Ebenezer Counseling Services

Child / Adolescent Intake Form

(If child, may be completed by adult)

Date _____ Parent Email: _____

Name _____

Address _____

City _____ State _____ Zip_____

Home Phone _____Client Cell # _____

Social Security Number _____ Date of Birth _____

Age _____ Sex _____ School _____ Grade level _____

Clubs / groups / sports you're active in _____

Do you work? _____ Employer _____ Total hrs/week _____

Work # _____ May we contact you at work? _____

Presently living with: Parents____ Roommate____ Alone____ Other_____

Father's employer _____ Work phone _____ Cell _____

Mother's employer _____Work phone _____ Cell _____

Who will be responsible for payment of bill? _____

Relationship to patient? _____ Address if different_____

Will you be using insurance? _____ Primary Insurance Co. _____

ID#_____Group #_____Relationship_____

Policyholder_____DOB_____SSN_____

Denomination or Church _____
Active _____ Inactive _____

Family Members:

Relationship	Name	Age	Grade in school last completed	Occupation if out of school	Check if still living with you
Father					
Mother					
Step-mother					
Step-father					
Brothers					
Sisters					

CONFIDENTIAL

Describe any physical problems you have that require medication or physical care:

_____

Medication currently using: _____

Are you currently receiving medical treatment? Yes _____ No _____

Physician or health care provider _____

Previous Therapy / Hospitalization Yes _____ No _____

Where / with whom _____
Name Address Dates

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place **two checks** by those items which are most important. *You may add written comments in the additional space below.*

1. _____ Anger / temper
2. _____ Depression
3. _____ Fearfulness / nightmares
4. _____ Unhappy most of the time / sadness
5. _____ Worry (constant)
6. _____ Family problems (siblings / parents)
7. _____ Family transitions (divorce, remarriage, birth)
8. _____ Responsibilities / chores
9. _____ Physical problems
10. _____ Religious / spiritual concerns
11. _____ Thoughts of suicide / hurting others
12. _____ Trouble making decisions
13. _____ Use of alcohol
14. _____ Use of drugs / cigarettes
15. _____ School concerns (grades, peer interaction)
16. _____ Problems with social relationships (friends)
17. _____ Sexual concerns
18. _____ Victim of uninvited sexual advances
19. _____ Other (specify) _____

Additional comments regarding checked areas:

Is there any history of adoption in your family?

_____

_____

In your own words, briefly describe the main problem which prompted you to seek therapy at this time.

_____

_____

Is there anything else which you believe might be important for your therapist to know at this time?

_____

_____

Client's Name: _____

CLIENT AGREEMENT WITH POLICIES AND PROCEDURES
WELCOME TO EBENEZER COUNSELING SERVICES

The following information is provided to assist you in understanding policies and procedures at ECS. We strive to provide you care of the highest quality. Please do not hesitate to ask questions of your therapist or our administrative staff at any time about these matters. Please also read the Notification of Client Rights document provided for you as well.

Therapists:

All Ebenezer therapists are trained professionally at the Master's or Doctoral level. Therapists are trained as psychologists, professional counselors, marriage & family therapists, or social workers. All ECS therapists work from a Christian perspective. A list of therapists and their professional identities are posted in the waiting rooms of both of our offices. Some therapists are working toward their licensure and are indicated on the posted lists as "Counselor in Supervision." We often also have an intern who is a counselor in training working toward a Master's or Doctoral Degree and is under supervision at ECS.

Appointments:

Since clients are seen by appointment only *(unless an emergency situation dictates otherwise),* the appointment time given is reserved for you. Please give at least twenty-four (24) hours notice if you must cancel your reserved time. Therapists depend on their appointments being filled for their income. If an appointment is missed, the therapist does not get paid. Therefore, **you will be charged your usual fee for appointments not canceled twenty-four hours in advance**. Please understand that insurance companies, churches, and employee assistance programs as third party payers cannot be charged for late cancelations or missed appointments, and you are fully responsible for any resulting charges. In the event of your having an illnesses or emergency that prevents you from giving us notice, call us as soon as you can; and you will not be charged for that missed session. ECS has time-stamped voicemail so you can leave cancellations after hours and on weekends.

Emergencies and Telephone Calls:

Should you need to talk to your therapist between appointments, you may leave him or her a voicemail. Therapists vary in how frequently they check voicemail. If your call is an emergency during normal office hours, you should declare your call to be an emergency, and your call will be returned by our therapist-on-call. After hours, you will hear our message with our pager number to reach the therapist-on-call.

