Lighthouse Counseling Center, P.C.

Child Questionnaire

(Client age thru 17) Rev. 9/14

To be completed by the parent or legal guardian requesting services for a minor child.

This information will help your therapist understand your child better. This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia Law. **Proof of insurance coverage, guardianship & ID is required.**

Background information: Today's Date: _____

Name of Child: _____ Age_____ DOB: _____ M / F

Residing Address _____ City _____ State: ____ Zip _____

Mailing Address _____ City _____ State: ____ Zip _____

Name of Person (s) child resides with _____

Relationship: ▫ Biological Parent (s) ▫ Step Parent ▫ Grandparent ▫ Other_____

Home Telephone _____ Cell/Work/ other _____

Contact number for messages from our office : _____
(Our office is not responsible for confirming appointments with you.)

ER Contact Person Name _____ Tel # ____ ____ ____ Relationship _____

If parents/guardians are separated or divorced, for how long? _____ Is Custody Shared? Y/N

Other biological parent/legal guardian Name: _____ Tel:_____

Referral Source: _____ May we send a thank you? Y / N

School Name: _____ Grade_____

Insurance Information: PRIMARY SECONDARY
(PLEASE PRINT. COPY OF CARD IS REQUIRED)

Insurance Company _____ / _____

Policy Holder's Name _____ / _____

Policy Holder's Date of Birth _____ / _____

Relationship to Client _____ / _____

ID Number _____ / _____

Group _____ / _____

Policy Holder's SS #: _____ / _____

Employer: _____ / _____

Employer Telephone Number: _____ / _____

CONTINUED ON BACK ↓

Immediate Family Members : Name(s) Age(s) ✓ if lives w/client

Brother(s) _____

_____

_____

Sister(s) _____

_____

_____

Others living w/client_____Relationship _____

_____ Relationship _____

In your own words, briefly describe the main problem, which prompted you to seek counseling for your child at this time.

_____

_____

_____

_____

_____

Problem Areas: In the following list, place a check mark (✓) next to each item which identifies an area of *concern* to you. Place two checks (✓✓) by those items, which are *most important*.

_____Anger/Temper
_____Depression
_____Educational/School work
_____Family Problems
_____Fearfulness/Phobias
_____Physical Problems
_____Insecure/Timid/Lack of Self Confidence
_____Divorce
_____Problems with accepting discipline
_____Religious/Spiritual Concerns
_____Sexual Concerns
_____Thoughts of Suicide
_____Unhappy most of the time
_____Use of Alcohol
_____Use of Tobacco
_____Panic Attack
_____Worry
_____Traumatic Stress
_____Stress
_____Current substance use: ____Marijuana, ___Narcotics ___Amphetamines ___Methamphetamines ___Cocaine ___Hallucinogens ____ Acid ___Prescription ___ Alcohol ____ Cigarettes. If checked, frequency of use: _____

_____ Other: _____

CONTINUE ON NEXT PAGE

Has your child ever been the victim of or witnessed any type of traumatic incident? If yes, please explain:_____

_____

_____

Medical History

List illnesses, surgeries, and injuries. Indicate age when occurred and describe how severe.

_____

_____

Has there been any previous counseling or psychological, psychiatric, or neurologicalevaluations? _____
If so, please list names, addresses, and dates of contact.

_____

_____

Current medications:_____

_____

When did the child last have a physical examination?_____

Name of Physician:_____

Address:_____

Describe any Developmental Problems (such as walking and talking): _____

_____

_____

Describe any method of discipline used and how the child reacts to such discipline.

_____

_____

Describe child's appetite and eating habits at present._____

_____

Describe nervous habits such as thumb sucking, nail biting, etc._____

_____

Describe child's sleeping pattern now. Are there nightmares or night terrors now or in the past?_____

_____

(CONTINUE ON BACK PAGE)

Describe child's level of activity._____

_____

Describe any problems in attention or sitting still._____

_____

Food or drug allergies? _____

Academic/School Information

Name of School_____ Grade_____

Has child ever repeated a grade?_____ If so, when?_____

Has other family members had learning disabilities?_____

Describe what the child likes to do for fun, special interest, hobbies, etc._____

_____

Primary Care Physician: or other health care provider name: _____

Address: _____

Telephone: _____ Fax:_____

____ I authorize my therapist to release protected health information related to my evaluation and
(initial) treatment to my primary care physician or other health care provider.

____ I **DO NOT** authorize my therapist to release any information to my primary care physician.
(initial)

We very much appreciate your cooperation in filling out this questionnaire. Please add any additional comments which you wish to tell your therapist.

