CAMBRIDGE COUNSELING CLINIC INC.
120 East Main Street - P.O. Box 548 - Cambridge, WI 53523

Child/ Adolescent Client Information Sheet (Diag. Code_____)

Child's Legal Name:_____ Nickname: _____
First Middle Initial Last

Date of Birth: _____ Current Age: _____ Gender: Male ____ Female: _____

School: _____ Grade: _____

Classroom Teacher or School Contact Person : _____

Child lives with: ___ Biological Parents ___ Adoptive Parents ___ One Parent Alone ___ Parent/ Step-Parent

____ Extended Family Member _____ ___Other _____

Parents are: ___Married ___ Living Together ___Separated ___ Divorced ___ Widowed ___ Never Together

Custody Status: Physical Placement _____ Legal Custody _____

Mother's Name: _____ D.O.B.: _____ Phone:_____

Father's Name _____ D.O.B: _____ Phone: _____

Address:_____

City_____ State_____ Zip_____

Place of Employment: Father: _____ Mother: _____

Circle preferred way to contact Mother: Phone Call Text Email _____

Circle preferred way to contact Father: Phone Call Text Email _____

INFORMED CONSENT AND AUTHORIZATION

State and federal law requires that you be informed about the information to be released from your records. Permission for this release of information must be given in writing.

Communication with your physician: Our clinic policy is to keep your physician generally informed about your treatment progress because this affects your overall health.

Communication with insurance companies: Insurance companies are required to pay for services only for certain diagnoses and conditions. It is the policy of the clinic to release a minimum amount of information necessary to successfully process your claim; often this is just the diagnosis code and dates of visits but in some cases, more information is necessary.

Medicare authorization (if applicable): I request that payment of authorized Medicare benefits be made to me or on my behalf to Cambridge Counseling Clinic, Inc. for any services furnished by the clinic. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and it's agents any information to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Payment of Medical Benefits: I authorize payment of medical benefits I am entitled to under the terms of my health care coverage to Cambridge Counseling Clinic, Inc. and agree to be responsible for services not paid, in whole or in part, by my health care payer. This includes balances beyond the usual and customary reimbursement by insurance companies.

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By signing this document on page 3, I am authorizing the Cambridge Counseling Clinic, Inc. to release information and request payments as stated above for the duration of my treatment. I understand that this consent may be revoked by me at any time by giving written notice to the directors of the Cambridge Counseling Clinic, Inc. A photocopy of this consent will be considered as valid as the original.

EXPLANATION OF MENTAL HEALTH TREATMENT

Mental health practitioners at Cambridge Counseling Clinic and contracted practitioners administer services to referred members. Mental health services are provided based on a determination of the medical necessity and appropriate clinical interventions. Services are goal-oriented and usually of brief duration. Psychiatric consultations for medication are available as necessary through a referral by the therapist.

If I feel suicidal or assaultive while participating in treatment, I agree to tell my therapist immediately. In an emergency, I agree to call 911 or the emergency number provided to me by my therapist. I agree to use the mental health crisis line for emergency matters only. I will call the mental health clinic I receive my care from during regular business hours (8:00 a.m. to 5:00 p.m. Monday through Friday) for non-emergency questions.

I understand that I will be responsible for mental health services not authorized and/or not covered by my insurance. I agree to notify the mental health clinic at least twenty-four hours in advance if I must cancel a scheduled appointment.

I may stop treatment at any time. If I wish to begin treatment with another therapist, I may/request this by contacting the clinic I receive care from. If I have a complaint about my therapist, I understand that I can communicate this to my therapist directly or to your Client Rights Specialist: Maria Hanson, P. O. Box 14533, Madison, WI 53714, Telephone: (608) 446-8957.

