



Child Client Information

Client's Name (First MI Last):

Preferred Name or Nickname:

Date of Birth:

Age:

Gender:

Parent/Caregiver 1

Parent/Caregiver 2

Name:

Name:

Biological Adoptive Guardian
 Other:

Biological Adoptive Guardian
 Other:

Mailing Address:

Mailing Address:

Physical Address:

Physical Address:

Please DO NOT list any numbers where you would prefer not to receive calls or messages.

Home:

Home:

Cell:

Cell:

Work:

Work:

Email:

Email:

Check this box to receive email communication from Counseling Associates

Check this box to receive email communication from Counseling Associates

As a courtesy, we offer the option of appointment reminders by email, text, or landline phone message. These messages are delivered 48-hours in advance. These serve as reminders only and should not be relied upon exclusively. Please also be sure to note your appointment in your own personal calendar.

Would you like to receive optional courtesy reminders? Yes No

Requested Method: Email Text Landline Phone Message *(select one only)*

Insurance Information

Primary Insurance Company:

Secondary Insurance Company:

ID#:

ID#:

Group #:

Group #:

Please provide your insurance card(s) for copying at the time of appointment or upload a photo of the front and back of your card(s) via our secure portal on ca-mh.com.

Payment Authorization

Type of Credit Card:

Visa

Mastercard

Discover

AMEX

Name on Card:

eSignature:

Card Number:

Expiration Date:

Security Code (CVV):

Street or P.O. Box Number:

Zip Code:

Options:

Use for my co-payment for each session

Check all that apply

Use only when I call to give authorization

Use for any balance for which I am responsible

Use for balances on late cancellations or missed sessions

Special Instructions:



Financial Agreement

I understand and agree that Counseling Associates of New London, PLLC (offices including New London, Newport, Claremont, the Upper Valley, Hanover, and Plymouth), **requires payment at the time of service.** I understand that I have the option to leave a credit card on file to cover these charges. I understand that if I choose not to leave a credit card on file, after 2 visits of non-payment, my services may be suspended until my balance is paid in full. Payments can be made by check, cash, or credit card.

I understand that I am financially responsible for any and all costs associated with services which are considered part of my deductible, co-payment, and/or co-insurance stated by my insurance, and services my behavioral health insurance does not cover.

I understand that I am responsible for notifying Counseling Associates of any insurance changes. If I do not notify Counseling Associates of New London, PLLC, I will be responsible for paying in full any charges incurred for services provided that are not able to be billed to my new insurance company. Counseling Associates has 30 days to submit all claims to insurance. If they are not submitted within 30 days, insurance may not pay for the services. Services will be charged \$180 to \$365 per session, depending on the service, for any visits that are not covered by insurance.

Appointment Cancellation Policy: We have a standard 24-hour cancellation policy and \$60.00 missed session fee. Please notify us of cancellation at least 24 hours prior to your appointment to avoid the \$60.00 fee. Missed sessions cannot be charged to insurance.

Signature

Date

Coordination of Care

Coordination of care among healthcare providers improves quality of care and achievement of treatment goals. Authorizing this coordination of care with your child's primary care provider (PCP) or another professional is optional though, increasingly, insurance companies are requiring this and considering this standard of care. If you authorize coordination of care with your child's PCP, Counseling Associates will send a confirmation to your provider that we have met for this initial session. Coordination of care may also include brief periodic updates regarding treatment and other coordination communications either in writing or by phone. We are happy to answer any questions you may have about coordination of care and this authorization.

-
- I authorize coordination of care between my child's PCP and Counseling Associates. *Please sign release on following page.*
-
- I decline coordination of care at this time. *Do not complete release on following page.*
-
- I have questions about coordination of care and would like to wait and speak with my child's therapist.
-
- My child has other providers or individuals for whom I would like to authorize communications. *Please sign release on following page.*
-

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the following (available on our website or in office):

- Counseling Associates Practice Information
- CA Cancellation Policy
- NH Mental Health Bill of Rights

I understand the information about the therapy I am considering for my child. I have had all of my questions answered to my satisfaction.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that, as with any treatment, there are some risks as well as many benefits with therapy. I am aware that I may stop my child's treatment with this therapist at any time. I understand that I will still be responsible for paying for services already received. I understand that there may be consequences to such a decision outside of my child's therapist's control. (e.g. if my child's treatment has been court-ordered, I will have to respond to the court).

My signature below indicates that I understand the information about the therapy I am considering for my child, and I have had all questions answered to my satisfaction. I agree to abide by the terms outlined throughout our professional relationship with Counseling Associates of New London, PLLC, which includes Counseling Associates of New London, Newport, Claremont, the Upper Valley, Hanover, and Plymouth. I consent for my child to receive services from Counseling Associates and I agree to take an active role in my child's treatment.

Signature of Parent/Guardian

Date

Printed name

Relationship to client



Please Tell Us

In a sentence or two, please describe the reason for the appointment:

What do you hope to gain from therapy?

What strengths does your child have that they will bring to this work?

Has your child seen a therapist before? Yes or No
If Yes, please note the name of the therapist(s) and approximate date(s):

Health & Wellness Information

Form with fields for Date of Birth, Age, Gender, Height, Weight, Immunizations, Primary Care Provider, Date of Last Physical, Other Providers, Current Health, and concerns about child's health and development.

