Parental Permission to Treat a Minor

Kanawha Pastoral Counseling Center
16 Leon Sullivan Way, Suite 300
Charleston, WV 25301
304-346-9689 www.kpcc.com

Client Name: _____

Date: _____

I hereby give permission for (child's name) _____

my (child, ward, etc.) _____, who is _____ years old, for counseling at KPCC.

1. I hereby verify that I have the legal right to bring this child for counseling. Initial: _____
2. If child's parents live separately, or are divorced, I verify that I have sole/joint (circle) decision making responsibility for my child's emotional/mental/medical health care. Initial: _____
3. If the court order does not specify sole responsibility for regular (non-emergency) medical treatment, this form must be signed by both parents.
4. I understand that the therapist will likely contact both parents to gather information and to discuss treatment options.
5. I understand that all consultation between the above-named child/client and the therapist shall be held in strictest confidence. I will not ask the child/client or the therapist to divulge the contents of their conversations.
6. I may ask to be included in a joint session with the therapist and the child/client if I have any concerns which I wish to share with either of them.
7. I may also ask to meet individually with the therapist to discuss issues related to my parenting of my child.
8. Anything I choose to share with the therapist about the child/client by phone or otherwise may be communicated to the child/client by the therapist.
9. I understand that if the child/client poses a threat to the physical well-being of him/herself or others the therapist will inform me of the danger. I understand that if the therapist has a reason to suspect neglect or abuse of my child, the therapist is obligated to report this to Child Protective Services.

_____ _____ ____/____/____
Signature of Mother or Guardian 1 Phone Date

_____ _____ ____/____/____
Signature of Father or Guardian 2 Phone Date

Statement of Confidentiality

Maintaining confidentiality is very important to us at Kanawha Pastoral Counseling Center. No information about you will be released to other parties without your written permission. Limited information will be released to your insurance company as required.

We make every effort to protect your privacy; however, there are three occasions in which all therapists are mandated by law to break confidentiality.

1) If a client indicates he/she is considering suicide the therapist will take necessary action to help ensure the client's safety. If the client is a minor, his/her parent or guardian will be involved in the arrangement.

2) If a client indicates he/she is planning to harm another person, the therapist will notify the proper authorities and/or the intended victim. If the client is a minor, the parent or guardian will be involved.

3) If a client indicates he/she has knowledge of the abuse or neglect of a child, an elderly person, or a person who is mentally or physically impaired, Child or Adult Protective Services will be contacted. This may also be done without your consent or knowledge.

By signing below, I acknowledge the statement of confidentiality and agree to the above.

_____

Client/Guardian Date

_____

Client/Guardian Date

_____

Client/Guardian Date

_____

Therapist Date

Symptom Checklist- Under 18

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Name _____

Date _____/_____/_____

Please ***check*** all that apply and ***circle*** specific items in parentheses.

____ ***School Problems*** (frequent absences, poor grades, refusal to go, gets in trouble, doesn't do homework, suspended, disorganized, fights)

____ ***Drug Use*** (alcohol, cigarettes, marijuana, LSD, cocaine, other)

____ ***Abused by*** (physical, sexual, verbal) (parent, boyfriend/girlfriend, relative, other)

____ ***Depressed*** (crying, sadness, tired, sleeps a lot, can't sleep, grumpy, withdraws)

____ ***Parents*** (divorced, separated, argue)

____ ***Parent Problems*** (don't get along with, little contact, don't like partner/spouse, too strict)

____ ***Attention*** (Doesn't: listen, finish projects, organize, is: forgetful, distracted, easy mistakes)

____ ***Hyperactive*** (fidgety with hands or feet, talks a lot, can't sit still, interrupts)

____ ***Anxiety*** (nail-biting, crying, headaches, pulls hair, nervous body movements)

____ ***Fears*** (of _____)

____ ***Stress*** (school, parents, grades, schedules, step-parent, other)

____ ***Eating Disturbances*** (overeating, not eating, vomiting, bingeing)

____ ***Suicide*** (attempt, gesture, threat, warning signs)

____ ***Self-Harming Behaviors*** (cutting, body piercing, burning)

____ ***Behavior/Acting Out*** (argues, quick temper, not listening, breaking curfew, ignores rules)

____ ***Aggression with*** (animals, siblings, parents, peers)

____ ***Broken Laws*** (theft, weapons, fire setting, runaway, breaking in, destruction of property)

____ ***Self-Esteem Low*** (with friends, school, family, job, boy/girlfriend)

____ ***Compulsive Behaviors*** (excessive washing of hands, checking things, worrying)

____ ***Pregnancy*** (current, previous, has a child, miscarriage)

____ ***Trauma*** (death of someone, date rape, rape, car accident, other

____ ***Sexuality*** (dating relations, excessive curiosity by a child, acting out, STD's)

____ ***Wetting or soiling*** self

____ ***Sleep Disturbances*** (nightmares, falling sleep, sleeps too much, restless)

Directions

Kanawha Pastoral Counseling

KPCC offices are located in Church facilities

First Presby Church, Charleston - for Sky, Andy, Rosie, Sabrina, Ric, Bob
Take the Leon Sullivan exit from I-64. Go straight on Leon Sullivan Way, the Clay Center will be on your left. Stay on Leon Sullivan and go straight through four traffic lights, and cross straight through at Virginia. First Presby is the last Church on the left, across from the Charleston Catholic High School. There are no outdoor signs for KPCC. Click here to go to a street map: Map of 16 Leon Sullivan Way Charleston, WV 25301-2402, US