Privacy Policy

I understand that Cambridge Counseling Clinic is committed to protecting patient confidentiality and that information concerning my treatment will be kept confidential in accordance with organizational policies and procedures. I have a right to inspect my own medical records following Cambridge Counseling Clinic's policies and procedures. Mental health records are confidential and will not be disclosed to anyone outside of Cambridge Counseling Clinic without my consent except in circumstances mandated by law. I understand that medical and mental health practitioners are required to report child physical or sexual abuse to Child Protective Services authorities in the county within which they practice. I understand that confidentiality privileges are waived if I present a threat to my own safety or to that of others. I understand that under limited circumstances my records may be subject to court subpoena and that my therapist may be subpoenaed to testify. If I am attending therapy as a result of a court order or condition of probation or parole, my records will be available to the supervising authority.

CLIENT RIGHTS:

In Wisconsin, clients in outpatient mental health clinics like Cambridge Counseling Clinic, Inc. have many important rights. These are enumerated in the Notice of Privacy Rights found in the waiting room. Please read them at your convenience. The client Rights may be summarized around three issues, which include the following:

INFORMED CONSENT: The right to know the nature of your treatment – its benefits, possible consequences and available alternatives. You have the right to refuse your treatment or any treatment contact at Cambridge Counseling Clinic, Inc.

CONFIDENTIALITY: The right to privacy regarding all conversations and records unless you authorize, i.e., your insurance carrier, your doctor, and anyone else you authorize to become aware of your work at Cambridge Counseling Clinic, Inc. In specific situations involving allegations of child abuse or threat of danger to yourself or others Cambridge Counseling Clinic, Inc. is required to report to authorities. This information is released with our knowledge and preferably with your consent.

GRIEVANCES: The rights to file a grievance if you believe our Client rights have been violated. The grievance procedure is initiated by contacting any Cambridge Counseling Clinic, Inc. staff person with your concerns. If the grievance cannot be resolved at that time, the staff person will arrange a meeting for you with the Directors of Cambridge Counseling Clinic, Inc. If resolution of the grievance does not occur at this informal level, a meeting with Cambridge Counseling Clinic, Inc.'s Clients Rights specialist will be arranged.

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CLIENT PAYMENT INFORMATION

SERVICES:

Cambridge Counseling Clinic, Inc. provides evaluations and psychotherapy services conducted by licensed psychiatrists, psychologists, and licensed clinical social workers. These services may include individual, couple, family or group therapy, various intelligence and personality tests as well as an Admission Evaluation. The Court Ordered Evaluation may result in a referral to other facilities for ongoing treatment.

FEE PAYMENT:

Therapy costs are the responsibility of the client. (In the case of a child, the child's parent or legal guardian is responsible. In the case of a divorce or like situation, the parent seeking therapy services and signing this document will be solely responsible for payment of charges incurred at this facility.) **Please bring billing concerns to the attention of your therapist or office staff so your questions may be answered in a timely manner.**

Cambridge Counseling Clinic, Inc. is not responsible for collection of claims or the negotiation of a disputed claim. **If you are using insurance, any portion of your bill not paid by your insurance or health reimbursement account, is your responsibility.** In the event that Cambridge Counseling Clinic, Inc. needs to use collection or legal service to obtain payment, it is understood that copies of bills, work or home telephone numbers, and Social Security numbers will be provided to the professionals involved.

FEE SCHEDULE:

Insurance Co-Pays Due On Day of Service

Initial Assessment with a	
Psychiatrist	$240.00 per hour
Licensed Psychologist	$210.00 per hour
Clinical Social Worker	$195.00 per hour
Individual Therapy with a	
Psychiatrist	$200.00 – 50 minutes/hour
Licensed Psychologist	$140.00 – 50 minutes/hour
Clinical Social Worker	$130.00 – 50 minutes/hour
Family Therapy with a	
Licensed Psychologist	$180.00 – 50 minutes/hour
Clinical Social Worker	$165.00 – 50 minutes/hour
Medication Management	$120.00 per 15 minutes
Psychological Testing	$125.00 per 50 minutes
Group Therapy	$ 60.00 per 90 minute session

Fees Not Billable To Insurance: Fees Due At Time Of Service

Missed Appointments	$ 130.00 up to full hourly charge
Late Cancellations (less than 24 hours)	$ 130.00 up to full hourly charge
Correspondence, forms, specific reports	Regular rate pro-rated according to time spent
Telephone calls/consultations	Regular rate pro-rated according to time spent
Copies of Records	$ .30 per page

I have received/ reviewed and agreed to the privacy policy, fee schedule, mental health treatment explanation and client's rights for my minor child.

