Footsteps Christian Counseling, LLC
1025 Main St. Suite 507
Wheeling, WV 26003
(304) 242-8095

Child/Adolescent History Information

Name: _____
First Middle Last

Social Security Number: _____ Gender: _____

Current Age: _____ Birthdate: _____-____-_____

Is it okay to leave a messages? Yes ____ No ____ If yes, which one? _____

Home Phone: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Name and relationship of person bringing in client: _____

_____

Referred by: _____ Relationship: _____

Name of client's parents: _____

Parent's marital Status: Single Engaged Married Divorced
Separated Living Together Remarried Widowed

Parent's Occupations: _____

In case of emergency contact: _____

Phone: _____ Relationship: _____

People who currently live in child/adolescent's household:

Name	Sex	Age	Relationship

Reason for seeking help at this time:

_____
_____
_____

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Who is aware of this problem: _____

Significant people or family members not currently living with Child/ Adolescent:

Name	gender	age	relationship

Please check each item which is a concern to you or your child/adolescent about him/her:

__ Appetite/weight	__Stomach aches	__Health problems
__ Bowel problems	__Headaches	__Sleep-too little/much
__ Depression	__Loneliness	__Suicidal thoughts
__Low energy	__Unhappiness	__Tiredness
__Feeling inferior	__Shyness	__Making decisions
__Work	__Career	__Ambition – too little/much
__Concentration	__Education	__Difficulty relaxing
__Anger	__Temper	__Self-control
__Children	__Discipline	__Being a parent
__Nervousness	__Stress	__Fears
__Legal matters	__Finances	__Friends
__Nightmares	__Dreams	__Memories
__Alcohol use	__Thoughts	__Drug use
__Separation	__Marriage	__Sexual problems
__Moves	__Deaths	__Other losses
__Abuse, physical	__Abuse, sexual	__ Abuse, verbal
__Neglect	__ Visitation/custody	
__Other changes		

Other: _____

Circle symptoms your child has and number of times per week:

Anxiety___	Anger__	Overeating__	Acts out sexually with others____
Bedwetting__	Defiance__	Under eating__	Masturbates excessively__
Day wetting__	Controlling__	Sleeplessness__	Unusual or excessive sexual knowledge
Day pooping_	Lack of empathy__	Nightmares__	Plays out sexual themes___
Obsesses__	Lying__	Hyper vigilance__	Plays out violent themes __
Depression__	Low impulse control_	Startles easily__	Homicidal themes or actions__
Low energy__	Stealing__	Fears/Phobias__	Suicidal thoughts or actions___
Shy__	Drug/alcohol use__	Running away__	Stomach aches/ head aches __
Tantrums__	Impaired conscience_	Peer problems__	Spacing out____
Violent__	Excessive crying__	Low concentration__	Feelings of inferiority__
Grief__	Putting self down__	Memories____	Academic problems__

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Allergies __ Specific Fears_____
Hallucinations (hearing/seeing things) __
Other_____

Has your child ever been in counseling before? If so when? Was it helpful?

What would your child/adolescent or you like as a result of counseling?

Health History:
Overall Health condition of child/ adolescent: very good good average poor

Recent weight gain or loss? _____

Last physical exam: _____ Report: _____

Significant medical conditions: _____

List any childhood diseases: _____

List any allergies: _____

Any prolonged fever of more than 103 degrees? _____

Head Injuries: _____

Hospitalizations: _____

Medications currently taking: _____

Past medications including any adverse effects: _____

Was pregnancy planned or unplanned? _____
During the pregnancy was there drug or alcohol use? _____ Type: _____

What were the emotional/ financial / relational / situational stressors in your family during the pregnancy and early childhood of the child? _____
_____

Any unusual situations surrounding pregnancy, birth, and delivery:_____

School History

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Name of school child/adolescent is attending: Grade:
Average Grade Point:

Has your child/adolescent's behavior ever been a concern of one of his/her teachers? If so please describe:

Does your child/adolescent have any difficulties learning?

Does or did your child/adolescent have any difficulties at school with any of the following:
writing reading arithmetic poor coordination memories of letters or numbers
making friends bullying being bullied keeping friends concentration

What are your child/adolescent's strengths in school?

