CLIENT NAME _____ DATE OF BIRTH _____

A PROGRAM OF JEWISH FAMILY SERVICE OF GREATER HARRISBURG, INC.

CHILD AND ADOLESCENT INTAKE

CHILD'S INFORMATION

Name _____ **Date** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Birthdate _____ **Gender** _____

Describe the reason you are bringing your child for counseling _____

_____

Who referred you to JFS/Mynd Works? _____

Preferred method of contact (choose one and provide contact information):

Email _____ Text _____ Phone _____

FAMILY INFORMATION

Parent/Guardian _____ **Birthdate** _____

Phone *(home)* _____ *(work)* _____ *(cell)* _____

Address *(if different)* _____ City _____ State _____ Zip _____

Parent/Guardian _____ **Birthdate** _____

Phone *(home)* _____ *(work)* _____ *(cell)* _____

Address *(if different)* _____ City _____ State _____ Zip _____

Please list <u>ALL</u> persons living with the child (including parents/guardians):

Name	***Relationship to Child***	***Date of Birth***	***Gender***	***Marital Status***	***Employer/Occupation***

Please list family members <u>NOT</u> living with the child (Parent, Siblings, Stepparents, Birth Parents, etc.):

Name	***Relationship to Child***	***Date of Birth***	***Gender***	***Marital Status***	***Employer/Occupation***

CLIENT NAME DATE OF BIRTH

Family's religious, spiritual, cultural, or sexual identity information you wish to share _____

Is the child now or has the child been: ☐ *in foster care* ☐ *in the custody of a relative* ☐ *adopted*

If yes, please briefly describe the situation _____

DEVELOPMENTAL HISTORY

Was the baby carried to term? ☐ *yes* ☐ *no* **Birth Weight:** _____

Did mother or child experience medical complications during pregnancy, delivery, or following delivery?

☐ *yes* ☐ *no* If yes, please briefly describe _____

Has the child experienced any of the following (if yes, please briefly describe the situation):

☐ *abuse-physical, emotional, or sexual* _____
☐ *witnessing domestic violence* _____
☐ *prolonged separations from parents or caregivers)* _____
☐ *other trauma* _____

Did the child meet developmental milestones (walking, talking, toilet-training, school readiness skills, etc.) at expected ages? ☐ *yes* ☐ *no* If no, please briefly describe_____

EDUCATIONAL

Current Grade _____ **School/School District** _____

What other schools has the child attended? _____

Has the child repeated a grade level? _____

Does the child have an Individualized Education Plan (IEP)? ☐ *yes* ☐ *no*

Does the child have any other academic or attendance issues? ☐ *yes* ☐ *no* If yes, please describe:

CLIENT NAME _____ DATE OF BIRTH _____

SOCIAL

How does the child get along with peers/friends? _____

_____

_____

How does the child get along with parents/caregivers or other adults? _____

_____

_____

How does the child get along with sibling(s)? _____

_____

_____

Does the child have hobbies or participate in activities (sports, school clubs, scouts, etc.)? ____

_____

_____

PHYSICAL AND MENTAL HEALTH HISTORY

Please check all that apply to the child, and describe briefly if checked:

- ☐ *current medical conditions* _____
- ☐ *medical problems in the past* _____
- ☐ *allergies* _____
- ☐ *sleep problems* _____
- ☐ *problems with eating habits* _____
- ☐ *problems with personal hygiene* _____
- ☐ *other health concerns* _____

Has the child ever been involved with any of the following services?