Client Name(print)_____D.O.B._____

Parent/ Guardian Signature _____

Witness (must be 18 or over)_____Date_____

PHONE: 608-423-4700 FAX: 608-423-7751 EMAIL: info@cambridgecounselingclinic.com

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What brings your child to services today? [i.e. Parent's thoughts/concerns about presenting problem(s)]

How has the family attempted to deal with these issues? Were you successful or not?

When did these issues begin? _____

Approximate age of onset: _____ **Years Old**

History of presenting problem(s): When did problems start? What happened around that time? Has the issue changed over time? Is it a consistent problem or is it situational?

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CHILD/ ADOLESCENT INTAKE

Client Name: _____ DOB: _____

Primary Care Physician _____

Clinic Name and City _____

Clinic Phone #_____

Is your child/ teen currently under the care of this doctor for any physical or emotional condition? ☐ Yes ☐ No

Client Health History

List any hospitalizations within the last 3 years.

LOCATION	REASON	YEAR

List any prior mental health services received:

FACILITY OR THERAPIST	REASON	YEAR

Health Concerns/ Conditions

Check all that apply to your child/ adolescent's health.

( ) Allergies/ Asthma
( ) Cancer
( ) Chronic Pain
( ) Dental Health
( ) Diabetes; Type 1/Type 2
( ) Digestive Problems
( ) Ear Infections
( ) Epilepsy/ Seizures
( ) Headaches
( ) Hearing Loss
( ) Heart
( ) High Blood Pressure
( ) Overweight
( ) Sleep Disturbances
( ) Speech
( ) Stomachache
( ) Vision
( ) Other _____

Additional Information: _____

_____

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Current Health Status

List any prescription medications currently being taken. Use the back of the sheet if necessary.

MEDICATION	DOSE	REASON	DOCTOR/ PRESCRIBER

Health Impacting Behaviors

Briefly describe their:

Does your child have problems with sleeping? (Too much, too little, poor quality, night mares)

____No ____Yes If yes, please describe: _____

_____

Do you have concerns about your child's eating habits? (over eating, change in appetite, picky eater, erratic eating patterns)

____No ____Yes If yes, please explain:

_____

_____

What is your child's level of physical activity? How much? What types of activities does he/she do?

_____

_____

How do you rate his/her overall physical health?

( ) Excellent ( ) Good ( ) Fair ( ) Poor

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Please check *all* behaviors or issues that apply to your child/ adolescent; past or present:

( )	Aggression- physical or verbal	( )	Grief and loss	( )	School performance/ attendance
( )	Alcohol or drug use	( )	Hearing voices	( )	Self- harming thoughts/ behaviors
( )	Anger/ irritability	( )	Hyperactive behavior	( )	Sexual identity confusion
( )	Anxiety/ worry	( )	Impulsive behaviors	( )	Sexualized behaviors
( )	Bullying	( )	Juvenile crime	( )	Sibling conflict
( )	Compulsive behavior	( )	Lack of motivation	( )	Stealing/ Theft
( )	Cruelty to animals	( )	Loneliness	( )	Stress
( )	Crying spells	( )	Low self-worth	( )	Suspicion/ Paranoia
( )	Cutting	( )	Lying	( )	Swearing
( )	Defiance	( )	Manipulative behaviors	( )	Social discomfort
( )	Depression/ sadness	( )	Mood Swings	( )	Temper tantrums
( )	Destroying property	( )	Nightmares/ Night Terrors	( )	Thoughts of death
( )	Distractibility	( )	Obsessive thoughts	( )	Thoughts of harming others
( )	Family relationship issues	( )	Panic attacks	( )	Toileting problems
( )	Fear away from home	( )	Personal responsibility	( )	Vandalism
( )	Fire setting	( )	Phobias	( )	Victim of domestic violence
( )	Friendship problems	( )	Poor problem solving skills	( )	Visual hallucinations
( )	Gang involvement	( )	Running away	( )	Witness to domestic violence