Fees and Payments:

Payment is required at time of service. Fees were set when you made your first appointment. Appointments generally run 45-50 minutes. We will file third party insurance forms for you, if you desire. Special fee structure for certain specified tasks such as psychological testing, consulting, or court-ordered appearances will be discussed with you and agreed upon before any charges are applied to your account. If your fees are not paid in a timely manner, ECS will contact you about payment. If payment is not made, ECS retains the right to use collection agencies. Clients are responsible for all fees owed to ECS and for any collection agency fees.

Insurance Usage and Issues of Confidential and Privileged Communications:

Many clients elect to file third party insurance coverage for services rendered. We will file insurance for you provided you authorize us to do so and provide us with the necessary information for filing such claims. Some insurance plans require an initial precertification of care before you can use your insurance benefits. It is your responsibility to make sure such pre-certification requirements are met if you elect to use your insurance benefits (i.e., referral from your primary care medical doctor, employee assistance program, other "gatekeeping" mechanisms such as calling an 800 number for approval).

In filing our insurance claim for you, you are granting us permission to reveal confidential information, such as the dates you are seen, the length of the appointment, billing information, forms completed today, mental status information, your diagnosis, treatment plans, progress notes, reports or clinical summaries, and summaries of assessments. This type of information is required by your carrier if you want insurance to pay toward your claim. Additionally, many companies now require further utilization review and participation with outcome and quality measures. Unless your care is very brief, it is likely we will be forced to submit a more extensive report documenting

the clinical and medical necessity for your care, as well as, revealing some of the details of your care to date if further sessions are going to be authorized by your carrier. Some carriers will require auditing/review of your records and outcome/quality care studies.

If you identify a third party such as a parent, relative, pastor, friend, church, or any other third party to be responsible for part or the whole of your bill, then by signing this policy statement, you are giving your authorization for the bill to be released to that party. By doing so, you realize that the third party will know about the frequency and number of sessions, cancellations, no-shows, balances, payments, insurance payments, etc.

Psychologists/therapists have a strong privileged communication law in our state which carries the same legal status as that of attorney-client. What you talk about in your sessions is protected by privileged communication laws and confidentiality principles. There are a number of important exceptions to confidentiality including but not limited to: expressing clear and imminent danger to self and/or others, suspected child abuse, worker's compensation related cases, utilization review reports for authorization of care, and compliance with chart audits by your insurance carrier. Additionally, therapists at ECS reserve the right to seek peer consultation and supervision within our agency regarding your diagnosis and treatment in order to better serve you. Apart from these exceptions, you must sign a written release of information for us to communicate with or release records to other persons or entities. We strive to maintain the sacredness and privacy of your confidential communications with us.

Other Issues of Policy:

In the event that a client of Ebenezer Counseling Services becomes verbally or physically threatening to office staff, therapists, or other clients, we reserve the right to call for help from the police or other emergency services as needed. We also reserve the right to file a police report and to pursue charges as appropriate to the situation. In the event of a client having a medical emergency, we reserve the right to call appropriate emergency services.

When a parent or parents come to ECS to discuss issues related to their child or children, the consultation sessions cannot be filed for insurance reimbursement under the child's name until the child is actually seen and diagnosed in a face to face session. If the child is not seen, no diagnosis can be given, and the parents are fully responsible for payment of the consultation sessions. The laws and rules pertaining to therapy with children are complex. Please see our website for guidance or feel free to communicate with our staff about this.

Your Informed Consent to Care:

We have provided this information to you in the hope of fully informing you about the policies of our office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and Psychological care offer no absolute guarantee of success and there are limitations to any form of care offered a client.

Please feel free to discuss any of these matters with your therapist in more detail. By signing below, you acknowledge that you have read, understood, and agree to these policies and procedures. Your signature acknowledges your informed consent for care.