Legal History
Are there custody disputes or current custody arrangements in place for the child/adolescent?

Are there any restraining orders in place which affect the child adolescent?
Is child/adolescent currently on probation or parole: Y / N
Are any family members currently on probation or parole or currently incarcerated: Y / N
(please comment):

Family History
Describe for each parent the quality of home life (ie: happy, tense, communication, relations with children, stability, security, abuse, ect):

Does the family or child/adolescent have any religious affiliation?
If so what role does this play in the family's life and the child/adolescent's life?

What is the cultural background of the child/adolescent?

What types of discipline are used within the family?

Describe the relationship between the child/adolescent's parents:

Describe how the child/adolescent gets along with others within the family:

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Did either parent have similar characteristics or problems as the child/adolescent is experiencing?

Is there a history of mental illness, or emotional problems within the family or extended family?

Please list anyone in the child/adolescent's family, including the child/adolescent and extended family who used or uses alcohol or drugs (prescription or street drugs)

relationship to child types of drugs purpose for how long

_____
_____
_____
_____
_____

Personality of Child/Adolescent:

tense relaxed restless calm daydreamer self starter active sluggish
stubborn eager to please easy to manage disobedient happy sad angry
loving aloof friendly secure easily frightened bold cautious whining generous
generous jealous cruel aggressive affectionate relates easily to adults
relates poorly to adults attached to certain toys/objects to point of not being able to leave at home.

Have there been noticeable changes in behavior or personality at any time in his/her life?

How many moves has the family made and what was the age of child/adolescent at each move?

Child/adolescent's life in general: very happy happy average unhappy very unhappy

Child/adolescent's life in past 6 months: very happy happy average unhappy very unhappy

What is your child/adolescent's greatest fear: _____

What is your child/adolescent's greatest hope: _____

Please describe in detail the reason for having this child seen professionally.

Indicate the age the problem began and probable causes
What has made the problem better or worse?
Describe feelings and moods observed
In what way does this problem interfere with the life of the child or family?

_____

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COMMUNICATIONS CONSENT FORM

_____ _____

Patient Name ***Date of Birth***

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply)

Home Telephone #: _____□ Cell Phone #:_____

□ OK to leave message with information □ Leave message with call-back number only

□ OK to leave message at home or on the cell phone with the following family members: (list name(s) and relationship to patient)

_____

□ Work Telephone #:_____

□ OK to leave message with information □ Leave message with call-back number only

Appointment Reminders

Our office uses an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference on how we contact you: □ Home Phone □ Cell Phone □ Text Message

Written Communication

□ OK to mail to my home address □ OK to mail to my work address

□ OK to fax to this number**:** _____ □ OK to send to this e-mail**:**_____

Communication with Other Healthcare Providers

Patient information or medical records may be communicated to other Healthcare Providers, hospitals or insurance companies if necessary.

Please list the name, address, and phone number of health care providers that you want to receive a copy of your office visit report.

Name: _____ **Name:** _____

Address: _____ **Address:** _____

_____ _____

Phone #: _____ **Phone #:** _____

_____

Patient or Legal Representative Signature **Date**

_____

(If legal representative's signature appears above, please describe relationship to the patient)

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Insurance Information

Client Name: _____ **Date of birth:** ___/___/___

Address: _____

_____

City/Zip: _____

Phone #: ( ) -

Gender:_____
Relationship to Policy Holder:
self child spouse/partner

Employment: full, part, student, un-employed

Primary Insurance:		**Secondary Insurance:**	
Address of Insurance:		**Address of Insurance:**	
Telephone number:		**Telephone number:**	
Policy Holder's name:		**Insured's name:**	
Policy Holder's date of birth:	/ /	**Insured's date of birth:**	/ /
Policy Holder's Address:			
Policy or ID #:		**Policy or ID #:**	
Group #:		**Group #:**	
Effective date of policy:	/ /	**Effective date of policy:**	/ /
Employer or School :			
Policy Holder's SS number:			

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Footsteps Christian Counseling, LLC to:

1) Furnish my insurance company with any/all information requested concerning my present claim(s), including records if requested.

2) Bill my insurance company, and to accept payment from that company on my behalf, for all services relating to my care.

