7700 Cat Hollow Drive, Ste. 206
Round Rock, Texas 78681
www.greatoakscounselingcenter.com

(512) 807-8457 Phone
(512) 501-2259 Fax

Child/Teen Personal Data & Consent to Treatment

At Great Oaks Counseling Center it is important in starting a professional counseling relationship for you to understand both its nature and its limitations. Please review this document and feel free to ask any questions. It contains important information about our professional services, business policies, and the current legal and ethical requirements of the providers at Great Oaks Counseling Center.

Client's Name:_____ DOB:_____ Sex:_____
Client's Ethnicity:_____ School: _____
Parent/Guardian #1:
Name: _____DOB: _____Marital Status: _____
Occupation:_____ Employer: _____
Home Address:_____ City:_____ Zip:_____
Home Phone: _____ Cell Phone(s): _____
Email:_____
How would you prefer to be contacted? _____ May we leave a message? _____
Parent/Guardian #2:
Name: _____DOB: _____Marital Status: _____
Occupation:_____ Employer: _____
Home Address:_____ City:_____ Zip:_____
Home Phone: _____ Cell Phone(s): _____
Email:_____
How would you prefer to be contacted? _____ May we leave a message? _____

Insurance Information:
Primary Insurance: _____ I.D.#:_____ Group #:_____
Insurance Address_____ City:_____
State:_____ Zip:_____ Insurance Phone #: _____
Policy Holder:_____ Relationship to Patient:_____
Policy Holder DOB: _____ Policy Holder SS#:_____
Policy Holder Phone #: _____ Policy Holder Address: _____
City:_____ State:_____ Zip:_____
Policy Holder Employer: _____
Secondary Insurance: _____

Please initial next to each paragraph:

_____ **HIPAA CONSENT FORM:** *I have read Great Oaks Counseling Center, Inc.'s "Notice of Policies & Practices to Protect the Privacy of your Health Information" (also known as "HIPAA Consent") form either on the GOCC website, or the laminated form in the office and understand that it describes how psychological and medical information about me may be used or disclosed and how I can gain access to this information. In addition, I understand that I am welcome to a copy of this HIPAA Consent form if I request it from my GOCC therapist.*

_____ **Confidentiality:** Individuals seeking mental health services should be clearly informed about their confidentiality rights. Generally, information that you discuss with your therapist in session and the written records pertaining to those sessions is strictly confidential and will not be discussed with anyone without your expressed written consent. This means that anything that is told in a therapy session will not be reported to anyone, even other family members. However, there are some exceptions to confidentiality when disclosure is required by law:

1. If a court of law orders your records in regards to a legal proceeding.
2. If you threaten to harm yourself or anyone else or you are suspected of being a risk to yourself or others.
3. If you report any abuse or neglect of a child, disabled person, or elderly person.
4. If you are using a mental health insurance policy, to pay for your visits, we may be required to provide certain diagnostic and basic treatment information in order to process your claims to obtain payment for our services.

_____ **Confidentiality Regarding Mental Health Services with Minors:** All of the above applies as it would with an adult client. Although the legal guardian(s) of minors are permitted access to a minor's therapy records, it is in the best interest of the therapeutic relationship to preserve confidentiality between the minor and his or her therapist. In the first session, guardians are asked for a verbal commitment to allow confidentiality between the child and therapist. However, there are exceptions. The therapist must inform the guardian, or appropriate authority, if the minor is in danger of hurting himself or someone else, if someone is harming the minor, or if the minor is engaging in risky behavior that could result in harming himself or another.

_____ **Professional Records:** Both law and ethical standards of the profession require that appropriate treatment records be kept. As a client, you have the right to review or receive a summary of your records at any time if a request is made in writing, except in limited legal or emergency circumstances or when releasing such information might be harmful in any way. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommend records be reviewed with your therapist in session.

_____ **Fee Arrangements:** Fees for psychological services are as follows. All Initial Evaluations are 60 minutes while therapy sessions are 45-50 minutes. All fees are due and payable at the time of service. Payment is accepted by credit card, personal check or cash. Psychological assessment reports are typically available within two weeks after the initial evaluation and psychological tests are completed. Psychological assessment reports will not be released until full payment is rendered. If an account has an outstanding balance, a payment plan may be arranged. However, the balance must be paid within two sessions to prevent routine appointments from being ceased until the balance has been paid.

Services Provided:

Initial Evaluation of Child/Teen	$225
Individual Psychotherapy w/ Child/Teen	$160
Family Therapy Session	$140
Group Therapy Session	$75
Parent Consultation/Coaching	$160
Psychological Testing	$150/unit
Phone Calls greater than 15 min	$20 per 10 min
Late Cancellation (less than 24 hours)	$50
No Showed Appointment	$100
Returned Check Fee	$25

If I am not an in-network provider with your insurance company, your company may still reimburse you for a percentage of my fee. I will provide you with a coded receipt to submit to your insurance company as a reimbursement form, although your coverage may have limitations for out-of-network providers.

_____ **Canceled/Missed Appointments**: There is no charge for cancelling an appointment if notice is given more than 24 hours in advance. A fee of $50.00 will be charged if less than 24 hours notification is given. If you fail to attend a scheduled appointment without any notification, a $100 fee will be charged. These fees are not covered by any insurance company and will be the responsibility of the client to pay before the next appointment. If an appointment is missed, follow up appointments will not be held without contact from the client to reschedule. As a courtesy reminder, our office will attempt to contact you by phone or email prior to your appointment. It is the responsibility of the client to keep your therapist informed of any changes in contact information.

_____ **Court Testimony:** We do not testify in court as an expert witness. If your family is undergoing custody determination, your therapist will not testify as to parental fitness nor custodial rights. In rare and unusual situations where your therapist is court-ordered by a judge to testify, Dr. Melling requires payment of $250 per hour.

_____ **Emergencies**: If there is an emergency during your treatment process, either during or outside a therapy session, your therapist will do whatever can be done, within the limits of the law, to prevent you or your child from becoming injured and to ensure that proper medical care is received. This may include contacting the emergency contact person designated below. Additionally, consent is not required if emergency treatment is needed, as long as your consent is sought after treatment is rendered, or if attempt is made to obtain your consent and you are unable to communicate. If an emergency arises outside of your therapy sessions, please call 911 or go to your nearest Emergency Room for a risk assessment to determine your need for hospitalization to ensure your safety.

Emergency Contact:

Name: _____ Phone Number: _____
Relationship to client:_____

☐ YES ☐ NO I have carefully read, understand, and agree to comply with the above office policies and consent for treatment for psychological services.

☐ YES ☐ NO I understand that the psychological services are voluntary and that I can discontinue at anytime.

☐ YES ☐ NO I consent to the electronic transmission of data (e.g., email, fax) as a means of communicating with the clinician and other individuals who are involved in my child/adolescent's treatment.

☐ YES ☐ NO I understand that, to improve the likelihood that I receive positive outcomes from therapy, my clinician might consult with other practitioners at Great Oaks Counseling Center.

If you have any questions about the above information, or if you have questions about a specific situation, please feel free to discuss your questions or concerns at any point during the therapy process.

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____