_____ _____

Signature of adult client or parent/legal guardian of client less than 18 years of age

Date

Client Name: _____

PAYMENT – INSURANCE AGREEMENT
Ebenezer Counseling Services

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the doctor/therapist agrees otherwise. I understand that, unless the above named patient has coverage under a managed health plan (e.g., HMO, PPO, EAP, etc.) to which I subscribe and in which the doctor/therapist is a participating provider, I am personally responsible for the payment of all charges. I understand that, as a courtesy, the doctor/therapist will file insurance claims for the services provided, however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I also understand that any court order I have is an agreement between myself and the courts NOT the doctor/therapist and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency will be used in the event of delinquent payment, with the added cost of the collection agency being paid by myself, the client or responsible party for the client, and I realize that such action could require that the doctor/therapist release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. In addition, if I have requested that the doctor/therapist file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the doctor/therapist provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the doctor/therapist to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

_____ _____

Signature of adult patient or parent/legal guardian of patient less than 18 years of age

Date

EBENEZER COUNSELING SERVICES

325 EBENEZER ROAD
KNOXVILLE, TN 37923

(865) 670-0988
EBENEZERCOUNSELING.COM

131 N. CONCORD STREET
KNOXVILLE, TN 37919

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules").

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. Our Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.

By law, we are required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Ebenezer Counseling Services

I,_____, understand and have been provided a copy of Ebenezer Counseling Services' Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form. The Privacy Rights document is also available on our website, by clicking on the Privacy Rights button on the Forms page.

_____ _____

Patient Signature or Parent if Minor or Legal Charge Date

Date

If Legal Charge, describe representative authority:

_____

EBENEZER COUNSELING SERVICES (865) 670-0988

FAX: (865) 670-1991

Child/Adolescent Confidentiality

For Children Less than 16 Years of Age

Parents of children younger than 16 years of age have all rights regarding the initiation and conduct of their child's treatment at ECS. One parent or custodian must complete the ECS informed consent forms in order for the child to receive treatment. If the parents are divorced, special policies apply. (See the Divorced Parents Agreement Form) TN Law also allows for children to be seen on an emergency basis until informed consent can be obtained.

Though parents have legal privilege to access records for their child's treatment, parents and therapists must decide the limits of confidentiality in order to provide effective therapy. There are pros and cons with lesser or greater limits of confidentiality. The more confidentiality a child has, the more your child would be free to be open with his or her therapist without fear of parent discipline or reprisal. However, potentially risky behaviors, such as, drug use, sex, or illegal activities would not be made known to you as parents. If you and your child's therapist agree to lower limits of confidentiality, your therapist could inform you of risky behaviors, but your child may hold back on disclosure. Generally, ECS therapists would attempt to help your child disclose their risky behaviors to you directly.

ECS policy is for each therapist to work out the limits of confidentiality on a case by case basis when working with children. ECS therapists vary in their view of this issue. Families and children also differ in their needs and temperaments. We believe it is important to clarify this from the outset to minimize misunderstanding. Keep in mind also that TN Law requires therapists to break confidentiality when a client (child or adult) expresses significant lethal danger to self or others or any form of child abuse. Please talk about this important issue of confidentiality with your child's therapist and come to agreement about the limits of confidentiality.

I have read and understand the policies above and by my initials in the blanks below indicate that I understand my child's therapist will be free to disclose to me the following confidential information:

_____ Attendance of Therapy Sessions
_____ Goals of Therapy
_____ General Progress of Therapy
_____ Specific Issues: Drug Use, Sex, Illegal Behaviors, etc.

Child/Adolescent Name (Print): _____

Mother's Signature: _____ Print: _____ Date:_____
or Guardian
Father's Signature: _____ Print: _____ Date: _____
or Guardian

Informed Consent for Internet Assisted Counseling
Ebenezer Counseling Services v4

I the undersigned, declare that I understand the inherent risks and privacy concerns present in counseling via the Internet (Skype, Facetime, thera-LINK, etc.). Despite the concerns, I believe that using the internet to be the most effective method providing distance counseling (Tele-Therapy) and authorize Ebenezer Counseling Services (ECS) to provide counseling via the Internet or phone.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session. Please list your main number and an alternate number here: _____ _____.

By agreeing to Internet counseling with ECS, I understand that ECS will keep all information confidential to the degree that ECS has ability; however, I acknowledge that I am responsible for the security of my home computer or electronic device to ensure that electronic information remains confidential. I also acknowledge that Internet communications whether email, Skype, or other method are not secure, and I am willing to take the risk in order to proceed with the counseling process.

_____ _____
1st Signature Date

_____
Printed Name

_____ _____
2nd Signature Date

_____
Printed Name

Please return to ECS.
You may give this to your therapist.
Or drop it off at either office.
Or Fax it to us at 865 670-1991.
Or mail it to us at 325 Ebenezer Road, Knoxville, TN 37923.