Previous	Current		Approx. Date/Name of Provider/Agency
☐	☐	*Counseling or Therapy*	_____
☐	☐	*Psychological evaluation*	_____
☐	☐	*Psychiatric evaluation*	_____
☐	☐	*Psychiatric Med. Management*	_____
☐	☐	*BHRS Services (BSC, MT, TSS)*	_____
☐	☐	*Family-Based Mental Health*	_____
☐	☐	*Speech/Language Therapy*	_____
☐	☐	*Occupational Therapy*	_____
☐	☐	*Children & Youth/CPS*	_____
☐	☐	*Other (describe):*	_____

Has the child had any previous mental health diagnosis? If so, please list: _____

_____

If so, who gave the diagnosis and when? _____

_____

CLIENT NAME DATE OF BIRTH

Is the child prescribed any medication(s)? ☐ *yes* ☐ *no* If yes, please provide the following:

Name	*Dosage*	*Frequency*	*Reason For Taking*	*Who prescribed it?*

Please indicate if any person in the child's birth or adoptive family has experienced the following:

	Name/Relationship to the child:
☐ *Chronic Physical Illness*	
☐ *Depression*	
☐ *Bipolar Disorder*	
☐ *Anxiety Disorder*	
☐ *Learning Problems*	
☐ *Schizophrenia*	
☐ *Drug and/or Alcohol Abuse*	
☐ *Other Physical or Mental Illness*	

Please describe the child's overall strengths and weaknesses

Signature of Person Completing Form **Relationship to Child** **Date**

Therapist Signature **Date**

CLIENT NAME DATE OF BIRTH

ADVERSE CHILDHOOD EXPERIENCE QUESTIONNAIRE

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?
If yes enter 1 _____

2. Did a parent or other adult in the household often or very often…Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?
If yes enter 1 _____

3. Did an adult person at least 5 years older than you ever…Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
If yes enter 1 _____

4. Did you often or very often feel that …No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?
If yes enter 1 _____

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
If yes enter 1 _____

6. Were your parents ever separated or divorced?
If yes enter 1 _____

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit at least a few minutes or threatened with a gun or knife?
If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
If yes enter 1 _____

10. Did a household member go to prison?
If yes enter 1 _____

Now add up your "Yes" answers: _____ this is your ACE Score.

Name of Client _____ **Date of Birth** _____ **Age** _____

CLIENT RIGHTS AND RESPONSIBILITIES

Welcome to Jewish Family Service of Greater Harrisburg, Inc. Our goal is to make your experience at JFS as productive and beneficial as possible. As a client of JFS, you have rights and responsibilities as you participate in our programs and/or receive services.

Statement of Client's Rights:

1. JFS serves anyone in need within its service area, and will not discriminate on the basis of race, ethnicity, color, gender, sexual orientation, disability, age, country of origin or religion. You have the right to be treated with courtesy and respect.
2. You have the right to fair and equable treatment without discrimination on the basis of race, ethnicity, color, gender, sexual orientation, disabilities, age, country of origin or religion.
3. You have the right to receive information communicated in a manner appropriate to your age, cognitive, and/or linguistic ability.
4. You have the right to receive services appropriate for your needs.
5. You have the right to be referred to another program or service if your needs exceed the services available through JFS.
6. You have the right to participate in the treatment planning process and decisions regarding services.
7. II you are over the age of 14, you have the right to consent or refuse treatment or involvement in our programs or services, unless such authority has legally been given to someone else. Should you choose to refuse services, JFS staff will advise you of the potential consequences or effects of discontinuing services. JFS reserves the right to determine guardianship status for minor children and dependent adults.
8. You have the right to privacy. Your relationship and communication with JFS staff and any personal information and/or records are kept confidential. JFS will only release information with appropriate written authorization, except as required by law or professional ethics. Confidentiality will not be maintained in the case of suspected child abuse or neglect or if the client poses a threat to themselves and/or others.
9. You have the right to express concerns or complaints about the services provided through JFS in accordance with the Grievance Policy without fear of recrimination, and for such concerns or complaints to be addressed and, whenever possible, satisfactorily resolved.

