Lisa Hart, LCSW
4823 S. Sheridan Suite 315
Tulsa, OK 74145
(918) 574-2722 Fax :(918) 574-2782

ADOLESCENT UNDER 18 YEARS

Date_____

CHILD INFORMATION

Child's Name_____

Address _____

City_____ State_____ Zip Code_____

Birth date_____

School attending_____ Grade_____ Religious Affiliation_____

Home Phone: _____ Child's Cell Phone: _____

PARENT/GUARDIAN INFORMATION (If applicable)

Father's Name_____

Address _____

City_____ State_____ Zip Code_____

Birth date_____ Religious Affiliation_____

Occupation_____ Place of Employment_____

Education (Highest Grade Completed) _____ Marital Status_____

Phone: _____Work Phone: _____E-mail: _____

Mother's Name_____

Address _____

City_____ State_____ Zip Code_____

Birth date_____ Religious Affiliation_____

Occupation_____ Place of Employment_____

Education (Highest Grade Completed) _____ Marital Status_____

Phone: _____Work Phone: _____ E-mail: _____

CHILDREN/SIBLINGS

Name	Birthdate/Ages	Grade in School	Living at Home

Whom should we contact in case of an emergency?_____

Telephone Number_____ Relationship_____

Should we need to call you to confirm appointments or gather additional information is it acceptable to leave messages on voicemail or with whoever answers the phone? _____

Preferred way of confirming appointments: _____Home Phone _____Cell Phone

Whom may we thank for referring you to us? _____

May we send a thank-you to the referral source? Yes _____ No _____

_____

Client Name

1. Briefly describe the problem for which you are seeking help. _____

_____

_____

_____

_____

2. How do you think we can best assist you?

_____

_____

3. Who is your child's personal physician? _____

4. When was his/her last physical examination? _____

5. Please describe any physical disabilities or health problems.

_____

_____

6. Please list any medications your child is now taking.

_____

_____

7. Please describe any additional information that might be helpful in our understanding of the problem.

_____

8. Describe the type and frequency of your child's exercise.

_____

_____

9. Has your child received psychiatric help or psychological counseling before? (Circle)YES NO

If yes, with whom and dates? _____ **Please check any of the following symptoms/problems that pertain to your child:**

- ☐ Fears or phobias
- ☐ Shyness
- ☐ Having to do things over and over
- ☐ Intrusive thoughts
- ☐ Making decisions
- ☐ Need to be in control of everything
- ☐ Nightmares
- ☐ Relaxation
- ☐ Stress
- ☐ Coping with a traumatic event ☐ Unresolved grief
- ☐ Depression
- ☐ Unhappiness ☐ Parenting Issues/Skills ☐ Inferiority Feelings
- ☐ Suicidal thoughts
- ☐ Lack of ambition
- ☐ Blocked emotions
- ☐ Tiredness
- ☐ "Up-and-down" feelings
- ☐ Lack of Energy
- ☐ Loss/Increased Appetite
- ☐ Sleep problems
- ☐ Concentration
- ☐ Procrastination
- ☐ Memory
- ☐ Relationship problems
- ☐ Loneliness
- ☐ Discipline
- ☐ Anger/Temper
- ☐ Frustration
- ☐ Self control ☐ Headaches
- ☐ Stomach Problems
- ☐ Bowel Problems
- ☐ Health Problems ☐ Weight
- ☐ Sexual Problems
- ☐ Alcohol or drug use
- ☐ Education
- ☐ Work
- ☐ Career choices
- ☐ Separation/Divorce
- ☐ Legal Matters ☐ Divorce Issues

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ADOLESCENT UNDER 18 YEARS

CONSENT FOR TREATMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I acknowledge by affixing my initials next to each of the following points that I have received, read, and understand the Client Information handout.

_____ 1) Confidentiality - I am aware that an authorized agent of my insurance carrier or other third party payer may request and be provided with information about the type(s), cost(s), and date(s) of any services or treatments my child receives so that payment may be provided to my therapist.

_____ 2) Payment and Billing Policies - I am aware that I am responsible for payment in full for any charges for services provided on my child's behalf unless they are specific services provided under the benefit plans of my insurance and as designated in any contract between my therapist and my insurance company and its lawful delegates.