Has your child talked or thought about attempting suicide? ___Yes ___No ___Not Sure

Has your child ever made a suicide attempt? ___Yes ___No ___Not Sure

If yes or not sure, please explain the circumstances: _____

_____

_____

_____

Other significant behaviors of your child: _____

_____

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Parenting Information

What do you think are your strengths as a parent? _____

_____

Are the parenting skill areas you would like to learn more about? _____

_____

Legal Status and History

Has this child/ adolescent ever been arrested and/or been placed on probation? No Yes

Is this child /adolescent currently involved in a court action for any reason including custody issues? No Yes

Substance Use and Risky Behavior History

***ATOD= Alcohol, Tobacco, or other drugs**

Have you ever been concerned about your child/ adolescent's ATOD* use? No Yes

Have others expressed concern over your child/ adolescent's ATOD* use? No Yes

Has using ATOD* caused any problems for your child/ adolescent? No Yes

Has your child/ adolescent had prior treatment for ATOD use? No Yes

Approximate age of first ATOD* use: Alcohol? _____ Tobacco Products _____ Drugs? _____

Last date of use and amount of alcohol/drugs consumed: _____

Circle any of the following you would identify as a problem for your minor child:

Gambling	Pornography	Computer/Internet Use
Compulsive Eating	Unhealthy Sexual Activity	Social Media Use

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Family Members

Relationship	Name	Age	Same Residence?

Use the back of the sheet if necessary

Describe your child/ adolescent's current relationships with family members.

Other people in your child/ adolescent's support system besides family members?

Child's Developmental History

Mother's pregnancy was: Routine Problematic Don't Know

Mother used alcohol/ tobacco/ drugs/ medications while pregnant. No Yes Don't Know

The delivery was: Routine Problematic Don't Know

As an infant/ child experienced significant illness, injury, or major surgery. No Yes

If yes, please explain: _____

This child's behavior and personality made parenting and care: Easy Typical Challenging

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Significant Childhood Stressors (Check any that apply to your child/ adolescent.)

- ☐ Death of a Parent/ Caretaker at _____ years old.
- ☐ Death of a sibling at _____ years old.
- ☐ Parents divorced when child was _____ years old.
- ☐ Physical/Sexual Abuse when child was _____ years old. Duration of the abuse: _____
- ☐ Domestic/ physical violence occurred when child was _____ years old.
- Family Alcoholism/ Drug Dependency ___ One Parent ___ Both Parents ___ Other Family Member
- ☐ Family Member with Mental Health/ Psychiatric Illness: _____

Special Care Situations of Childhood (Check any that apply to your child/ adolescent.)

- ☐ Adoption- Age _____
- ☐ Resided with relatives: Age _____ Duration _____
- ☐ Foster Care placement: Age_____ Duration _____
- ☐ Inpatient placement: Age _____ Duration _____
- ☐ History of past or current involvement with Protective Services or County Human Services staff.

If so, please provide the name and contact information for the social worker/ case manager

Name _____

Phone Number _____ Email: _____

Agency: _____

Academic Information:

How many different **school districts** has this child/ adolescent attended? _____

Does he/she have attendance problems? No Yes

Does he/she have a history of behavior problems? No Yes

If yes, please describe: _____

_____

Does he/she receive additional academic support? No Yes- Special Education/ 504 Plan

Tutoring/ Mentoring

Other