Statement of Client Responsibilities:

1. You are responsible for participating in the treatment service or program.
2. You are responsible for behaving appropriately within the treatment service area.
3. You are responsible for attending all scheduled appointments. Your appointment time is reserved exclusively for you. If you must cancel an appointment, do so at least 24 hours in advance or you may be charged a fee for the appointment.
4. You are responsible for payment of any fee-based services at the time of your appointment. It is your responsibility to contact your insurance regarding coverage information and fee reimbursement. JFS will provide you with any invoices or receipts for your insurance company, should you have coverage that may reimburse you.. You may apply to have your fee adjusted based upon a sliding scale. You will be expected to pay your fee at the time of your appointment even if you have sliding scale fee.
5. JFS makes every effort to inform clients of the basic expectations it has for individuals using its services and any activity which could result in discontinuation of service. JFS reserves the right to terminate services if a client becomes abusive, violent, or in any way threatens a staff member; or if JFS believes continuation may create risk to the client, staff or other clients. JFS may also refuse to serve a client who does not wish to participate in the treatment planning or comply with a specific program requirement; if client is an active substance abuser; or if the client misses three appointments in a row without 24 hour notice or reasonable explanation. If JFS terminates service, the client will be given the names of three referral sources.

I understand these rights and responsibilities.

Signature of Client or Responsible Party	**Date**	**Relationship to Client**

Mynd Works COUNSELING SERVICES

jfs
A PROGRAM OF JEWISH FAMILY SERVICE OF GREATER HARRISBURG, INC.

AUTHORIZATION FOR TREATMENT - MINOR UNDER AGE 14

Name of Client _____ **Date of Birth** _____ **Age** _____

In cases where the client is a minor, and there is a custody order issued by the court, our agency policy requires that you furnish us with a photocopy of your current Custody Order as it relates to the minor child. In family law matters, Joint (or Shared) Legal Custody can be awarded separate from Physical Custody. The Custody Order will typically state who has Legal Custody and who may make decisions about or consent to medical and/or mental health treatment. Orders specifically requiring shared medical and/or mental health decision-making will require the consent of both parties for the child to be seen by the therapist.

If you need help determining your rights to obtain and authorize mental health treatment for your child, please contact your legal representative.

Please complete EITHER Box A or Box B:

A ☐ **There is no current Custody Order regarding this child.**

I, _____, give my consent for the above-named minor child to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc.

I understand that participation in this program is voluntarily and I may revoke this consent at any time.

_____ _____
Signature of Parent/Guardian Date

B ☐ **There is a current Custody Order regarding this child, and I agree to provide a copy of the Order to Jewish Family Service of Greater Harrisburg, Inc.**

☐ Custody Order does not specify shared medical and/or mental health decision-making responsibilities.

I, _____, give my consent for the above-named minor child to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc.

_____ _____
Signature of Parent/Guardian Date

☐ Custody Order specifies shared medical and/or mental health decision-making responsibilities

We, _____ and _____, give our consent for the above-named minor child to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

FINANCIAL RESPONSIBILITY

- Fees for outpatient mental health services at Jewish Family Service of Greater Harrisburg, Inc., are:

Intake/Diagnostic Session	$140.00
Individual therapy session - 30 minutes	$ 45.00
Individual therapy session - 45-60 minutes	$125.00
Family or Couples Session	$125.00 per hour
Group Therapy Session	$ 45.00 per hour
Group DBT Session	$100.00 per hour
Preparation for Court	$100.00 per hour
Appearing in Court	$250.00 per hour
Form Completion	$25.00

- I assign directly to Jewish Family Service of Greater Harrisburg, Inc., all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I hereby authorize Jewish Family Service of Greater Harrisburg, Inc.to release all information necessary to secure the payment of benefits.
- I authorize the use of this signature (as “Signature on File”) on all insurance submissions.
- Missed appointments or late cancellations represent a cost to us, and time to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Depending on my insurance plan’s policies, I understand that I may be charged a $25.00 fee for missed or late-canceled appointments.

Signature of Client or Responsible Party **Date** **Relationship to Client**

Revised 06/26/2019

AUTHORIZATION TO CONFIRM OR CORRESPOND

I hereby authorize Jewish Family Service of Greater Harrisburg, Inc., to contact me at my home or work to confirm my appointments (or my child's appointments), and to send periodic correspondence to my home. I am responsible for providing the method of contact I prefer.