I acknowledge:

1) I am responsible for all charges not covered by my insurance, including missed appointments.
2) Any money credited as overpayment due to me will be refunded after completion of treatment.
3) I will be charged for any appointment that I fail to keep or cancel within 24 hours prior to that appointment time.

_____ _____

Client's Signature Date Responsible Party Signature Date

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Fees and Insurance

The established fee for individual counseling is $100.00 per session.
A 30% discount is offered for payment at the time of service ($70.00)

Marital and relationship counseling is available at $55.00 per session. No discount available

Payment plans are available upon request when meeting the required income guidelines. Proof must be supplied.

Co-pays should be paid at the end of every session. Footsteps Christian Counseling, LLC, accepts cash and checks only as payment.

When special considerations warrant, funding may be secured from a local church to cover your services. As a Christian counselor I do not want to neglect counseling because of an inability to pay. Please let me know if you are in need of this special funding so that it may be secured.

Clients are responsible for payment of any services not covered by insurance.

When an appointment is scheduled for you, 1 hour is set aside specifically for you.
Because of this commitment of time, if you cannot keep this appointment, you must cancel at least 24 hours in advance by calling the office, unless it is an **Emergency**! Insurance companies do not pay for missed sessions. Therefore, you will be billed for all appointments not properly canceled.

Signature: _____ Date: _____

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Footsteps Christian Counseling, LLC Payment Agreement

_____Please bill my insurance company. I understand that I am responsible for any balance not paid by my insurance company. *Individual counseling sessions $100.00 per session*

_____I understand that *marriage counseling* is rarely covered by health insurance. Insurance may cover marriage counseling if the counseling focus is helping a mentally ill spouse as it relates to the marriage. *Marriage counseling is available at $55 per session*

_____I will be paying for my sessions by cash, check, or credit card. (Discount available if paid in full on the date of service.)

_____Our office is not permitted to accept Medicare or Medicaid. Charity care may be available for those with this type of coverage.

_____I request that a payment plan be approved so that I may receive services. I am able to pay $_____per month until my bill is paid in full.

_____My counseling fees are being paid by an outside agency or grant. Please list source:

_____.

_____I am unable to contribute to my counseling costs because of the following circumstances: (verification may be requested) I request that local churches, donors, and outside sources be contacted on my behalf to cover the cost of services.

_____
_____
_____

_____I would like to make a donation for those unable to pay for services

_____Other

Name_____
Date_____

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☐ *Client Request*

☐ Counselor Request

Authorization to Release Protected Health Information

I, _____, hereby authorize
Name of Client/Guardian

_____Virginia Loew/Shelhammer____ of Footsteps Christian Counseling, LLC, 1025 Main Street, Wheeling, WV (304) 242-8095, to disclose or receive, a copy of specific health/mental health information initialed below regarding
_____ consisting of:
__Therapy/case notes __Psychological reports __Progress reviews __ Psychiatric reports
__Medical reports __ Treatment Plans __Medications used in treatments
__ Assessments __School reports __ Discharge Summary
__ Psycho-educational reports
__ Results of court proceedings (other than expunged records)
__Other (specify): _____
to or from (name and address of recipient or sender):

_____
Name, Title, Business Name, Address, and Phone Number

I have been informed and fully understand that this protected health information may be in written, oral, or report form. I understand that the information used or disclosed related to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/ AIDS information, mental health information, and drug/alcohol diagnosis, treatment, or referral information.

I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits. You may revoke this authorization in writing anytime, but such recovation may not be retroactive. If you revoke your authorization, the information described above may no longer be disclosed for the purposes described above. To revoke this authorization, please send a written statement that you are revoking this authorization to Footsteps Christian Counseling, LLC at the address listed above.
I have read this authorization and I understand it. Unless revoked, this authorization expires in 180 days from the date of the signature below.

