CLIENT INFORMATION—CHILD

Today's Date: ________________

Referring Agency/Person: ____

Client Name: ______________________ Form Completed By: ___________________

Address: ____

City: ______________________ State: ____________ Zip Code: _____________

Home Phone: _________________ Alternate Phone (cell) (work): ________________

E-Mail: ______________________ (Confidentiality of email communication cannot be guaranteed.)

Date of Birth: __________________ Social Security #: _______________________

Gender: Male _____ Female _____ Ethnicity: ______________________________

Emergency Contact: ____

Relationship: __________________ Phone Number: ________________________

Current Family Information

Mother's Name: ____

Mother's Address: ____________________________ Apartment Number: ___________

City: ___________________________ State: ________ Zip Code: _______________

Birthdate: __________________ Occupation: _________________________________

Employed by: _______________________ Social Security Number:_________________

Telephone Numbers: ______________________ (Home) ___________________ (Work)

______________________ (Cell) ___________________ (Other)

Father's Name: ____

Father's Address: ____________________________ Apartment Number: ___________

City: ___________________________ State: ________ Zip Code: _______________

Birthdate: __________________ Occupation: _________________________________

Employed by: _______________________ Social Security Number:_________________

Telephone Numbers: ______________________ (Home) ___________________ (Work)

______________________ (Cell) ___________________ (Other)

Names of Siblings: Birthdates of Siblings:

________________________________ ____________________________________

________________________________ ____________________________________

________________________________ ____________________________________

________________________________ ____________________________________

What is the status of the client's parents' relationship? ____

If parents are remarried or living with someone else, please give names and birthdates of step-family members:

Name of step-family members: Birthdates of step-family members:

________________________________ ____________________________________

________________________________ ____________________________________

________________________________ ____________________________________

________________________________ ____________________________________

To which relatives does the client feel closest and why? ____

Developmental History

Please describe any developmental difficulties the client has had such as sleeping, eating, etc... ______________

____

Does the client have any unusual fears and if so, please describe? ______________________________________

____

What significant losses and/or trauma, if any, has the client experienced? ________________________________

____

Educational Information

School: ______________________________________ Grade: ________ Teacher: ________________________

Did the client have any difficulty starting or continuing in school and if so, please describe? ________________

____

How does the client do academically? ____

How does the client do socially? ____

To which friends does the client feel closest and why? ____

Describe any school problems: ____

What kinds of discipline have been used with the child? ____

What special interest, skills, or hobbies does the child have? ____

____

Medical Information

Doctor: ____ Telephone Number:_________________________

Is the client currently under a doctor's care: Yes No

If yes, please explain: ____

____

Addiction Information

What is the client's current alcohol/drug usage: ____

Does the client have a history of substance misuse and/or abuse: Yes No

If yes, please describe:____

____

Does the client have a history of other addiction issues? (eating disorders, gambling, sexual, etc.)? Yes No

If yes, please describe: ____

____

Abuse Information

Is the client exposed to any substance use/abuse?Yes No

If yes, please describe: ____

Has the client experienced any emotional abuse? Yes No

If yes, please describe: ____

Has the client experienced any physical abuse? Yes No

If yes, please describe: ____

Has the client experienced any sexual abuse? Yes No

If yes, please describe: ____

Spiritual Information

What are the family's beliefs about God? ____

____

What are the client's beliefs about God? ____

____

How would the client describe God?

____

Presenting Information

What is the problem for which you are seeking counseling for the client? ________________________________

____

____

What changes would you like to occur as a result of counseling? _______________________________________

____

____

What about the client's life is currently most stressful and why? _______________________________________

____

What counseling/treatment has the client had in the past? ____

____

Miscellaneous Information

Please feel free to tell us anything about the client and the client's life situation that we have not already asked:

____

____

____

____

____

____

____

____

________________________________ ________________________

Parent/Guardian Signature Date

________________________________ ________________________

Pastoral Counselor Signature and Credentials Date

TREATMENT GOALS AND PHILOSOPHY
New Life Counseling is a Christ-centered counseling ministry of Arizona Baptist Children's Services. We serve individuals, children, couples and families who are looking for new answers to old problems.

