Old Town Psychological Services
Child Intake Form

DATE: _____/_____/_____

PERSONAL INFORMATION

Name: _____DOB: _____/_____/_____ Age: _____

Gender: ☐M ☐F Preferred pronouns: _____

Parents' Names: _____ *Okay to leave a message?*

Address: _____Cell Phone: (_____) _____-_____ ☐yes ☐ no

_____ Other Phone: (_____) _____-_____☐yes ☐ no

City State Zip Code Email: _____

Employment/School Status: ☐ Employed ☐Unemployed ☐Full Time Student ☐ Part Time Student

Siblings: *Name* *Age*

_____ _____
_____ _____
_____ _____
_____ _____

INSURANCE INFORMATION

Primary Insurance: _____

Insured:_____ Gender: ☐M ☐F

Relationship (self, child):_____

DOB of subscriber:_____

Policy#: _____

Employer: _____

Secondary Insurance: _____

Insured:_____ Gender: ☐M ☐F

Relationship (self, child):_____

DOB of subscriber:_____

Policy#: _____

Employer: _____

RELEASE AND ASSIGNMENT

I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to Old Town Psychological Services. I understand and agree that I am ultimately responsible for the balance on my account.

_____ _____

Signature of Client Date

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SCHOOL INFORMATION

School: _____ Grade: _____ Counselor: _____

Teacher/s:	*Subject:*	
_____	_____	☐Regular Ed.☐Special Ed.
_____	_____	☐Regular Ed.☐Special Ed.
_____	_____	☐Regular Ed.☐Special Ed.
_____	_____	☐Regular Ed.☐Special Ed.
_____	_____	☐Regular Ed.☐Special Ed.
_____	_____	☐Regular Ed.☐Special Ed.
_____	_____	☐Regular Ed.☐Special Ed.

MEDICAL INFORMATION

Family Physician: _____ Phone:_____

Medication:	*Dosage:*
_____	_____
_____	_____

Medical Conditions: _____

_____

_____

REASON FOR SEEKING TREATMENT/EVALUATION

Statement of Concern: _____

_____

_____

_____

Was patient referred? ☐No ☐Yes Name:_____

Give authorization to send progress notes and/or treatment results to this person? ☐No ☐Yes

How did you hear about Old Town Psychological Services?

☐Physician (Name: _____) ☐Friend ☐Yellow Pages ☐ Other: _____

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CONSENT TO RECEIVE SERVICES

CLIENT RIGHTS: As a client of Old Town Psychological Services you have a/the right to:

- Be treated with dignity and respect
- Not be discriminated against on gender, race, religious preference, sexual orientation or handicap
- Be informed of the therapeutic process, including the benefits and risks of treatment and to participate in treatment decisions
- Confidentiality (note the *limits of confidentiality* below)
- Be informed of therapist and supervisor credentials and licenses
- Receive services in a manner that is non-coercive and that protects your right to self determination
- File a grievance should you have a disagreement or misunderstanding with your therapist.
    - GRIEVANCE POLICY:
        - You should discuss disagreements and misunderstandings, between and your therapist, directly with your therapist.
        - Should the situation need further assistance you may file a complaint against your therapist with the clinical director.
        - The clinical director will then address the client's concern and attempt to work out an agreement between the client and therapist.
        - If this does not resolve the problem the client has the right to, and will be provided with a State of Michigan Citizen's Guide for Filing a Complaint.

LIMITS OF CONFIDENTIALITY: All information shared between the client and Old Town Psychological Services is held strictly confidential with the following exceptions:

- Client presents a physical danger to oneself or others
- Previous or current suspected child abuse/neglect
- Suspected abuse of adults age 18+, who are mentally/physically incapable of protecting themselves
- Suspected abuse of elderly, ages 65+
- Old Town Psychological Services is court ordered to release information
- The client authorizes release of information to an outside person/agency

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I, (print name) _____, have read and understand the client rights and limits of confidentiality. Further, I give my consent to receive services from Old Town Psychological Services and agree to the terms and conditions outlined in the office packet I received. Also I understand that treatment is voluntary and I may refuse to receive services.

_____ _____

Signature of Parent/Guardian of Client Date

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The adult that will be financially responsible for this minor

Relationship to client: _____

Name: _____

S.S. #: _____

DOB: _____

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I understand and agree to the financial and cancellation policies printed in the welcome packet. (To be signed by responsible party listed above.)

Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICE

I have been made aware that Old Town Psychological Services has a copy of the *HIPAA Notice of Privacy Practices* available on file if I wish to view it.

Signature: _____ Date: _____

**Please sign the page at the time of receipt. You may review this document at your convenience.