Signature: _____Date:_____
Individual, Legal guardian, or Personal representative

Description of personal representative's authority: _____

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Parental Consent to Counseling

I, _____, give consent to have my daughter/son
(Name of parent or guardian)

_____ enter into counseling with
(Name of client)

_____ at Advance Proefessional Counseling.
(Name of counselor)

I understand that the communication between _____
(name of client)
and her/his counselor is confidential, and that confidentiality will be broken only in the case of her/his being a danger to herself/himself or to others, or if she/her is involved in illegal activity, or if otherwise required by law. Therefore, I fully understand that even I as parent will not be provided with any information regarding communication between _____
(name of client)
and his/her counselor. I have had the opportunity to fully discuss with said counselor the risks and benefits of treatment, as well as treatment choices and methods. I have had all my questions answered and I understand and approve the treatment that is planned.

Under penalty of law, I hereby declare that I am the parent of this child. Parent means a biological or adoptive parent having legal custody of the child or a person or agency judicially appointed as legal guardian of the child.

Dated this _____ day of _____, _____.

Signature of Parent or Guardian: _____

Signature of Parent or Guardian: _____

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HIPAA Privacy Notice

Notice of Privacy Practices
Effective Date: November 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is this Notice and Why is it Important? As of April of 2003, a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how the practitioners at Advance Professional Counseling required to be HIPAA compliant will protect your medical information, how I may use or disclose this information, and describes your rights. If you have any questions about this notice, please contact me directly at (304) 650-3820.

Understanding Your Health Information During each appointment, I record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed
- A tool with which I can assess and work to improve the care I provide

Your Health Information Rights You have the following rights related to your medical record:

- *Obtain a copy of this notice.*
  You can read this notice in the waiting room, and you can also obtain your own copy if you would like.
- *Authorization to use your health information*.
  Before I use or disclose your health information, other than as described below, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- *Access to your health information.*
  You may request a copy of your medical record from me at any time.
- *Change your health information*.
  If you believe the information in your record is inaccurate or incomplete, you may request that I correct or add information.
- *Request confidential communications*.
  You may request that when I communicate with you about your health information, I do so in a specific way (e.g. at a certain mail address or phone number). I will make every reasonable effort to agree to your request.
- *Accounting of disclosures*.
  You may request a list of disclosures of your health information that I have made for reasons other than treatment, payment or healthcare operations.

My Responsibilities

- I am required by law to protect the privacy of your health information, to provide this notice about my privacy practices, and to abide by the terms of this notice.

- I reserve the right to change my policies and procedures for protecting health information. When I make a significant change in how I use or disclose your health information, I will also change this notice.
- Except for the purposes related to your treatment, to collect payment for my services, to perform necessary business functions, or when otherwise permitted or required by law, I will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.

When Can I Legally Disclose Your Health Information Without Your Specific Consent?

- *In order to facilitate your medical treatment.*
  For example: Your primary care physician or your psychotherapist might call me to discuss your treatment, and in that situation I would disclose information about your diagnosis, your medications, and so on.
- *In order to collect payment for health care services that I provide.*
  For example: In order to get paid for my services, I have my billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, I fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis.
- *In order to facilitate routine office operations.*
  For example: Occasionally, I dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.

Will I Disclose Your Health Information to Family and Friends? While the new law allows such disclosures without your specific consent (as long as it contributes to your treatment), my office policy is that I will *never* share your clinical information with your family without a signed authorization from you. The BIG EXCEPTION to this is if I believe you pose an immediate danger to yourself or someone else—in that case, I will do whatever is necessary, even if that means breaching confidentiality.

Less Common Situations in Which I Might Disclose Your Health Information

- Workers compensation: I may disclose your health information to comply with laws relating to worker's compensation or other similar programs.
- Law enforcement: I may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order. This includes any information requested by the Department of Social Services (DSS) related to cases of neglect or abuse of children.
- Food and Drug Administration (FDA): I may disclose to the FDA your health information relating to adverse events due to medications.
- Business associates: I hire a billing company to send out bills to insurance companies. Some of the employees of this company have access to a small portion of your health information in order to allow them to do their job.

For More Information or to Report a Problem. If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us any time at (304) 650-3820. If you feel your privacy rights have been violated in any way, please let me know and I will take appropriate action.
You may also send a written complaint to:

Department of Health & Human Services, Office of Civil Rights,
Hubert H. Humphrey Building 200 Independence Avenue
S.W. Room 509 HHH Building
Washington, D.C. 20201

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We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Name: _____ Date: _____/____/_____

Signature: _____

Witness: _____