Reflections Counseling Center

Child Personal History Information

Welcome to Reflections Counseling Center (RCC)! The purpose of this form is to get a better understanding of your child's background and presenting issues. Please note that this information is confidential and, within all legal limits, will not be shared with others.

Child's Full Name:_____ Date of Birth: _____
Parents/ Guardians: _____
Child's parents are: married divorced separated deceased unknown
Who has custody of the child and in what proportions? _____
_____
Are you willing to provide paperwork of any custody agreements? Yes No
Child's Primary Address:_____
City:_____ State:_____ Zip Code: _____
Parents/ Guardians Phone #'s: _____
May we leave a message at any of the above #'s? Yes No Specify: _____
Parents/ Guardians E-Mail Addresses: _____
May we email you with announcements and other clinic information? Yes No
Child's School: _____ Grade Level:_____
Child's Typical Grades/ GPA: _____

EMERGENCY CONTACT

Name: _____ Phone: _____
Address:_____
Relationship to child: _____

REASON FOR VISIT

Provide a brief history of the issues for which you are seeking assistance:

What is your desired outcome from therapy?

SOCIAL HISTORY

Describe how your child relates to people. (e.g., outgoing, shy, leader, follower, etc.)

_____

Does your child isolate himself/ herself from others? Yes No

With whom does your child socialize?_____

What are your child's strengths and abilities?_____

_____

Has the child ever affiliated with a church? Yes No

Is the child affiliated with a church now? Yes No

If yes, what church?_____

Would you like prayer incorporated into therapy sessions? Yes No

What cultural or ethnic groups does the child belong to?_____

Does the child closely identify with this group? Yes No

What strengths has the child acquired from this identity? _____

_____

Which of the following substances does the child use or have they used in the past?

Type	Amount	Frequency
Alcohol		
Marijuana		
Cocaine		
Hallucinogens		
Amphetamines		
Pain Medication		
Sleeping Pills		
Tranquilizers		
Narcotics		
Other		

How often does the child become intoxicated or high at the present time?

Never____ Once a month____ Once a week____ 2-3 times a week____ Daily____

Has the child had a problem (now or in the past) with substance abuse? Yes No

If yes, please explain:_____

_____

FAMILY HISTORY

Please provide the names and ages of the child's family members:

Parents _____

Siblings _____

Extended family that the child is currently close to: _____

_____

What patterns of dysfunction might the child's family have? _____

_____

_____

What strengths and resources does the child's family have? _____

_____

_____

Has any family member suffered from mental illness or severe depression? Yes No
If yes, please explain: _____
Has any family member had a problem (now or in the past) with substance abuse? Yes No
If yes, please explain:_____

_____

Does any family member suffer from any chronic medical conditions? Yes No
If yes, please explain:_____

_____

MEDICAL HISTORY

Child's Primary Care Physician:(name, phone#, address, etc.) _____

_____

Please list current medications/ dosage/ frequency _____

_____

If prescribing physician is different from the child's primary care physician, please state name and contact phone:_____
Date of most recent physical exam:_____
Any abnormal results? Yes No If yes, please explain: _____

_____

How would you describe child's general health? Good Fair Poor
Is child experiencing any abnormal physical symptoms? Yes No
If yes, please explain:_____
Is child currently receiving medical treatment? Yes No
If yes, please explain:_____
Child's birth was: Vaginal Cesarean Term Premature Adopted
Any complications at birth or shortly after birth? Yes No
If yes, please explain:_____
Has child ever been diagnosed with learning disorder? Yes No
If yes, please explain:_____
Has child ever been diagnosed with ADD or ADHD?
If yes, when and by whom?_____
Does child have any chronic conditions? (e.g., diabetes, anemia, cancer, asthma, etc.) Yes No
If yes, please explain:_____
Does child have any allergies? Yes No
If yes, please explain:_____

Any history of serious accidents or injuries? Yes No
If yes, please explain:_____
Does child have any physical disabilities or limitations? Yes No
If yes, please explain_____

Does child currently use self-injury as a coping mechanism? Yes No
If yes, please explain:_____
Has child self-injured in the past? Yes No
If yes, please explain:_____

Please list child's prior treatment for emotional and/ or behavioral difficulties including outpatient and inpatient treatment and approximate dates:_____
_____
_____
_____
_____

How were you referred to RCC? Google Facebook Friend/ Family Doctor Newspaper other: _____

History completed by:

_____	_____	_____
Parent/ Legal Guardian Name	Signature	Date

_____	_____	_____
Therapist Name	Signature	Date

Thank you for taking the time to share this important information!
We look forward to a relationship of health and healing with you.

