All treatment charges will be billed with this credit card unless I request otherwise.

Signature of Card Holder \_\_\_\_\_ Date \_\_\_\_\_

I authorize the Studio For Change® office to charge my credit card the full therapy fee of \$\_\_\_\_\_, to pay for my therapy services (*Check box only if you are also planning on paying for all treatment charges with this credit card*)

***Studio For Change® Cancellation & Rescheduling Policy  
Client Acknowledgement***

By my signature below, I certify that I have read and fully understand the contents of this permission form and that the disclosures referred to herein were made by me.

I authorize the Studio For Change® office to charge my credit card the full therapy fee of \$\_\_\_\_\_, if I do not cancel or reschedule my appointment with 24 hour notice.

Signature \_\_\_\_\_ Date \_\_\_\_\_