_____ 3) Financial Responsibility - I am aware that I may terminate treatment at any time without consequence, but that I will still be responsible for payment of the services my child has received. I am aware that if I have not paid for services received, my child's treatment may be discontinued and my account turned over for collection.

_____ 4) Appointments and Cancellations - I am aware that any cancellations of appointments must be made at **least 24 hours in advance** of the appointment and if I do not cancel or do not show up I will be charged for that appointment.

_____ 5) Intra-agency Consultation - I am aware that my therapist may consult or share information with other members of the professional staff in the therapeutic office if such consultation can be expected to be helpful in dealing with a problem being discussed in therapy and that those staff may have access to relevant information in my client file. I am also aware that no information about me or my child may be communicated to others outside this therapeutic office without my explicit permission unless such action is required by law.

_____ 6) Risks of Psychotherapy - I am aware that the practice of psychotherapy is not an exact science and that predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the therapist identified below.

_____ 7) Court Testimony and Custody Evaluations – I am aware that therapists make every effort to maintain client confidentiality and therefore do not testify in court regarding custody, divorce action, or other legal matters. I agree not to contact my therapist personally or via my attorney to testify in court. If my therapist is contacted or subpoenaed on my behalf for testimony, I agree to pay all court costs, legal fees, and hourly rates for my therapist's time.

_____ 8) Electronic Communications – Cell phones, faxes, texts, Skype, and email may be used on some occasions. I understand that the use of electronic communication compromises confidentiality.

_____ 9) I do_____ do not _____ have questions about this consent for treatment/financial policy.

I do hereby seek and consent to my child's participation in evaluation and/or treatment with the therapist identified below.

Name of Adolescent Client_____

_____

Signature of Adult Responsible Date

_____

Therapist Date

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Business Policies

Our experience has been that counseling and psychotherapy are most effective when expectations regarding fees, billing, insurance, reimbursement, and cancellation policies are understood by all parties in advance. Please review the information below, and feel free to ask if there are any questions.

FEES

Initial Session…….……$150.00
30 minute session……..……$75.00
45-minute session …….……...$125.00
60 minute session…….……$150.00

Other fees may be charged for specific services such as: hospital visits, consultation with attorneys or other professionals, structured group programs focusing on a particular topic, detailed psychological evaluations completed at the request of a physician or attorney, etc. In some situations, clients may be asked to complete psychological testing instruments. Fees for other test will be communicated in advance and vary according to the nature of the test.

Payment
Fees for services are collected at the time services are provided. Payment may be made by check, cash, Visa or MasterCard. Checks should be made payable to **Lisa Hart, LCSW**. Payment for the non-insured portion of your bill (the "co-pay" or "co-insurance") is due at the time services are provided. In the event fees remain unpaid for an extended period of time services may be discontinued. We reserve the right to retain a collection agency or attorney to collect unpaid fees after termination of therapy.

INSURANCE
Health plans vary widely in their mental health benefits. It is your responsibility to familiarize yourself with the authorization procedures, reimbursement rate, limitations, and specific provisions of your health policy. Keep in mind that even if you have insurance, you are the one who is responsible for payment of your bill. This is true even if the insurance company withdraws authorization for services after the services have been received. We cannot take responsibility for negotiating settlements on any disputes with your insurance company.

CANCELLATIONS AND MISSED APPOINTMENTS
If you cannot keep an appointment, please notify our office at least 24 hours in advance. **The regular session fee may be charged for appointments missed without notice or cancelled with less than 24 hours notice.** There is no charge for appointments cancelled due to illness or emergency if the office is notified prior to the scheduled appointment time.

My signature below indicates that I have read, that I understand, and that I agree to the business policies outlined above. I agree to assume financial responsibility for the cost of services to me or to the person whose name appears below. I authorize **Lisa Hart, LCSW** to act as my agent in helping me obtain payment from my insurance company (if applicable). I agree to the release of whatever information is necessary for the insurance company to process my claim. Unless I pay in full at the time of each session, I authorize my insurance company to pay benefits directly to **Lisa Hart, LCSW**. I permit a photocopy of this authorization to be used in placed of the original.

Printed Name of Client: _____ Client Date of Birth: _____

Signature of Parent/Guardian: _____

Date: _____ Witness: _____

Lisa Hart, LCSW

Notice of Privacy Practices Effective Date

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Counseling Services of Tulsa If you have questions and would like additional information, you may contact us at 918 574-2722.