ID: **MINOR INTAKE** Referred by:

***NOTICE: WE DO NOT PARTIPICATE IN COURT APPOINTED OR COURT CASES. SEE FEES FOR SUBPEONAED OR MANDATORY SERVICES.**

Child Name: DOB: AGE: Grade: School:

ADDRESS: City: Zip:

Parent's Name: Phone: Email:

Mental health Guardian: ☐Yes ☐NO Relationship:

Is it okay to call and identify or leave message on phone? ☐Yes ☐ No

Is it okay to contact and identify via e-mail? ☐ Yes☐ No

Is it okay to text to number above and you release us to do so? ☐ Yes ☐ No

Parent Initial in agreement: ___

Divorced or Separated Parent's or spouses Names: Phone:

Email:

Mental health Guardian: ☐Yes ☐No Relationship:

Is it okay to call and identify or leave message on phone? ☐Yes ☐ No

Is it okay to contact and identify via e-mail? ☐ Yes☐ No

Is it okay to text to number above and you release us to do so? ☐ Yes☐ No

Parent Initial in agreement: ___

Prior Inpatient Center Name: Provider: Phone:

Dates Inpatient: Amt of time: How many times:

Release to speak to this provider _____ Yes _____ NO _____INITIALS

****Prior Counseling Agency Name:** Provider Name: Phone:

Length of Service: Modality: Diagnosis:

Was service Helpful (why or why not?)

Why did you discontinue service?

Release to speak to this provider _____ Yes _____ NO _____INITIAL

* Minor currently having suicidal ideation? ☐ Yes ☐ No Explain:

* Suicidal ideation in the past? ☐ Yes ☐ No Explain:

*What has been done in the past to remediate this / these problem(s) or other situations?

*What do you want to see counselor about/ goals?

*How long has this been a problem? (days, weeks, months, etc.)?

How would you estimate the severity of the problem (place "X" on the line)

Mild Moderate Serious Severe

Please check those that apply for your child.

☐ Learning / academic (poor grades, specific academic problems) ☐ Behavior Problems (temper tantrums)

☐ Depression or poor self-esteem ☐ Bed Wetting

☐ Delinquent Behavior (stealing) ☐ Adjusting to divorce or blended family

☐ Adjusting to death of loved one ☐ Fears and anxiety ☐ bizarre behavior

☐ Poor attention span / hyperactivity ☐ Aggressive behavior ☐ Extreme worrier

☐ Child gambles ☐ Hyperactive ☐ Disobedient

☐ Has had an unwanted sexual experience ☐ Physical abuse ☐ Self-injurious threat

☐ Emotional abuse ☐ Sexual abuse ☐ Impulsive

☐ Physical abuse ☐ Used Laxatives for weight ☐ Repeats others

☐ Vomiting to control weight ☐ Not eating ☐ Diet pills ☐ Daydreams often

☐ Excessive exercise ☐ Other Weight Issues ☐ Lack of attachment

☐ Not trustworthy ☐ Often sad ☐ Elimination Distur
☐ Chronic lying ☐ Indecisive ☐ Fatigue/ low energy
☐ Fire-setting ☐ Frequently tearful ☐ Grief
☐ Hopelessness ☐ Poor grooming ☐ Worthlessness
☐ Poor concentration ☐ Social Isolation ☐ Mood swings
☐ Guilt ☐ Agitation ☐ Elevated mood
☐ Emotionality ☐ Somatic complaints ☐ Panic attacks
☐ Phobias ☐ Significant weight loss ☐ Obsessions/
☐ Paranoid ☐ School problems ☐ Hallucinations
Other:

*I am interested in the following counseling services: Check all that apply
☐ Individual ☐ Family ☐ Psychological Evaluation ☐ Family Coaching ☐ ADD /ADHD Testing

Family History

Parent's current marital status:
Living Situation:

Describe Childhood Family Experience:
☐ Outstanding home environment ☐ Mother deceased for _____ years ☐ Normal home environment
☐ Father deceased for _____ years ☐ Chaotic home environment
☐ Witnessed physical/verbal/sexual abuse ☐ Experienced physical/verbal/sexual abuse
OTHER:

Current Functioning

1. Family and Child are: ☐ In an unsatisfactory relationship ☐ Unable to talk about personal issues
☐ Not emotional close ☐ Emotional close

2. Child's family has a history of:

☐ Poor communication	☐ Counseling	☐ Depression	☐ Abuse
☐ Eating disorders	☐ Bipolar	☐ Hospitalization	☐ Alcoholism
☐ Gambling	☐ Addiction	☐ mental retardation	☐ Heart disease
☐ Emotional problems	☐ behavior problem	☐ Cancer	Other:

3. Describe child's relationship with siblings and immediate family:

4. Explain support system:

5. Other Information (Hobbies and Interest):

Please list all other members of child's immediate family including brother, sisters and even step or extended family that may influence or be helpful in the process.

Name	Age	Relationship	Residence

Medical History

Describe child's current physical health: ☐ Good ☐Fair ☐Poor Significant Allergies:
*Problems during mother's Pregnancy?

*Childhood health up to this point?

Delayed developmental milestones

(check only milestones that did not occur at expected age):

☐ sitting	☐ controlling bowels	☐ rolling over	☐ sleeping alone
☐ standing	☐ dressing self	☐ walking	☐ engaging peers
☐ feeding self	☐ tolerating separation	☐ speaking words	☐ playing cooperatively
☐ speaking sentences	☐ riding tricycle	☐ controlling bladder	☐ riding bicycle

☐ other _____

* Describe child's grades and school performance:
* If you re-requesting a Psychological Evaluation or assessment of learning problems, try to complete the

following. Most schools can get you this information. Past testing given, dates, and scores:

Social Interaction:
☐normal social interaction
☐isolates self
☐very shy
☐alienates self
☐inappropriate sex play
☐underachieving
OTHER:

Intellectual/ academic functioning:
☐normal intelligence
☐high intelligence
☐learning problems
☐authority conflicts
☐attention problems
☐associates with acting-out peers
☐mild retardation
☐severe retardation
☐moderate retardation
☐other:
☐dominates others

Name 3 positive qualities that you see in your child:

What form of discipline is used in the household?

How do you think your child feels about his/her-self?

Is there any other information that may be helpful in better understanding your child?

School Name: Teacher or Staff Name: Phone:
Email: Past Testing: Diagnosis:
Discipline Issues: Grade: 504 or other special services in Place? If yes, please explain:

YES _____ Release to speak to minor's school and teachers. NO_____ INITIAL_____

CONSENT FOR TREATMENT: I agree that _____may be treated by a counselor of Ichange /Amber Kuntz LPSC. At times it may be necessary to schedule appointments or observations during school hours, we ask for your cooperation to provide the timeliest treatment and a release to use a system approach to benefit your child. I will provide court documents regarding conservatorship of my child(ren). I understand that in the event of established custody, consent from both parents or guardians must be obtained prior to treatment. Court documentation regarding custody and the psychological rights of the child are required prior to treatment. Court documents must be provided before services are rendered.

_____ _____ _____
Parent/ Guardian Printed Name Parent/ Guardian Signature Date

- You understand it is the parent's duty to communicate and share information amongst parents. You understand once your child turns 18 that it is their chose to release private information. You agree to office policies and understand we have a 24 business hr no show / late cancellation policy that applies to all clients.

POLICIES

Informed Consent for Therapy

Thank you for choosing iChange. We realize that starting counseling is a big decision. The counseling relationship is a partnership in which you, the client, are the best advocate for your care while the counselor offers tools and support. Ichange providers provide outpatient mental health services for many conditions. Techniques used may vary depending on need. Your therapist can provide you with their particular approach to therapy if requested. The main responsibility for change rests with the client. You have the right to decline any technique or procedure. It is the client's responsibility to discuss any concerns with the staff and to be aware that we are here to support and are not liable for emotional health. If there are signs of crisis, the client should see a psychiatrist or be assessed by a local hospital. This document is intended to inform you of our policies, State and Federal laws and your rights. Ichange and the name Amber Kuntz are used interchangeably.

