CHILD/ADOLESCENT INFORMATION FORM

Date:_____

Name:_____

Address:_____

City:_____State:_____Zip:_____

DOB:_____Home Phone:_____SS#:_____

School:_____Grade:_____

Hobbies:_____

Parent/s Name: Mother_____DOB:_____

SS#:_____Cell Phone:_____

E-Mail:_____

Father:_____DOB:_____

SS#:_____Cell Phone:_____

E-Mail:_____

Mother's Employer:_____Contact at Work? Yes/No Phone:_____

Father's Employer:_____Contact at Work? Yes/No Phone:_____

Other Children in your home:

Name:_____DOB:_____Name:_____DOB:_____

Name:_____DOB:_____Name:_____DOB:_____

Medications, dosages, if any: _____

Please explain why you are seeking counseling at this time:

_____

_____

_____

RIGHTS AND EXCEPTIONS TO THE RELEASE OF CONFIDENTIAL INFORMATION

Joel S. Brooks, LCSW, maintains a strict ethical and legal obligation to protect the privacy of clients by not disclosing names, diagnosis or any other personal information disclosed in the course of treatment to anyone outside of the treatment setting. Treatment information will only be released to appropriate persons or institutions, (such as physicians, mental health professionals, etc.) upon a signed consent to do so.

All inquiries about any client of Mr. Brooks, whether by mail, telephone or person will be responded to with a statement such as, "I cannot release that information unless I have the patients written consent."

It is very important to know and understand that there are rare occasions when Mr. Brooks will be required by law to breach confidentiality. The exceptions to confidentiality are as follows:

1) Cases that involve suspicion or knowledge of abuse or neglect of children, elderly persons or disabled adults. Florida law requires all Mental Health Professionals and a variety of other professionals to immediately report any suspected or known abuse, neglect or abandonment of a child, elderly person or disabled adult. These reports will be made to the Florida Abuse Registry.

2.) When there is a clear and immediate probability of physical harm to self or to other individuals or to society and the therapist communicates the information only to the potential victim, appropriate family members or law enforcement or other appropriate officials.

3) When the therapist is a defendant in a legal proceeding arising from a complaint filed by the client.

4) A court order is obtained for an evaluation or report and the therapist is appointed or retained to provide these services. However, only the records required to prove the case should be released.

I have read and understand the terms as stated above. I also understand that Mr. Brooks can not be held accountable for any breach of confidentiality as long as the release of information falls withing the exceptions as described.

Client Signature_____ Date_____

CANCELLATION POLICY

Mr. Brooks is committed to providing you the most effective and efficient treatment services possible. To do so, it is important for you to be aware of the fee policy and reasoning behind it as well as your cooperation.

Payment is due at the time services are rendered, unless other arrangements have been made with Mr. Brooks. If you have an HMO, or PPO plan, you will be responsible for your co-pay, if any, at the time you are seen. Any other out of pocket fee will be due at the time of service. By having you pay at each session this will eliminate the need to bill you. This helps to keep our costs as low as possible, prevents accumulation of large debts on your part and avoids possible risk of your privacy that occur when invoices for services are mailed to you.

Mr. Brooks encourages you to discuss any assistance you may need due to unexpected or temporary financial problems that you may experience. Mr. Brooks will always take into consideration any problems you may have that could limit your ability to pay.

Mr. Brooks requires 24 hour advance notification if you are not able to keep a scheduled appointment. This notice permits Mr. Brooks to offer that time to someone else. If you have given 24 hours' notice, you will not be charged for the appointment. However, if you break your appointment and do not call within 24 hours, you may be charged for the session.

Mr. Brooks understands that there may be occasional emergencies when you will not be able to keep your appointment and also will not be able to provide notification within 24 hours. These circumstances will be considered and taken into account.

Charges for broken appointments and appointments cancelled without 24 hours notice cannot be billed to your insurance. You will be personally responsible, therefore for the full amount of the session.

I have read the above policy and understand I wll be responsible for payment in full should it become necessary.

Client signature:_____ **Date:**_____

If you would like a copy of this, please let Mr. Brooks know and he will be glad to provide you with one.

PARENTAL INFORMED CONSENT

The following is to inform you regarding your son or daughters treatment with me. Please take a few minutes to read these guidelines.

Your son or daughter will always be treated with the utmost respect with confidentiality and an atmosphere of safety to discuss his/her problems. Sessions will be conducted both individually and as a family with parental involvement as necessary. Your son or daughter will be provided an opportunity to discuss his or her problems confidentially as he or she requests. There may be some information that your son or daughter wishes to discuss without your knowledge. If this is the case, confidentiality will be respected. However, your son/daughter will be encouraged to participate in the therapy with you so problems can be addressed within a family approach. There may be times when I request a session with you without your son/daughter when necessary. Your active involvement and participation is highly appreciated and encouraged.

There are exceptions for some young adults who may wish to be seen alone without their parents involvement. This can a very valuable experience for many who are most comfortable talking to me in a highly confidential manner. When this is appropriate, such an arrangement will be honored.

There are three simple rules that I ask that you please follow:

1. While your son/daughter is being seen, please remain in the waiting room without leaving the building.

2. Please do not have your son/daughter bring food to the session.

3. If for some reason you must have another family member, (grandparent, aunt, uncle, etc) bring your son/daughter to the session, please inform me at least 24 hours in advance. Otherwise, it is strongly encouraged that you attend all the sessions.

Sessions are scheduled Monday through Thursday, 10:00 am to 7:00 pm depending on availability and your schedule. At the end of each session, a new appointment will be arranged.

You will be provided with two phone number as well as my e-mail address to contact me with questions, concerns or for cancellations/rescheduling. Should you have any problems between sessions, please feel free to use e-mail and I will respond within the same day.

If you have an insurance co-pay or fee, payment is expected at the time of service.

Each session is 45 min in length and will begin on time on the hour. Should I be delayed and your session begins a few minutes late, the full 45 min will be provided. However, if you are late for your session, therapy will end on time as scheduled.

Please feel free to discuss any questions or concerns you may have about the therapy and how your son/daughter is progressing. I will always be available and willing to listen and respond to your thoughts and feelings about the therapy process. I want to be sure that your feelings as a parent are taken into consideration and your needs are being met.

Any or all family members important in your son/daughter's life are invited to participate at any time. Please let me know if there are others in your family that you believe could be a asset for your son's or daughter's therapy.

Parent signature: _____ Date:_____