Our goal is to help clients move beyond their old life of problems and stress to a new life of peace and healing by providing effective solutions and coping strategies. These strategies are based on Christian principles, integrated with recognized counseling techniques, aimed at pointing people to a loving and caring God. **Because we are committed to God's healing and redemption in our client's lives, we do not provide forensic services, that is assessments, treatments or recommendations to the courts and legal community. In the unfortunate event that a judge's order is issued for our counselor's records and/or testimony, the therapeutic counseling relationship will be ended and a referral to another professional will be made.**

AVAILABLE SERVICES
New Life Counseling employs treatment modalities which assist individuals, couples, and families in resolving their difficulties as an outpatient provider. These modalities include individual, couple and family therapy. **Counseling sessions are 45 to 50 minutes in length**.

CANCELLATION NOTICE or "NO SHOW" APPOINTMENTS
A 24-hour notice is required when canceling or rescheduling an appointment. A $25 fee will be assessed for any missed and rescheduled appointment with less than 24 hour notice or "no show" appointments. Arriving 15 minutes or more late for a scheduled appointment will be considered a "no show" appointment. If payment for services is handled through a third-party and the third-party does not cover cancellation or "no show" fees, the fee will be assessed to the client. Failure to cancel in advance two times or two "no show" appointments may result in termination of services.

FEE FOR SERVICES
Payment is expected at the time of service. Case management services (ie. staffings, communication with other professionals involved with client/family, consultations, report writing) will be prorated based on counseling fee with a 15 minute minimum. Cases requiring court-ordered involvement with the legal and judicial system (ie. communication with attorneys, forensic research, judge-ordered court appearances) will also be prorated on twice the counseling fee with a 15 minute minimum.

CLIENT RIGHTS
The rights and concerns of our clients are a primary concern to the professionals of New Life Counseling. We strive to provide quality care to our clients in a professional, caring and ethical atmosphere. Each client accepted for services shall be afforded the basic right to:

- Treatment and services under conditions that support personal liberty and restrict such liberty only as necessary to comply with treatment needs

- A reasonable explanation of all aspects of one's own condition and treatment

- Be informed in advance of charges for services
- All available services without discrimination because of race, creed, color, sex, age, handicap, national origin, or marital status
- Refuse treatment at any point in the treatment process
- Confidentiality of records; within guidelines of state law
- Be informed, in appropriate language and terms, of rights including the right to legal counsel and other requirements of due process
- Referral, as appropriate, to other providers of behavioral health and other services

URGENT/EMERGENCY CARE

Arizona Baptist Children's Services/New Life Counseling does not provide crisis services. If you are in need of crisis services, please contact the 24-hour Crisis Line at 520-323-9373 or Southern Arizona Mental Health Center at 520-622-6000. In an after-hours emergency, please call 911 for assistance.

PARENT RESPONSIBILITY

Parents/guardians are responsible for supervising their children at all times while at the New Life Counseling office. Parents/guardians are financially responsible for any damages their children may cause while in the office or public restrooms.

NO WEAPONS POLICY

No weapons are allowed on the premises of New Life Counseling or in your possession during sessions with representatives of New Life Counseling. Our staff will take the necessary reporting steps in the event that you are found to be in possession of any type of weapon. This strict policy is designed to ensure the safety of everyone.

NO ALCOHOL OR STREET DRUGS

Do not attend counseling sessions if you have taken alcohol or street drugs.

CUSTOMER SATISFACTION SURVEY

When you are discharged you will be asked to fill out a client satisfaction survey or it will be mailed to you. This allows you to comment on the quality of your services at New Life Counseling. We strongly encourage you to honestly fill out this survey to provide us with information to improve the quality of our services.