Signature of Client or Responsible Party **Date** **Relationship to Client**

NOTICE OF PRIVACY PRACTICES

I have read the notice of privacy practices of Jewish Family Service of Greater Harrisburg, Inc., in regard to protected health information. A copy is available upon request.

Signature of Client or Responsible Party **Date** **Relationship to Client**

EMERGENCY SERVICES

After office hours, if your call is of an emergent nature, please go to the closest emergency room to be seen by Crisis Intervention Services or call Crisis Intervention at one of the following numbers:

Cumberland County: 717-243-6005 or 717763-2222
Dauphin County: 717-232-7511
Franklin County: 717-264-2555
Perry County: 717-834-3326

A PROGRAM OF JEWISH FAMILY SERVICE OF GREATER HARRISBURG, INC.

HIPPA CONSENT

PERMISSION FOR EXCHANGE OF PROTECTED HEALTH INFORMATION

Client Name: _____ **DOB:** _____

- This release covers the release of information to and/or from Mynd Works Counseling Services of Jewish Family Service of Greater Harrisburg, Inc., and the following organization:

_____ _____
Name of Person, Facility, or Agency Address/Phone Number/Fax Number

☐ I hereby grant permission to the above organization to release confidential information to Mynd Works Counseling Services of Jewish Family Service of Greater Harrisburg, Inc.

☐ I hereby grant permission to Mynd Works Counseling Services of Jewish Family Service of Greater Harrisburg, Inc., to release confidential information to the above organization.

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. Please indicate if you would like this information released and/or obtained:

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No
HIV or AIDS Testing and Results	☐ Yes	☐ No
Behavioral or Mental Health Records	☐ Yes	☐ No

- Please indicate the specific information that may be released:

☐ Assessment documents
☐ Psychiatric/Psychological evaluation
☐ Educational Records
☐ Medical Records
☐ Summary of contacts and content
☐ Treatment Plan/Service Plan
☐ Discharge Report
☐ Other (please specify) _____

_____
☐ Report of Most Recent Physical Examination

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services at Mynd Works Counseling Services of Jewish Family Service of Greater Harrisburg, Inc.
- The information covered by this release may be exchanged through **Oral** or **Written** Communication.
- The information covered by this release shall be used for the purpose of **treatment planning and coordination** unless another purpose is specified here: _____.
- The information obtained through this release may not be released to any third party.
- This release expires 6 months from the date signed unless otherwise indicated: _____.
- It may be revoked at any time in writing by the person giving consent.

_____ _____
Signature of Client (if 14 years of age or older)or Authorized Representative Date

_____ _____
Print Name of Client (if 14 years of age or older) or Authorized Representative Relationship to Client

_____ _____
Signature of Witness Date

A PROGRAM OF JEWISH FAMILY SERVICE OF GREATER HARRISBURG, INC.

HIPPA CONSENT
PERMISSION FOR EXCHANGE OF PROTECTED HEALTH INFORMATION

Client Name: _____ **DOB:** _____

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Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No
HIV or AIDS Testing and Results	☐ Yes	☐ No
Behavioral or Mental Health Records	☐ Yes	☐ No

- Please indicate the specific information that may be released:

  ☐ Assessment documents
  ☐ Psychiatric/Psychological evaluation
  ☐ Educational Records
  ☐ Medical Records
  ☐ Summary of contacts and content
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  ☐ Other (please specify) _____
  _____
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- This release expires 6 months from the date signed unless otherwise indicated: _____.
- It may be revoked at any time in writing by the person giving consent.

_____ _____
Signature of Client (if 14 years of age or older)or Authorized Representative Date

_____ _____
Print Name of Client (if 14 years of age or older) or Authorized Representative Relationship to Client

_____ _____
Signature of Witness Date