POTENTIAL BENEFITS OF COUNSELING
Improved understanding of self and others
Progress toward defined goals and objectives
Greater sense of control over moods and behavior
Improved self-esteem
Improved relationships with others

POTENTIAL RISKS OF THERAPY
Lack of progress
Change in relationships
Upsetting insight
Feelings of distress

Counseling Relationship:
Sessions are usually held on a weekly basis and are approximately 45-50 minutes long. Sessions vary upon need. Although your sessions may be personal and intimate in nature, the relationship between you and your counselor is a professional one.

24-Hour Cancellation Policy: **You will be required to pay a no show fee for an appointment that is not cancelled within 24 business hours prior to the session or missed all together.** Insurance does not pay for missed or late rescheduled appointments. If you are 10 minutes late it is considered a "no show." The 24-hour cancellation policy will apply. You will be charged for that session.

Rescheduling: You may reschedule an appointment 24 **business** hours in advance. Anything cancelled the day of will be charged a counseling no show or late fee.

Telephone and Email Policy: Ichange staff returns phone calls on a regular basis during office hours from 9:30 AM-4:00 PM. Any call after 3:45 may be returned the next business day. Phone calls over 10 minutes will be billed at $2.00 per minute. For appointments call your counselor directly, or go to website: www. ichangetx.com and (if you feel comfortable) fill out the online form, or email help@ichangetx.com.

By signing, you authorize and consent for Ichange business and its providers to contact you. I understand that if I choose to be contacted by email, text, or leave voice messages **confidentiality and encryption cannot be ensured.** Furthermore, if I chose to be contacted via telephone I understand that Ichange designee will take the necessary efforts to preserve your confidentiality. You agree to electronic signatures.

May contact by telephone	☐Yes	☐No	May contact via email	☐Yes	☐No
May contact via text	☐Yes	☐No	May leave a message	☐Yes	☐No

Client Printed Name _____ Signature _____ Date _____

COORDINATION OF TREATMENT:
It is important that all health care providers work together. As such, we would like your permission to communicate with your teachers, supporters, primary care physician, and/or psychiatrist. Your consent is valid for the term of your time as a client with Ichange unless requested otherwise. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent, no information will be shared.

☐You may inform my physician (s) ☐I decline to inform my physician

1.Physician Name & Info: _____

2.Physician Name & Info: _____

ASSESS OF CURRENT SUBSTANCE/ALCOHOL ABUSE
Under no circumstances will a counselor treat a client in the event that the client is under the influence of drugs, alcohol, or any illegal substances of any kind. If the counselor suspects that the client is under the influence, the client will be asked to leave. At this time the client will be required to pay the designated amount for the session, as it will be qualified as a missed session. The counselor has a legal duty to inform the proper authorities if it is suspected that the client is in danger of harming one's self or another by driving from the office. A cab or your emergency contact can be called for you. This policy is made for the protection of the clients.

*We are a no record practice. Taping of sessions or conversations is prohibited.

Client Bill of Rights

Ichange providers earnestly wish to provide you with the best possible services while you are a client and to treat you with the utmost respect. We have listed the considerations you may expect while a client at Ichange. Please see full Bill of Rights and Grievance policy on our website for you to print out and have at anytime.

