



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 (carrier: _____) 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 ALL persons living with the child (including parents/guardians):

Name	Relationship to Child	Date of Birth	Gender	Marital Status	Employer/Occupation
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Please list family members NOT living with the child (Parent, Siblings, Stepparents, Birth Parents, etc.):

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

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.)? _____

EDUCATIONAL

Current Grade _____ School/School District _____

What other schools has the child attended? _____

Does the child have an Individualized Education Plan (IEP)? *yes* *no* If yes, what type?

- | | |
|---|---|
| <input type="checkbox"/> <i>Autism</i> | <input type="checkbox"/> <i>Orthopedic impairment</i> |
| <input type="checkbox"/> <i>Deaf-blindness</i> | <input type="checkbox"/> <i>Other health impairment</i> |
| <input type="checkbox"/> <i>Deafness</i> | <input type="checkbox"/> <i>Specific learning disability</i> |
| <input type="checkbox"/> <i>Emotional disturbance</i> | <input type="checkbox"/> <i>Speech or language impairment</i> |
| <input type="checkbox"/> <i>Hearing impairment</i> | <input type="checkbox"/> <i>Traumatic brain injury</i> |
| <input type="checkbox"/> <i>Intellectual disability</i> | <input type="checkbox"/> <i>Visual impairment</i> |
| <input type="checkbox"/> <i>Multiple disabilities</i> | |

Does the child have academic, attendance, or behavioral issues? *yes* *no* If yes, please describe: _____

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 _____

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

PHYSICAL AND MENTAL HEALTH HISTORY

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

Name Dosage Frequency Reason For Taking Who prescribed it?

Does the child have any allergies? yes no If yes, please describe: _____

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

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

Has the child had any previous mental health diagnosis? yes no If yes, please list: _____

If yes, who gave the diagnosis and when? _____

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

Previous	Current		Approx. Date/Name of Provider/Agency
<input type="checkbox"/>	<input type="checkbox"/>	Outpatient Counseling/Therapy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Psychological evaluation	_____
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric evaluation	_____
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Med. Management	_____
<input type="checkbox"/>	<input type="checkbox"/>	BHRS Services (BSC, MT, TSS)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Family-Based Mental Health	_____
<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language Therapy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Children & Youth/CPS	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other (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* _____

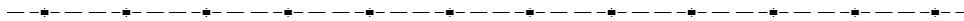
- other trauma* _____

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

Name/Relationship to the child:

- ADHD* _____
- Anxiety Disorder* _____
- Bipolar Disorder* _____
- Chronic Physical Illness* _____
- Depression* _____
- Drug and/or Alcohol Abuse* _____
- Learning Problems* _____
- Other Physical or Mental Illness* _____
- Schizophrenia* _____

Please describe the child's overall strengths and weaknesses _____



Signature of Person Completing Form

Relationship to Child

Date

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 equitable 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. If 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

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	<p><input type="checkbox"/> There is no current Custody Order regarding this child.</p> <p>I, _____, give my consent for the above-named minor child to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc.</p> <p>I understand that participation in this program is voluntarily and I may revoke this consent at any time.</p> <p style="text-align: center;"> _____ Signature of Parent/Guardian _____ Date </p>
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B	<p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> Custody Order does <u>not</u> specify shared medical and/or mental health decision-making responsibilities.</p> <p>I, _____, give my consent for the above-named minor child to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc.</p> <p style="text-align: center;"> _____ Signature of Parent/Guardian _____ Date </p> <p><input type="checkbox"/> Custody Order specifies shared medical and/or mental health decision-making responsibilities</p> <p>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.</p> <p style="text-align: center;"> _____ Signature of Parent/Guardian _____ Date </p> <p style="text-align: center;"> _____ Signature of Parent/Guardian _____ Date </p>
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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
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



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GREATER HARRISBURG, INC.

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