First Presby takes up the whole block on the left side of Leon Sullivan Way, between Virginia and Kanawha Boulevard, in Charleston. The driveway entrance into the Church parking lot is half-way down this last block, on the left. As you pull into the driveway you will see a double glass door on the building on your left (the bigger building), come in through those doors and take the elevator up to the 3rd or 4th Floor.

Sabrina, Rosie, Ric, and Bob are on the 3rd floor. Go down the hall to the waiting area.
Sky and Andy are on the 4th floor, the waiting area is in the hallway. If you are not sure if you are at the right place or the right time, please feel free to check in at the KPCC main office on the 3rd floor. Call us if you are lost, 304-346-9689.

Directions to Ann Martin's office at Christ Church United Methodist in Charleston
Take the Leon Sullivan exit from I-64. Go straight on Leon Sullivan Way to Virginia St. Turn left, go two blocks and left again on Morris St, one block and left on Quarrier St. then immediately left again into the church parking lot. If the first lot is full go across the alley for more parking.
When you enter the church from the parking lot you will be in a wide hallway. About half-way down the hallway there is an elevator. Take the elevator to the second floor, Room 230..

Directions to Jack Stringfellow's office at Trinity Lutheran Church in Charleston
Trinity is at 1600 Kanawha Blvd East. From I-64 take the Greenbrier St exit and head towards the river, the capitol will be on your left. Go all the way to the end at Kanawha Blvd (by the river), take a right, Trinity Lutheran will be on one block at Elizabeth Street. It is a red brick building. Turn Right onto Elizabeth and another quick right into the parking lot. Come to the double doors off the parking lot. I'll meet here at your appointment time. If, by chance, the door is open and you get into the building, turn to your right, go up the short steps, and go right into the lounge area till I come out of my office for you at the appointment time.

Directions to Andy Counts' Friday office in Hurricane in the Reese Building
The Reese Building is located at 3520 Teays Valley Rd. (Rt.34) in Hurricane, right across from the Hurricane City park; next door to the Family Practice of Drs. Yeager and Smith, in the office of King's River Worship Center.

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Client Information and Consent Form

Name _____

Street_____

City _____ State _____ Zip _____

Day Phone _____ Night Phone _____ Cell Phone_____

Email address (useful for scheduling - please print clearly) _____

Birth date _____/_____/_____ SS # _____/_____/_____ Age ___ Sex (M/F) _____

Emergency contact person: _____ Phone: _____

Parent, Guardian or Family Member: _____ Phone: _____

Insurance Information: (Please give your insurance card to the receptionist so we can make a copy of it for our records.)

Name of Insurance Co: _____ Telephone:_____

Name of Policy Holder: _____ Policy Holder's SS#:_____/_____/_____

Policy Holder's Employer: _____ Policy Holder's Date of Birth: _____

Group / Policy #:_____ Insurance ID# (if different than SS#) _____

Authorization and Consent for Treatment and HIPAA Notification

I hereby give my consent to KPCC to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate.

I authorize KPCC to directly bill and receive payment from my insurance company and/or other persons liable to pay my bill. I assign my right to receive payment directly from any available source to KPCC. I will get authorization from my insurance company for any of KPCC's services if it is required by my policy. I will personally pay all charges not paid by my insurance company or anyone else.

I am aware of the KPCC "Notice of Privacy Practices" and understand a hard copy can be provided at my request and via www.kpcc.com/counseling/forms/. I understand that KPCC may make verbal summaries or send summaries or records of my evaluation and/or treatment to my insurance/managed care company for clinical review as part of its responsibility to manage my care. I further understand that these services are confidential and that information about me will not be disclosed or released to anyone other than authorized KPCC staff without my written consent, with the following exceptions: 1. Information necessary to authorize services or pay claims will be communicated to the insurer/claims payor when required. 2. If I disclose information in the course of evaluation or treatment which indicates I present a clear and present danger to myself or others. 3. As mandated by state or federal law.

Signature of Client: _____ Date: _____

If signed by guardian, guardian's authority is based on ___

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Medical History Form

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Client Name _____

Date _____/_____/_____

Family History:

Where were you born? _____ Where did you grow up? _____

Number of siblings _____ Your birth order _____ (youngest, oldest, etc.)

Do you have any family members who have been in counseling or hospitalized for psychiatric reasons?

Do you have any family members who have struggled with addictions?

Do you have any family members who have struggled with hurting themselves or others?