Office Use Only
Therapist:_____
Diagnosis:_____

Reflections Counseling Center

Client Rights & Orientation Agreement

Welcome to Reflections Counseling Center! This document contains important information about your rights as well as our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our meeting. Please be aware that once you sign this, it will constitute a binding agreement between you and Reflections Counseling Center (RCC).

Client Rights:

As a client of RCC, you have certain rights. Along with your rights, you have our promise that we will not only keep you informed of your rights, we will protect them on your behalf.

You have the right to confidentiality. The information you exchange with your therapist is held in strict confidence and can only be shared under very specific circumstances. Your therapist will discuss exceptions to confidentiality with you should the need arise.

You have the right to privacy. The care that you need will be provided in a private and safe atmosphere. You do not have to interact with anyone not directly involved in your treatment.

You have the right to caring, respectful service. You will never be exposed to physical, emotional, or any other form of abuse.

You have the right to be free from any and all forms of exploitation. You will never be taken advantage of financially. You will never be subject to any type of retaliation, humiliation or neglect.

You have the right to access any information regarding your care at the clinic. You have the right to discuss with your therapist your plan of treatment and to request any literature or educational materials pertaining to your plan of treatment.

You have the right to choose a therapist who best suits your needs and purposes. You may, of course, seek a second opinion from another mental health practitioner, and you have the right to terminate your treatment at any time.

You have the right to consent to or refuse treatment.

You have the right to be informed of policies regarding the release of treatment information. We handle your confidential information with the utmost care. Your therapist will discuss our Authorization/ Release of Information Form with you should the need for release of such information ever become necessary.

You have the right to view your own record at RCC. Should you desire to view all or part of your file/ record at RCC, you (and your therapist) will complete an Authorization/ Release of Information Form. Unless it is deemed unsafe by the clinical staff, you will receive access to this file within one week of your written request. See your therapist or the clinic director for details on this and for possible fees for this process.

You have the right to consent to the release of your treatment information for the purpose of concurrent treatment or continuity of care with other medical or mental health professionals.

You have the right to be informed of and consent to the opportunity to participate in research projects should any members of our clinical staff become involved in such projects. Our staff will always adhere to professional and ethical research guidelines.
You have the right to request and receive information regarding self-help or advocacy groups that pertain to your care.

You have the right to report any suspected unethical behavior to:
Department of Health, Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling, 4052 Bald Cypress Way Bin C-08, Tallahassee, FL 32399-3258

You have the right to formally complain to Reflections Counseling Center about any aspect of your care or treatment by any member of our staff. Complaints will not result in any retaliation or barriers to further service. Complaints will be addressed in a timely manner. A Complaint Form is available from your therapist or if confidentiality is desired, make a comment through our website at www.reflectionscc.com

Orientation Agreement:

I acknowledge and understand that:

- I am voluntarily authorizing treatment for myself, or for my dependent,_____, at Reflections Counseling Center.
- Appropriate personnel will render the treatment. The primary therapist will be:_____
- I may contact the clinic or the primary therapist as the need arises at 941-301-8420. If the primary therapist is unavailable, the clinic will arrange for contact as soon as possible by the primary therapist, another professional staff member, or direct me to go to my nearest hospital's emergency room.

Psychological Services:

Psychotherapy at Reflections Counseling Center incorporates the integration of psychology and Christianity. It involves a set of techniques intended to improve mental health and emotional or behavioral issues in individuals. Psychotherapy varies depending on the particular problems that the client brings, as well as the personalities of both the therapist and the client. There are a number of different approaches that can be utilized to address your problems. At Reflections Counseling Center, our clinicians most often work from well-known and researched theoretical perspectives. Coming to counseling is not like visiting your family doctor in that therapy requires active effort on your part. In order to be most successful, you will have to work on your goals both during sessions and at home.

Psychotherapy has both benefits and risks. Psychotherapy often requires thinking about and discussing unpleasant aspects of your life. Risks sometimes include experiencing uncomfortable levels of feelings such as sadness, guilt, anxiety, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to benefit people who undertake it. It often leads to more healthy relationships, resolutions of specific problems, and ultimately a significant lessening of feelings of distress. However, although there are no guarantees about results you will experience, know that your therapist is a committed Christian who cares and is prayerful about you and your treatment.