_____

_____

I declare that I am the custodial parent **or** legal guardian of the child described in the document and that I have the legal authority to bring him or her for psychological treatment. Proof of guardianship or ID is available upon request by Lighthouse Counseling Center PC.

Signed_____ Relationship: _____

Print Name: _____ Date: _____

Signed_____ Relationship: _____

Print Name: _____ Date: _____

R11/07

FINANCIAL STATEMENT
THIS IS IMPORTANT – PLEASE READ CAREFULLY AND UNDERSTAND BEFORE INITIALING IN BLOCKS AND SIGNING WHERE INDICATED
(Both Parties Initial and Sign for Couple Counseling)

Client(s) Name(s) _____ / _____

Lighthouse Counseling Center PC (LHCC) is owned by Thomas S. Freeman, Psy. D and offers professional out patient behavioral health services by trained and experienced psychologists and psychotherapists. LHCC staffs' goal is to provide quality, caring and professional services to clients, and their family members, regardless of race, ethnic origin, religion, creed, gender, age, disability status, sexual orientation, or source of payment.

Confidentiality: My session with a therapist is confidential. Information about my sessions will not be released without a signed consent for release ***except*** in emergencies or when there is a court order, determination, or law requiring the information be released. If I have been referred for counseling by a court order, information about my treatment is not confidential and can be released to the court without my permission. I will *not* hold LHCC liable for such disclosure.

Duty to Warn: Information about dangerous behavior, including serious thoughts of hurting myself or others, as well as information about possible child abuse, is NOT confidential and is required by law to be reported by my therapist to the appropriate authorities.

E-Mail: I understand that email communication with LHCC or its therapist is not secure and may be read by others on the network. I agree to take this risk when I email LHCC.

Social Media: It is the policy of LHCC that our providers do not engage our current or past clients through social media. We will not accept friend requests for Facebook. This is for our privacy and yours. It also helps maintain the therapist/client relationship. Thanks for understanding.

After Hour On-Call and Fees: If I feel I have a life threatening emergency after regular office hours, I will call 911 or go to the closest Emergency Room in my area. LHCC provides 24-hour non-life threatening emergency on-call coverage. I can call 770-251-5873 and follow the instructions. I am responsible for providing my name, number where I can be reached and my regular therapist's name. *I will be billed a telephone consultation fee*, pro-rated and based on the length of the call and therapist's hourly rate. Insurance will not be billed for this service. I agree to pay this charge. (10 minute increments).

For collection actions with an outside agency, LHCC may release the financial party's name, employer info, contact telephone numbers and addresses, social security number, proof of previous communication attempts to settle the account and dates past due charges incurred. Third party information (related to the above) obtained through attempts to settle the account may be disclosed as well.

Professional Phone consults I will be billed a telephone consultation fee, pro-rated and based on the length of the call (10 min. increment) and therapist's hourly rate. Insurance will not be billed for this service. I agree to pay this charge. **Court/Expert Witness Appearance,** fees are billed in advance and explained separately.

Professional letters, written at my request or on my behalf will require a minimum fee of $15 paid prior to release.

FINANCIAL PARTY RESPONSIBILITIES INSURANCE &/OR SELF-PAY

[/] (Initial) **Missed Appointment or Late Cancellation Fees / 24-Hour Notice**

I WILL BE BILLED, NOT MY INSURANCE

LHCC IS NOT RESPONSIBLE FOR CONFIRMING MY APPOINTMENT WITH ME

I (NOT my insurance) will be billed the amount "allowed" by my insurance carrier for a session OR my self-payment fee if I miss an appointment or give late cancellation notice. LHCC requires 24 hours notice. If the client is under the age of 18 years, the parent or legal guardian is responsible for confirming all appointments with LHCC. I may leave a message on voice mail and the date and time of the voice mail will be noted in the system. Reasons given will be considered prior to imposing charges. LHCC will make every effort to extend the same courtesy to me. **Acceptance of an appointment from the call list is considered "a confirmed appointment" and any previous scheduled appointments will remain on the schedule, unless the office is notified otherwise. Fees will apply.** No one else can call to schedule or cancel for me without my authorization on file.

[/] **If I accept an appointment off the call list, it is a confirmed appointment.** All other scheduled appointments I have will remain on the schedule unless I cancel them. Missed Appointment & Late Cancellation charges will apply.

[/] **I can not schedule if I have a Missed Appointment or Cancellation Charge outstanding on my account** and will notify my therapist of reasons for the Missed Appointment or Late Cancellation for consideration.