Medications

Has your child ever received medications for emotional, physical, learning, or behavioral concerns?
Yes No If yes, please list all below:

Table with 6 columns: Medication, Dosage, Current (Y/N), Taken since, Is it helping?, Side effects

Please attach additional sheet(s) as needed for additional medication information.

Over the counter / Supplements / Herbal:

Allergies or adverse reactions: No Known Drug Allergies

Educational History

Current School: Grade in School:

Do you or someone else have any concerns about your child's education? Yes No
If yes, please describe:



Authorization to Disclose Health Information

_____, born on this date _____
(Name of person whose information is being disclosed)

authorize **Counseling Associates of New London, PLLC** to

Release Receive Exchange

Protected Health Information (PHI) about the above referenced individual to:

Name: _____ Phone: _____

Address: _____

Information as described below:

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

Mental Health (MH) Substance Use Disorder (SUD) Both (MH/SUD)

Type of Information / Record: Check the information / record type you wish disclosed

Check **Yes** if you request the **Entire Record** to be disclosed - *this includes, but is not limited to:*
assessment, treatment plans, progress notes, medication, attendance, test results,
behavioral support plans, discharge reports, etc.

Check **No** if you wish to specify which of the items below to disclose:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Attendance
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Assessments/Evaluations including diagnosis, treatment recommendations
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Treatment Plan/Individual Plan of Care
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Progress Notes
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Medications Prescribed
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Agency Discharge Summary/Plan
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Behavioral Support Plans
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Test Results (includes lab results and urine toxicology reports)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	HIV/AIDS
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other (must specify):

Date range of information to be disclosed: _____

The purpose of the disclosure: _____

Date or event upon which this authorization will expire: _____

I understand that if I do not note a date or event, this authorization will expire one year from the date signed below.

If none is indicated the means of this disclosure may be written, verbal, or electronic.

- I understand that my substance use disorder treatment records are protected under federal regulations, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise allowed by the regulations or required by law.
- I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization.
- For disclosures of information made to organizations outside of the State of New Hampshire, health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Standard of HIPAA.
- I understand that confidentiality of such records is also protected by State law.
- I understand that generally Counseling Associates may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied participation in the services if I do not sign an authorization form.
- I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment payment or healthcare operations.
- I also understand I will not be denied services if I refuse to authorize a disclosure for other purposes.
- I understand that I may request restrictions on the use or disclosure of information for the purposes of treatment, payment, and healthcare operations that Counseling Associates may or may not agree to the requested restrictions.
- I understand I may revoke this authorization at any time except to the extent that the practice or other agency making the disclosure has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the practice at our address.

I have read all of the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

Name of Client (please print)

Date

Signature of Parent/Guardian

Date



Comprehensive Core Standardized Assessment (Child/Minor)

Name:

DOB:

PCP:

PCP Phone:

Office Location: New London Upper Valley Newport Claremont

1. Do you ever need help reading or understanding your child's health information? Yes No

2. Does your child currently use tobacco products? Yes No

3. Do you or your family currently have any legal issues that interfere with your child's healthcare? Yes No

4. What is your family's housing situation today?

We don't have housing (couch surfing, motel, on the street, vehicle, abandoned building or a homeless shelter)

We have housing today, but I'm worried we might lose it in the next 90 days

We have housing that is safe and adequate

5. In your child's housing situation, do you have issues with any of the following?

Lead paint or pipes Bug infestation Mold

Oven or stove does not work No smoke detector/detectors do not work

Other: _____ None

6. How hard is it for you to pay for your family's basic needs of food, housing, heat, or medical care?

Not hard at all Somewhat hard Very hard

If **Somewhat hard** or **Very hard**, what do you have trouble paying for? *(Check all that apply)*

Food Health Needs Utility bills (electric, oil, propane, etc.)

Housing Childcare Debts Other: _____

7. Does your child need assistance with any of the following tasks?

Bathing Getting in or out of chairs Grooming Dressing

Walking Eating Using the toilet No, I do not have difficulty with these activities

8. Does your child have someone they could call for help or a favor? Yes No

9. In the last 12 months, has your child or anyone in your household been threatened or abused physically, emotionally, or sexually by a partner, spouse, or family member? Yes No

10. Do you have any concerns related to your child's health? Yes No

Pediatric Symptom Checklist

<i>Please mark under the heading that best fits you:</i>	Never	Sometimes	Often
1. Complain of aches or pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Spend more time alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Tire easily, little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fidgety, unable to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have trouble with teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Less interested in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Act as if driven by motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Daydream too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Distract easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are afraid of new situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feel sad, unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are irritable, angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feel hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Less interested in friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Fight with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Absent from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. School grades dropping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Down on yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Visit doctor with doctor finding nothing wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Having trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Want to be with the parent more than before	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Feel that you are bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Take unnecessary risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Get hurt frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Seem to be having less fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Act younger than children your age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do not listen to rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Do not show feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Do not understand people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Tease others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Blame others for your troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Take things that do not belong to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Refuse to share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>