Amy Allen Meyer & ASSOCIATES
Where families find hope

Amy Allen Meyer, M.Ed. LPC, RPT-S, NCC
5850 Town and Country Blvd., Suite 1201
Frisco, Texas 75034
972.335.3933
www.AmyAllenMeyer.com

Child/Teen Intake Form

Date_____ Referred by_____

Child's Name_____
Last First Middle Nickname

Date of Birth_____ Age_____ Sex_____ Grade_____

Mother's Name_____ Date of Birth_____

Address_____
Street City State Zip

Phone Home _____ Cell _____ Work_____

Mother's Employer _____ Email_____

Father's Name_____ Date of Birth_____

Address_____
Street City State Zip

Phone Home _____ Cell _____ Work_____

Father's Employer _____ Email_____

Religious Preference (Optional)_____

In the event of an emergency and I must cancel, where should I call?_____

Non-Family Emergency Contact_____
Name Cell/Home Work

What concerns do you have about your child?_____

_____

_____

How long have these existed?_____

What do you think might be causing this?_____

_____

_____

Anyone else expressed concerns about your child?_____

_____

What are your expectations for therapy? _____

_____

Has your child ever been seen by another counselor? Yes_____ No_____ Dates_____

Who?_____ Outcome_____

_____

Family

Name	Age	Education Level or Grade	Occupation	Does child get along with them?
Mother_____	_____	_____	_____	_____
Father_____	_____	_____	_____	_____
Sibling_____	_____	_____	_____	_____
Sibling_____	_____	_____	_____	_____
Step Parent_____	_____	_____	_____	_____
Step Sibling_____	_____	_____	_____	_____
Half Sibling_____	_____	_____	_____	_____

List all persons living in the home with child_____

Current marital satisfaction of Mom _____ Dad_____

Has child been impacted by any serious marital strife? Yes_____ No_____ When?_____

_____

Is child adopted? Yes_____ No_____ When?_____

Parents significant unhappiness or worry during child's first three years?_____

_____

Divorce? Yes_____ No_____ When?_____ Length of marriage to child's biological parent_____

If divorced, describe **your** relationship with the child's other biological parent_____

Dates of remarriage: Mom_____ Dad_____

Describe **child's** relationship with step mom/dad_____

Any history of mental illness in family, diagnosed or undiagnosed in child's blood relatives (parents, grandparents, siblings, aunts, uncles, etc)? _____

_____

Biggest struggle in your family's history_____

Current stressors in family_____

Child's reaction to birth of sisters and brothers_____

Parental unemployment? Dates:_____

Any deaths your child has experienced? (family, friend, pet)_____

Any moves? If so, when and where_____

Child exposed to disaster? Describe_____

Any lengthy separation from either parent?_____

Child's contact with other children (church, sporting events, etc.)_____

_____ How often?_____

What are your child's favorite activities?_____

What does your child dislike doing the most?_____

Describe your child's temperament_____

Who is your child like?_____

What are your child's strengths?_____

What makes your child mad?_____

What are your child's responsibilities?_____

Developmental History

Parental attitude of pregnancy_____

Was mother on medication or drugs during pregnancy? If yes, explain_____

Mother's health after delivery_____

Primary caretaker for first year_____

Did Mother and child attach/bond? _____ Did Father and child attach/bond?_____

Birth weight_____ Age walked_____ Age talked_____ Age potty trained_____

Please rate your child's development in the following areas:

	Below Average	Average	Above Average
Social	_____	_____	_____
Emotional	_____	_____	_____
Intellectual	_____	_____	_____
Physical	_____	_____	_____
Language	_____	_____	_____
Behavioral	_____	_____	_____

Age began nursery school/day care _____ Any separation problems?_____

Any speech/language isues?_____

Any problems with bed-wetting? _____

Any problems with bladder/ bowel control? _____

Any eating problems? _____

Any sleep problems? _____ Hours per night?_____

Any fears? _____

Any gender identity issues?_____

Sensitivity to sounds, noises, textures?_____

Does your child engage in rituals or exhibit any compulsive behaviors?_____

Any physical, sexual, emotional or verbal abuse?_____

_____

Parenting

Discipline style: Mom_____

Dad_____

How does each parent spend alone time with the child doing something they both enjoy?