- You have the right to be treated with consideration, respect, and dignity by the staff and designees Amber Kuntz, LPCS / Ichange.
- You have a right to the highest quality of services available, regardless of your race, nationality, age, sex, disability, sexual orientation or religion.
- You have the right to be told about services and recommendations in terms you can understand.
- You have the right to have all releases and other forms requiring your signature explained to you before signing.
- You have the right not to be exploited or abused in any way while you are a client of ichange
- You have the right to refuse to participate in surveys, evaluations, assessments, and research projects.
- You have the right to have your interests and self-determination recognized as our primary responsibility.
- You have a right to have your civil and legal rights protected.
- You have the right to have your privacy and confidentiality respects, except when the information disclosed is subject to mandatory reporting as required by laws and regulations.
- You have the right to stop counseling when you want, whether or not your therapist agrees with your decision.
- You have the right to be provided with personalized services, including referrals that are in your best interest.
- You have the right to refuse any services offered.
- You have the right to choose you therapist and reserve the right to seek another therapist if you so choose. You have the right to file a client grievance procedure if you feel your rights have not been respecte

Grievance

Ichange staff is committed to providing the highest quality of services to all clients. If a person receiving services is not satisfied with the services being provided or experience a situation that cannot be resolved satisfactorily between themselves and a counselor, staff member, intern, or other office staff, he or she will be provided the opportunity to initiate a grievance by first sharing concerns with business owner.

Each step of the outlined procedure should be carried out within a timely manner. In addition to an oral conference throughout this process, the client shall submit in writing a statement of the grievance issue to ichange designee. **The following procedure should be implemented by the client:**

1. Discuss the matter with the staff, counselor, dietician, volunteer, intern or representative of the private practice to seek a satisfactory resolution, which may include referral.
2. In the event that a satisfactory resolution cannot be achieved, the client reserves the right to file a grievance with the Texas Department of State Health.

The information below is provided in the event the client finds it necessary to file a grievance with the Texas Department of Health and Human Services and/or the counselor's licensing board.

Texas Department of Health and Human Services
701 W. 51st Street
Austin, Texas 78751
512-438-3011

Texas State Board of Examiners of Professional Counselors
P.O. Box 141369
Austin, Texas 78714-1369
1-800-942-5540

HIPAA

Health Insurance Portability and Accountability Act Privacy Rule (45C.F.R, parts 160 and 164)

*FULL POLICIES AVAILABLE ONLINE AT ALL TIMES

The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164).This form documents that Mrs. Amber Kuntz, LPC, NCC, NBCCH, MS has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment & payment. PHI is information in your health record that could identify you. The Notice contains information about:

1. How your PHI may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice)
2. Which uses and disclosures require authorization from you and which don't
3. How you may revoke an authorization you have made
4. Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records, to have an accounting of disclosures
5. A list of my duties to protect the privacy of your PHI, my right to change the privacy policies and practices described in the Notice, and how I will inform you of changes
6. What you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make
7. Any restrictions and limitations you or I wish to put on the use and disclosure of your PHI.

This page documents that you have received a copy of the Notice that can be seen fully on line or where given to you in person. Patient's right to request a restriction on certain disclosures to their health plan if the disclosure is purely for carrying out payment or health care operations and the requested restriction is for services paid out-of-pocket. Practice is required to notify affected individuals of breaches of their unsecured PHI. Uses and disclosures of psychotherapy notes, most uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI can be made only with an individual's authorization; If a health plan intends to use or disclose PHI for underwriting purposes, a statement that the plan is prohibited from using or disclosing genetic information for such purposes; and individual has a right to be notified when a breach of his or her unsecured PHI has occurred.

_____ _____ _____

Client Printed Name Client Signature Date

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your clinical records are strictly confidential except for a) in an emergency b) billing / collection. c) collaboration with on-site psychiatrist or counselor, information (diagnosis and dates of service) shared with your insurance company to process your claims, or information necessary for case supervision. If you provide information that informs Ichange that you are in danger of harming yourself or others, information you and/or your child or children report about a threat to National Security or a plot of terrorism, information you and/or your child report about physical or sexual abuse; then, by Texas State Law, I am obligated to report this information to the Department of Children and Family Services or proper authorities.

Client understands that business programs such as practice fusion, google calendar, google drive ,availity, trillian are used for scheduling, billing, and charting. Clients release these programs to be used. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community **(911)** for those services. Treatment plans are kept in client's chart for documentation and goal purposes though, strategies in plan may change for client's benefit.