Policy Regarding Assessment, Treatment Plan and Continuing Care Planning:

Reflections Counseling Center is a client-centered counseling clinic. As we meet in our first session, your therapist will be asking you questions regarding your previous and current health status, in order to help best understand your current situation. This assessment helps your therapist to know which treatments are best suited for you as you develop a plan together. We also want you to know that *your* goals during treatment are of utmost importance to us, and we will be implementing a treatment plan by your fourth session, with those goals at the foreground, using our assessment as the clinical mechanism. We are also aware that your ultimate goal may be to achieve your goals and discontinue services at REFLECTIONS COUNSELING CENTER. We support this goal and will help you create a Continuing Care Plan that will assist you in making your life changes last after you have ended counseling. We believe this will aid you in continuing to live a more meaningful and healthy life, thereby accessing your God-given potential.

Policy Regarding Termination:

The successful termination of treatment is determined when my therapist and I agree that the treatment goals have been substantially completed. I understand that I may be discharged from the clinic by my therapist for the following reasons:

1. I have successfully completed the treatment program to which I initially agreed, implying that I have made significant progress toward meeting treatment goals.
2. I chose to terminate treatment.
3. I need to withdraw due to medical, financial, legal problems, or geographic issues.
4. My lack of attendance and/ or motivation prevents further progress toward goal achievement. If I have not appeared for face-to-face contact for sixty days, I will be contacted and asked if I want my file terminated. If a response has not been given within ninety days, the case will be terminated.
5. I have demonstrated inappropriate behavior relative to self, staff, or other clients, which is disruptive to the therapeutic process (i.e. threatening and/ or intimidating behavior).

6. I refuse to make appropriate financial arrangements to pay for therapeutic services when I have the financial ability to do so, and this is seen as a treatment issue.
7. I fail to comply with the provisions of this orientation agreement.

Payment Policy:
My therapist, _____ and I have agreed that I will pay $_____ for the initial 50 minute therapy session, and $_____ for each 50 minute session thereafter.

It is the policy of the clinic that all services rendered are paid for at the time of session. Acceptable method of payment consists of cash, check (payable to Reflections Counseling Center), Visa or MasterCard. If paying with insurance, when possible RCC will assist you in determining what your benefits are, but you are to verify this information with your insurance company. If problems arise with respect to reimbursement, RCC will attempt to help you resolve them, but the ultimate responsibility for the full fee for service is yours. When insurance companies notify RCC of changes in your insurance policy, RCC will let you know about them but this also, is ultimately your responsibility. There will be a $25.00 service fee for all bounced checks. You have the right to pay for services out of pocket. If you choose to pay out of pocket but are in financial need, let your therapist know as some therapists also offer reduced rate plans. Accounts overdue 60 days will be given a written final notice. If no payment is received on your account after 30 days from the final notice your Reflections Counseling account will be sent to collections with an additional 10% collection fee added to your balance.

Confidentiality:
1. If you use health insurance or government grant money to pay for services, the payer must require access to your records to validate that the services were needed and/ or provided. You should be aware that most insurance companies require a clinical diagnosis and other treatment information, which will become part of the insurance company record. A release of information form signed by you will be required before your records are released to the listed person(s) and/ or agencies.
2. If a court ("court-ordered" therapy) has referred you the court will expect to receive an evaluation or report(s). Before you disclose any confidential information, speak with your therapist about what information may be disclosed in any report to a court. Court-ordered cases are usually not covered by your insurance, and are to be paid for in full at the time of services.
3. If you threaten to harm either yourself or someone else, the law obligates us to take whatever action is necessary to protect you and others from harm. This may include divulging confidential information to others. Such action will be taken when someone's life appears to be in danger.
4. If we have reason to believe that you are, or are party to, abusing or neglecting children, we are legally obligated to report this to the appropriate state county, or city agency.
5. If you are involved in litigation of any kind and inform the court that you are receiving or have received services from us resulting in your mental health being an issue before the court(s), you may be waiving your right to keep our records confidential. You may wish to consult your attorney before disclosing to a court that you have received or are receiving services.

Hours of Operation:
The services through Reflections Counseling Center are offered Monday through Saturday from 9:00AM to 8:00PM by appointment only. Appointments at times other than the regular office hours may be scheduled only with the agreement of the primary therapist. If you would like to leave your therapist a message, you can do so by calling 941-301-8420. If you have an emergency at any time, you must call 911 or go to your nearest emergency room.