Mom _____ How often?_____

Dad _____ How often?_____

Is spending time alone with your child pleasurable or frustrating?_____

Are you confident in your parenting abilities?_____

What desires do you have for your child?_____

What does your family do together?_____

Do parents support each other in parenting?_____

Additional parenting concerns_____

_____

Medical History

Child's Pediatrician_____ Phone _____

Is child currently being treated for any medical problem?_____ If yes, please explain_____

_____

Is child currently taking any medications? If so, list_____

Explain any problems during pregnancy or soon after, including mother's illness_____

_____

Were there problems with delivery?_____

Was child carried full term? If no, explain_____

Any hospitalizations or surgeries?_____

Any head trauma**?**_____ Any physical handicaps or deformities?_____

Any seizures or convulsions**?**_____ Any allergies or drug tolerances?_____

Describe any serious health problems or injuries in family_____

School History

Child's School_____ Teacher_____

Special Class? Yes_____ No_____ Descrribe_____

Current School Performance: Academic

Above average_____ Average_____ Below Average_____ Failing_____

Current School Performance: Behavior

Above average_____ Average_____ Below Average_____ Failing_____

Please describe any academic or behavioral problems your child is experiencing in school_____

_____

When did these begin?_____ Repeated a grade? Yes_____No____ Which one?_____

What do teachers say about your child?_____

Has your child changed schools for any reason?_____

What does your child like best about school?_____

What does your child like least about school?_____

Is your child currently in any after school or daycare program?_____

Any additional comments_____

_____

_____

_____

_____

_____

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Informed Consent

Qualifications

I am a Licensed Professional Counselor in the state of Texas, a Registered Play Therapist-Supervisor and a National Certified Counselor engaged in a private practice providing mental health services to clients directly. My specialization is in Child Therapy and I am qualified to work with individuals, adolescents, children, and families who are confronting various personal, emotional, social and behavioral issues. I am not qualified to work with those individuals who I feel are in need of medical attention.

Nature of Counseling

I believe that the therapeutic relationship with the child and parent is the basis for change and growth to occur. We (parents and therapist) will all work together as a team. Your child's feelings, thoughts, behaviors and perceptions will be explored in session and I will help them understand how their behavior is directly related to their views on self, others and the world. I will encourage them in finding new solutions while working with you, the parent, to find ways to have a more satisfying and rewarding family life.

Some children need only a few counseling sessions while others may require more. I will be working with you (parents or legal guardians) offering feedback, suggestions, and parenting skills that I feel might be helpful. You have the right to refuse any suggestions you believe might not be beneficial. I can assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Although therapy has proven to be highly successful, please note that it is impossible to guarantee any specific results regarding your child's counseling. Be advised that therapy is not always a pleasant experience. In some cases, it can be a painful and emotional experience and may get worse before it gets better.

This is a professional and therapeutic relationship. In order to preserve the integrity of the relationship, it is imperative that we not have any other type of relationship. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I cannot accept gifts from you or your child, barter or trade services. In public, I cannot acknowledge you and your child unless you and your child acknowledge me first.

Referrals

If at any time for any reason you are dissatisfied with my services, please let me know. You may end our counseling relationship at any point. If you decide to terminate our relationship, please notify me in advance, as it is best to properly terminate the relationship with your child. If at any time a referral is made during our ongoing relationship, I will refer you to a competent professional.

Appointments

Appointments can be made by calling 972.335.3933 or by rescheduling when you are in the office. **In the event that you will not be able to keep an appointment, please notify the office at least 24 hours in advance. Otherwise, you will be billed the customary fee for the missed appointment.**

Your appointment time has been reserved for you and you are encouraged to arrive on time. In the event that you are late, you will still be responsible for the entire fee and will be seen for the remaining portion of your session. I will not be able to make up the time as others with scheduled times after you are affected. I make every effort to be on time. In unusual circumstances, I may be late. If that is the case, you will be seen for your full session.

Fees

The initial intake session, for parents only, is 50 minutes and the fee is $175.00. Each subsequent session is 45 minutes and the fee is $150.00 (or my current "session rate"). Full payment is due at the time of the session and is the responsibility of the parent who brings the child to the office for treatment. In divorce situations, this is regardless of the terms outlined in the divorce decree or custody arrangement. Payment is accepted by cash, check, MasterCard and Visa.

By consenting to treatment, you acknowledge that you are responsible for the cost of these provided services to you or your minor child and agree to pay them at the time of service. There is a $25.00 service charge for rebilling for all returned checks. If your account is not paid timely, then you agree to pay a separate service charge after 30 days notice and if collection services are required, you agree to pay attorney fees and/or collection fees and expenses. Be advised that if your account is not paid in full in 90 days, it will be turned over to a collection agency. I have the right to terminate treatment if fees are not paid in a timely fashion. If rates should increase in the future, I will advise you at least 30 days prior to the increase. If at any time you have questions about the fees, please feel free to discuss them with me.

I do not testify in court, but if legal actions occur in which I am requested or subpoenaed to provide testimony (such as in a custody case) you must provide the following even if the subpoena is sent from the opposing side of the case and even if our ongoing relationship has ended:

1. Travel expenses. ($.55 per mile plus the actual cost of meals and lodging, if needed).
2. Hourly fees of $300.00 per hour from the time I leave my office until I return.
3. Hourly fees of $300.00 for the time expended in preparation and research.
4. You must deposit a retainer of $2000.00 72 hours prior to a court appearance or deposition.
5. Record copying fees are $.50 per page

Telephone Calls

Phone calls are returned in a timely manner. If your phone does not accept blocked or private calls, please be advised that I might not be able to reach you. Telephone calls that exceed 5 minutes will be billed based on the time spent per call. Multiple short calls may also be cumulated and billed.