* If ichange / Amber Kuntz, LPCS Counseling or one of the providers becomes incapacitated or dies, I give my consent for Ichange / Amber Kuntz, LPCS and its providers to be custodian of my file and to access it for me. I also give my consent to contact me via telephone or email in the event my therapist becomes incapacitated or dies.

*I understand that ichange providers may have a duty to warn. Below is a list of people (but not limited to) that may be contacted in order to help prevent harm. EMERGENCY Contact RELEASE:

Name: *Relationship:* *Phone:* *Email:* *Consent to Release Information:*

_____

_____

_____ _____ _____

**Printed Name Signature Date

POLICY OF FINANCIAL AND INSURANCE:

- We ask that at each session you pay **100%** of your fees. If fees are not rendered at the time of service there will be a **$25.00 fee attachment**.
- There is a $35 overdraft fee for returned checks, which will be added to the cost of the session.
- If your insurance fails to pay, the **client is responsible for all fees**.
- In the event that an account is overdue and turned over to our collection agency, the client or **responsible party will be held responsible for any collection fee charged to our office to collect the debt owed plus a $50.00 fee.**
- Per your request, if your provider is in network with BCBS PPO, we will file to your insurance. We cannot confirm insurance reimbursement. We will use a diagnosis code for filing insurance. It is your duty to know your benefits and approved services before appointment time. 100% of all fees are client responsibility. If insurance does not reimburse, it is the client's duty to call their insurance. **If iChange issues a reimbursement you have 30 business days from the date of the check to deposit.**

Intake session: $80.00 -$100.00
Half-sessions (30 minutes): $55-$70
Full sessions (45-50 minutes): $80-$100
Family and Couples (45-50 minutes): $90-$120

Sliding scale: To qualify proof of income is required.
Family annual income less than $25, 000 for $68.00
$25,000 to$35,000 for $72.00
$35,000 to $40,000 for $76.00

Treatment Reports $45.00 and 35cents a page

** Missed or rescheduling less than ***24 business hours: $50***-$120 full session cost. We have the right to waive portion of fee in emergency crisis situations.

** Copy of chart is **.35 cents per page, $35.00 per hour clerical fee,** $120.00 per hour redacting fee.

** In the event that your session exceeds the allotted time, you will be billed at the rate of $1 per minute, in addition to the agreed upon session cost.

* We do our best to reimburse credits we are aware of pending on your account. Credits past 365 days or 1 year from last seen session will be voided. It is your duty to request any credit reimbursements in writing.

****There is an additional fee for crisis appointments.**

Counselors may travel to accommodate the client's needs, however there is a minimum $25 travel fee plus $0.40 charge per mile traveled fee that will be added to the cost of the counseling session. There is no refund policy. All policies apply in all cases. All fees are dependent on the requirements of the service provided.

Assessments:

Depression:$50 MMPI:$525.00
ADD/ADHD: $195 / $90 for additional portions such as teacher, parent or observer.
Disability Forms: $50 plus copy cost

- IF YOU RECEIVE TESTING WITH OUR PRACTICE DUPLIATES MAY BE REPRODUCED FOR SESSION TIME. IF RESULTS ARE SENT DIRECTLY TO SCORING CENTER AMBER KUNTZ LCPS HAS NO WAY OF KNOWING THE RESULTS AND THEREFORE CANNOT PROTECT, PREVENT, OR MAKE EMERGENCY SERVICES AWARE. IF YOU RECEIVE RESULTS AND FEEL UPSET PLEASE CALL OR GO TO YOUR NEAREST PHYSICIAN OR EMERGENCY ROOM. IF TEST IS RETURNED NON-VALID THE FEE IS STILL THE SAME AS THE TEST WAS USED COMPLETELY AND SCORED.

Court Charges (we are not court appointed and typically do not attend court)

Clerical: $55 an hour
Mediation or Consultation: $135.00
Deposition: $175.00 per hour (in court time)
Supervised Visitation: $135.00
Treatment Reports: minimum $225.00

Subpoenaed file record and statements ***$65.00*** plus other above fees apply.