Policy Regarding Late Appointments & Cancellation:
If you need to cancel an appointment, Reflections Counseling Center requires that you give 24-hour notice in order to avoid being charged a session fee. Your therapist has reserved that time slot for you, and you will both benefit if you are on time to your appointments and responsible about cancellations. If you are late for your appointment, you will not get extra appointment time, but will use whatever time is left of your planned session when you arrive (example: 1PM to 1:50PM appointment time is still your allotted time even if you arrive fifteen minutes late and miss part of it). If you have a true emergency that is not anticipated, the 24-hour notice policy is waived. Please note that insurance companies cannot be billed for missed sessions for which you are charged and therefore you will be personally responsible to pay the fees.

Policy Regarding Continuous Quality Improvement:
It is the policy at Reflections Counseling Center to carefully monitor ourselves to make sure our services are of utmost quality for our clientele. With your permission, we may utilize surveys throughout the counseling process, which help us to determine client satisfaction, how successful treatment is/ was, and also the quality of care we are giving.

Policy Regarding Tobacco, Drugs, Weapons, Violence and Threats:
We at Reflections Counseling Center want to protect all clients and staff. We will not tolerate any violence or jeopardize the safety of our clients. If you bring a weapon, commit an act of violence or threaten to, you will be terminated from the program and the police will be called immediately. **REFLECTIONS COUNSELING CENTER prohibits the use of seclusion and restraint so we will not physically place holds on violent persons. Instead, the police will be called immediately. If this is the case, you will be given a referral to another program within 72 hours. If you would like re-admittance into REFLECTIONS COUNSELING CENTER as a client after a violent, threatening, or otherwise unsafe act, we require a one-year waiting period as well as a written referral from the program you participated in.** If you bring any illicit or licit non-prescription drugs into REFLECTIONS COUNSELING CENTER, and are under the influence of them when you arrive, we will call your emergency contact to arrange for a ride to pick you up if you drove to the clinic. If you leave, we will call the police. The tobacco policy is that we are a smoke-free environment. All smoking will be done off premises. Underage smoking is not allowed anywhere in or around our building.

Policy Regarding Advance Directives:
If you have advance directives [1] that involve your therapist and treatment, please submit a copy of them in writing.

Policy Regarding Infectious Diseases and Universal Precautions:
According to state law, communicable diseases such as HIV, Hepatitis B and C, TB and other infectious diseases must be reported to the Michigan Department of Community Health. If it is discovered that I have a communicable disease, I consent to such disclosure. To prevent any spread of germs, infections, or diseases, I agree to universal precautions.

Policy regarding Safety:
There are emergency exits, stairs as well as an elevator in The Swift Building. There is a first aid kit located in the counseling room. In case of power failure, there are battery-operated flashlights in your counseling room. Ask your therapist if you become in need of these services while you are here.

I have read the RCC Orientation Agreement and understand my rights as well as obligations as a client:

_____ _____

Parent/ Legal Guardian Signature Date

[1]These directives pertain to treatment preferences and the designation of a surrogate decision-maker in the event that a person should become unable to make medical decisions on their own behalf. Advance directives generally fall into three categories: living will, power of attorney and health care.

Reflections Counseling Center

HIPAA Agreement

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.

1. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
2. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
3. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by Reflections Counseling from or on behalf of Client/ Client Guardian.
4. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.
5. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

Obligations and Activities of Reflections Counseling

1. Reflections Counseling agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
2. Reflections Counseling agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
3. Reflections Counseling agrees to mitigate, to the extent practicable, any harmful effect that is known to Reflections Counseling of a use or disclosure of Protected Health Information by Reflections Counseling in violation of the requirements of this Agreement. [This provision may be included if it is appropriate for the Client/ Client Guardian to pass on its duty to mitigate damages to Reflections Counseling.]
4. Reflections Counseling agrees to report to Client/ Client Guardian any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
5. Reflections Counseling agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Reflections Counseling on behalf of Client/ Client Guardian agrees to the same restrictions and conditions that apply through this Agreement to Reflections Counseling with respect to such information.
6. Reflections Counseling agrees to provide access, at the request of Client/ Client Guardian, and in one week's time, to Protected Health Information in a Designated Record Set, to Client/ Client Guardian or, as directed by Client/ Client Guardian, to an Individual in order to meet the requirements under 45 CFR 164.524.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, and we may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures.
Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. You may revoke the authorization, at any time, in writing, except to the extent that your therapist or practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
The following are statements of your rights with respect to your protected health information:
You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.
You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.
You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.
You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Complaints:
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our director in person or by phone at our main phone number.

Please sign this acknowledgement form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

_____ _____

Parent/ Legal Guardian Signature Date