Medical/Surgical History:

Do you have a regular Doctor? _____ Name _____ Phone _____

Date of Last checkup _____

KPCC encourages its clients to have a regular medical exam at least once a year. Medical issues can sometimes cause mental, emotional or relational distress, and so it is important to rule these out as not being a factor in what has brought you to counseling.

If you do not have a regular doctor, we urge you to get one. If you do not have insurance or a medical card, you may qualify for free medical service at WV HealthRight.

Please check any illness you currently have or had in the past.

_____ Diabetes	_____ High Blood Pressure	_____ Lung Disease	_____ Sex Trans Disease
_____ Rheumatic Fever	_____ Low Blood Pressure	_____ Cancer	
_____ Arthritis	_____ Heart Disease	_____ Jaundice	_____ Kidney Disorder
_____ Thyroid Disease	_____ Pneumonia	_____ Hepatitis	_____ Head Injuries
_____ Anemia	_____ TB	_____ Cirrhosis	_____ Injuries
_____ Ulcer	_____ Colitis	_____ Bone Disorder	_____ Muscular Disorder
_____ Nerve Disorder	_____ Seizures		

_____ Other: _____

(over please)

Please list any medications you are currently taking**.**

Medication	Dosage	Reason	Start Date	Doctor

Any drug sensitivities or allergies: _____

Daily consumption of coffee, tea, or soft drinks containing caffeine: _____

Estimated consumption of tobacco: _____ per day per week. Type: _____

Estimated consumption of alcohol: _____ per day per week. Type: _____

Estimated use of "recreational drugs": _____ per day per week Type: _____

Do you have easy access to a firearm? _____ Is it loaded? _____ Is it locked? _____

KPCC recommends that clients who have access to firearms take precautions that the firearms be locked and stored unloaded. If there is anyone in your household, including yourself, who may be depressed or angry, we urge you to remove the firearms completely from the house.

Traumatic Life Experiences _____

_____

Have you had counseling before? When? _____

With Whom? Was it helpful? _____

Have you ever thought about hurting yourself? _____ How recently? _____

Have you ever tried to hurt yourself? _____ How recently? _____

Have you ever thought about hurting someone else? _____ How recently? _____

Have you ever tried to hurt someone else? _____ How recently? _____

Client / Therapist Agreement

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Name _____

Date _____/_____/_____

I agree to abide by the following policies in my relationship with my therapist and Kanawha Pastoral Counseling Center, Inc.:

1. I agree to keep any appointment made between me and my therapist. I understand that any change or cancellation must be made 24 hours in advance of the appointment time or the Missed Session Fee will be charged. Messages can be left on KPCC voice mail when the office is closed. If my Insurance does not pay for a late cancellation, I will be responsible for the full fee. Sessions are considered cancelled due to inclement weather if there is a county school closing. Missed group sessions will be charged full group fee, even with advance notice. KPCC may use a medical billing agency if I have an overdue or outstanding balance.

2. I may be asked to have a psychiatric examination, a medical checkup, and/or psychological testing. I will be responsible for these fees. Appointments with the KPCC Medical Director require advance payment of the full fee and payment is expected before an appointment is scheduled.

3. My confidentiality will be carefully protected by the KPCC staff. I am aware of specific situations in which WV law sets limits on my privilege of confidentiality: These are if I disclose to my therapist or a staff member any of the following: a) my intent to harm myself; b) my intent to harm other persons; c) my involvement in abuse or neglect of children or of elders. I will be honest and candid with my therapist about any of the above impulses or actions. I understand that KPCC will take action to protect me or others; such as notifying the Department of Human Services and/or other appropriate persons or agencies.

4. KPCC may offer me a fee subsidy based on my financial circumstances. This subsidy will not apply for missed sessions, for psychiatric services, or for case management services, such as letters or conferences related to my therapy or for offering legal testimony, etc.

5. Telephone contacts for purposes other than setting appointment times will be billed on a prorated basis. Long distance conferences will be initiated by the client.

6. KPCC office hours are Monday through Friday, 9 am through 5 pm. My therapist will be available to meet with me by appointment only. Emergency services are not available at KPCC. If I am in crisis I agree to seek help through the Emergency Room services of the hospital closest to me, or by calling 911. If I anticipate a crisis I will make arrangements with my therapist for appropriate support.

7. If I receive a benefit for therapy costs through a health insurance plan, I may elect to pay my share at the time of the session and to sign over insurance payments to the Center. Statements not honored by the insurance company remain my responsibility. I will reimburse KPCC for any insurance benefit incorrectly paid to me.

8. Fees: $ 175 per 60 minute session; $85 per group session; $175 case management hour

   My payment: $_____; insurance payment: $ _____; Other 3rd Party $ _____;
   Fee Subsidy: $ _____; deferral: $ _____
   Missed Session / Late Cancellation Fee: $100
   I understand that payment is expected and due at the time of each session.

9. I understand and agree to follow the KPCC policies stated above:

_____ _____
Witness Client Signature

_____/_____/_____ _____/_____/_____Date
Date