____

Client Name

______________________________________ ______________________

Parent/Guardian Signature Date

FINANCIAL AGREEMENT

Current counseling fees range from $40 to $80 an hour based on a sliding scale. NEW LIFE COUNSELING is a non-profit ministry and it is our desire that no one be turned away because of finances. We will negotiate and arrange a suitable payment schedule for you as resources are available.

Payment is expected at the time of service unless other arrangements have been made. Third-party payments will be billed as I and my counselor agree. If an agreed upon third-party does not pay, I will be responsible to pay the sliding scale fees. I understand that I will be informed in advance of any changes in the agreed upon fees for service.

Checks are to be made payable to ABCS/NEW LIFE COUNSELING. Donations to ABCS/NEW LIFE COUNSELING are tax deductible as charitable contributions, but counseling fees are not.

If you must cancel a scheduled appointment, you must provide at least 24 hours notice. If you experience a scheduling emergency, call our office as soon as possible. If you do not provide adequate notice or attend your scheduled appointment, you will be billed $25.00 for the missed appointment.

Yearly Gross Income	Payment per Session
_____less than $30,000	$40
_____30,001 – 35,000	$45
_____35,001 – 40,000	$50
_____40,001 – 45,000	$55
_____45,001 – 50,000	$60
_____50,001 – 55,000	$65
_____55,001 – 60,000	$70
_____60,001 – and above	$80

I ____agree to pay $____________ for each session.

I have read, understand and agree to the above financial policies.

____ ______________________________

Parent/Guardian Signature Date

INFORMED CONSENT

The following information is for your benefit so you can enter a therapeutic partnership in an informed manner. Counseling is a professional relationship, which you are voluntarily seeking for yourself/minor child/family for assistance with relevant treatment issues. While counseling should end through mutual agreement once desired goals have been reached, you have the right to end counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

I consider all information and issues presented in the course of counseling as confidential by law. Confidential information may be released only with the written consent of the person being treated or that person's parent or guardian. State law also requires the release of confidential information under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under age 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may court-order treatment records or require a deposition or testimony from a counselor. The contemplation or commission of a crime or harmful act is not considered confidential communication.

Consultation and Professional Training

In accordance with accepted professional behavior, I am required to participate in direct supervision. I require your consent to allow me to obtain professional supervision or collegial consultation when I feel it will facilitate my work with your/your child/or family. Your name and any uniquely identifying information about you/your child/family will be deleted or changed to protect your identity. **Your signature on this form indicates your consent. Please let me know if you are withholding consent.**

Professional Records

The laws and standards of my profession require that I keep treatment records. Records are locked and kept on site. You are entitled to receive a copy of your records or a summary of your treatment if you make a written request. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents at any time that is convenient for both you and me. You may also ask to amend that record. I will not disclose your record to others unless you direct me to do so or unless the law compels me to do so. Communications between the counselor and client will otherwise be deemed confidential as stated under the laws of this state. You will be charged an appropriate fee for any professional time spent in responding to your request for information.

AUTHORIZATION TO TREAT

Authorization for Treatment

My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my counseling for relevant treatment issues.

____
Client Name

______________________________ ______________________
Parent/Guardian Signature Date

______________________________ ______________________
Pastoral Counselor Signature/Credentials Date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Presented to: ____
Parent/Guardian Printed Name

For: ____
Client Printed Name

Presented by: ____
New Life Staff Printed Name

I, ____, hereby acknowledge that I have received and read the Notice of Privacy Practices for Arizona Baptist Children's Services and that their staff was available to answer any questions I had and to offer further clarification of the contents of the Notice. * *You may refuse to sign this acknowledgement**

Signature: ____ **Date:** _____________
Parent/Guardian Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining the acknowledgement

____ Other (Please Specify) ____

Arizona Baptist Children's Services Staff Signature: ____________________________

Arizona Baptist Children's Services
1779 N. Alvernon Way
Tucson, AZ 85712

Phone 520.795.7541
Fax 520.795.7581
Web www.abcs.org