[/] **I will pay co-payments, deductibles, and other service charges at the time of request by LHCC staff.** I may pay by cash, valid check ($25.00 returned check fee), Visa or MasterCard (by phone with an authorization). Payment deferral will require approval by my therapist prior to my visit.

[/] LHCC may charge my account for reimbursement on fees incurred and/or commission paid for collecting on my past due account with an outside collection or court agency. These charges will be due LHCC upon request to avoid further collection actions. **LHCC will proceed with collection actions if the account is past due 60 days from date charges were allocated to the account and/or efforts by LHCC have been exhausted to collect on the account balance (no response to billing, letters, phone calls and/or payment promises verbal or written).**

HIPPA NOTICE (Rev. 7/6/04)

(As required by the Privacy Regulations, created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this notice describes how health information about you (a client of this practice) may be used and disclosed, and how you can get access to your protected health information. Please review carefully.)

I understand that LHCC is a healthcare provider and may share my health information for treatment, payment, and healthcare operations. I have been provided with access to a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that LHCC has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer in the office or by phone at 770-251-5873. ☐ **I decline** a copy of my HIPAA / PHI ***OR*** ☐ **I requested and received** a copy of my HIPAA / PHI

INSURANCE AUTHORIZATION (please read and initial)

I WILL NOTIFY LHCC 24 BUSINESS HRS OF ANY CHANGES IN MY INSURANCE PRIOR TO MY NEXT SCHEDULED SESSION COVERED UNDER THE NEW INSURANCE OR PAY THE SESSION FEE CHARGE AT TIME OF VISIT.
I will be billed per the quoted insurance information received by LHCC and/or Explanation of Benefits only.

☐ / ☐ **I authorize payment directly to Lighthouse Counseling Center PC of insurance benefits,** not to exceed the balance due of the charges for my treatment. In the event that insurance remits payment to the "member" for services rendered or if LHCC is notified by my insurance carrier of such remittance, I will notify LHCC and reimburse LHCC for dates of services rendered, not to exceed the balance due of the charges for my treatment.

☐ / ☐ **I am required to provide Lighthouse Counseling Center with accurate and detailed insurance information 24 hrs prior to any session to be filed. I will present proof of ID and insurance coverage.** LHCC reserves the right to cancel my session(s) or charge for the full session fee without proof of benefits. I am responsible for contacting my insurance carrier(s) to assist with the payment of a claim, upon request by LHCC or my insurance carrier. Delay in contacting my insurance carrier and assistance in getting claims paid will cause my account to become delinquent and LHCC will have no other choice but to refer my account to collections. LHCC is not a third party contractor with my insurance. I will not hold LHCC responsible for denials by my insurance. Insurance is filed as a courtesy to me. **I will pay balance upon request for all denials.**

☐ / ☐ **I am required to pay my *co-payment, deductible, & my patient responsibility portion at each visit.*** An authorization or a quote from my insurance carrier is not a guarantee of payment or benefits. I am responsible for any balance due LHCC after insurance and will settle any discrepancies with my insurance carrier(s) upon request by LHCC. LHCC *will not* accept a verbal estimate that my deductible has been met.

ONLY THE BILLED PARTY CAN SIGN. COPAYMENTS ARE DUE AT TIME OF VISIT.
CLIENTS OVER THE AGE OF 18 ARE THE RESPONSIBLE PARTY UNLESS OTHERWISE SIGNED BY PARTY TAKING RESPONSIBILITY FOR BILLING.

FINANCIAL RESPONSIBLE PARTY SIGN: _____ / _____
I (we) have read, understand, and agree with all the above

PRINT NAME(S): _____ / _____ Date: _____

MAILING ADDRESS: _____

TEL #: (_____) _____ Work #: (_____) _____ Other #: _____

EMPLOYER: _____

SELF PAYMENT AGREEMENT Fee $ _____

I (we) do not wish to have LHCC file claims with my insurance carrier(s). I will pay the amount of the session fee amount at each visit. I will notify, in writing, any change in these agreement 24-hours prior to my visit and provide all the necessary insurance information to assist LHCC with any billing or claims as stated above.

(INITIAL) _____ / _____ SIGN BELOW

BEHAVIORAL HEALTH
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about LHCC its practitioners, services and role in the treatment process.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature Date

Lighthouse Counseling Center PC (LHCC)

Approved June 20, 2003

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) two days before your scheduled appointments.

Your name: _____

Your email address: _____

Your cell phone number: _____

Your cell phone carrier (circle one):

Alltel AT&T Boost Mobile Nextel Sprint SunCom

T-mobile Verizon VoiceStream Virgin Mobile (Other) _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature

Date