*If Ichange staff are to deliver, expedite, or work on court documents there is a ***$25. 00*** for their hourly time. Patient also acknowledges and agrees to all financial fees accrued for company lawyer, collaboration, and guidance.

I have received a copy of my fee schedule

Client Signature _____ Date _____

** I agree to my credit card information to be exchanged and swiped over the phone:

☐Yes ☐No Initial _____

INITIAL EACH SPACE

_____ *CONSENT FOR* SERVICE and FINANCIAL FEES: I am aware that ***PAYMENT IS DUE in full at the beginning of the session*** for all services rendered. I agree to pay any **outstanding balances**, attached fees for **late payments ($25), bounced checks ($35), and no show/ late cancel fee ($50).** Appointments are considered No Show / Late Cancel if they are cancelled with less than **24 business hours** notice. **Session rates may change due to length and/or complexity of session.** I am aware that Saturdays, Sundays and Holidays are not business days. I acknowledge that if payment is not rendered, iChange employees and **workers reserve the right to breech confidentiality** by contacting a designated collection agency to ascertain payment. I understand that court, assessments, and other fees may apply and that I am 100% liable. I understand that square reader may not be 100% confidential. If there is a credit on your account you have 12 months from date of service to request reimbursement. All funds after 12 months are forfeited.

_____ *STATEMENT OF CONFIDENTIALITY:* I am aware of iChange / Amber Kuntz, MS, LPCS Confidentiality, Consent, HIPAA, Financial, Insurance and Privacy Policy. I understand my rights, the limits to confidentiality, encryption, and the duty to report. I understand the use of 3rd party vendors are used such as Availity, Google, Practice fusion, QuickBooks, scheduling, un- encrypted programs, and emails. I understand that receipts and other information may be emailed to me via QuickBooks. I understand that if I have questions, I can approach any iChange staff and receive information at any time. I am aware secretaries abide by privacy act. This also applies to any other business in our joined suite.

_____ *STATEMENT OF RECEIPT OF PRIVACY POLICY:* I acknowledge that provider of iChange have given me a copy of the Privacy Notice either by web, email, US Mail, or in person, as required by the federal government's HIPAA legislation. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information. You agree to electronic signatures.

_____ I understand insurance may ask for diagnosis, coding or other private information and agree to information being shared. Insurance or EAP may not pay. You **are 100% liable for all fees**. We recommend **YOU** checking your insurance information for deductible, copay, and pre-authorization necessities. I am aware fees may change due to coding changes throughout the year. The front desk and your insurance provider can provide you updates as they happen.

_____ *CLIENT BILL OF RIGHTS:* I understand my rights as a client seeking counseling services and/or other services provided by an iChange provider. We prohibit recording of sessions. Weapons of any kind with or without license are strictly prohibited. We do enforce penal codes 30.06-30.07.

_____ If client's parents are separated or divorced we speak directly to parent who has arranged services and request parents to communicate to one another.

_____I understand this office works on an appointment basis therefore calls, e-mail, or other communication may not be handled in 48 business hours. I must plan accordingly. I understand iChange is not a crisis clinic and staff does not return calls after hours. Please call 911. I am aware of iChange client *grievance policy*. If I feel I have been treated less than supportive I will first attempt to resolves any issue with business owner and hold harmless company or sole providers.

_____In the situation a payment is made over the phone, I agree to my **credit card** information being collected, entered, and processed. **Sign: _____**
_____I agree to using electronic signatures.

_____I agree to non-encrypted communication via the means listed and initialed below although encryption cannot be guaranteed **_____ Text _____email _____voicemail**.

I have read and consent to the **entire** policy list. I am aware of HIPAA, privacy policy and security. I understand my rights and responsibilities and choose to enter into services with iChange / Amber Kuntz, LPCS or its designee.

Printed Name of Client	Signature of Client	Date