Emergencies

Should you need emergency assistance after hours you can call my office at 972.335.3933. You may also go to the nearest hospital emergency room, call the 24 Hour Mental Health Crisis Hotline at 972.562.7722, the Dallas Suicide & Crisis Center at 214.828.1000 or Contact Dallas at 214.233.2233.

Records and Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without written consent unless mandated by law. Possible exceptions include but are not limited to the following situations:

1. I determine any information revealed in session indicates physical, sexual, or emotional abuse or illegal neglect of children, or abuse, neglect, or exploitation of elderly or disabled persons.

2. I determine you or your child is a danger to yourself or others.

3. I am ordered by the court to disclose information.

4. You (parent or legal guardian) sign a written consent.

5. I may engage staff or an Administrative Services provider to assist in the administrative aspects of handling your case. To the extent the law allows, they will be bound to honor all confidentiality.

6. If you or your child receives concurrent services from another practitioner, we are both obligated to disclose.

7. I learn of sexual exploitation by another mental health services provider.

8. I receive supervision and/or consultation in order to provide you with quality care (you or your child's name will not be disclosed).

9. In the event that you bring a legal action against our office your file will be subject to discovery and exposure.

10. In the event of my death, you authorize our office to appoint a responsible custodian for your records.

Consent to Treatment

I, voluntarily, agree to receive and authorize the undersigned therapist to provide such care, treatment, or services that are considered necessary and advisable for me and/or my minor child.

I have the legal authority to seek professional services for my minor child. I have read and understood all the terms and information contained here and ample opportunity has been offered to ask questions and seek clarification of anything unclear to me. I engage Amy Allen Meyer, P.A. to render services as provided herein.

_____
Child's Name

_____ _____
Parent's Signature (Mom) Date

_____ _____
Parent's Signature (Dad) Date

Acceptance by Counselor

_____ _____
Counselor's Signature Date

CONCERNS REGARDING ETHICAL QUESTIONS MAY BE ADDRESSED TO THE CONSUMER HOTLINE AT 1.800.942.5540

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Notice of Privacy Practices

This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice is effective June 1, 2005.

Our office is required by law to maintain the privacy of protected health information and are are committed to treating and using protected health information about you responsibly.

Use and disclosure of protected health information for the purposes of providing services is required at times. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

When you receive treatment or services from Amy Allen Meyer, P.A., health information will be created about you. This information can include you/your child's past, present or future physical and/or mental health condition, the diagnosis and treatment plan for you/your child.

Our office is required to abide by the terms of HIPPA and/or the state laws. We have the right to change the terms of the Notice at any time and if we do, we will have copies of the new notice at our office and at amyallenmeyer.com. The new notice may apply to all health information we have, no matter when we received it.

We may not make, use or disclose any information from your record unless you give your written authorization, except as described in this Notice. You may revoke an authorization in writing at any time, but it will not affect any use or disclosure made by us before the revocation.

How Amy Allen Meyer, P.A. May Use and/or Disclose Protected Health Information

We may use the information in your record as a basis for planning your care and **treatment.** We may disclose information in your record to help you get health care services from another healthcare provider, such as a hospital, family physician or psychiatrist. We may consult with another professional about your case.

We may disclose information from your record to obtain **payment** for the services you receive.

We may also use and disclose your protected health information for certain **healthcare operations.** We may share that information with separate entities that provide services for us. These Administrative Services Providers may require your health information in order to accomplish the tasks that we ask them to provide, provided we have a written contract with them that prohibits them from disclosing your protected health information. Some examples of these Administrative Services Providers might be billing services, collection agencies, answering services and computer software/hardware providers. Your protected health information may also be used for staff training and improving services.

Your Rights

You may request restrictions on how your protected health information will be used and disclosed. However, we do not have to agree to the restrictions.

You have a right to receive confidential communication from us. If you request to receive communications by alternative means or at an alternative location, your request must be made in writing.

You have a right to inspect and obtain a copy of your health record with very limited exceptions. Your request must be made in writing and access or denial will be provided within 30 days.

You may also request to have the recorded amended. You can ask us to limit some of the ways we use or share your health information. We will consider the request, but the law does not require we have to agree to it. This request must be in writing.

You have the right to receive an accounting of certain disclosures made by us.

You have the right to receive a copy of this Notice of Privacy Practices.

Other Permitted Uses Required/Allowed Without Your Permission

We may disclose your protected health information without your permission. We will use our professional judgment before doing so. We will do so to the extent that the use or disclosure is required by law.

We may disclose your protected health information if we believe that you or your child has been a victim of child abuse or neglect.

We may disclose your protected health information to medical or law enforcement personnel if you or others are in danger.

We may disclose information for research with certain limitations and conditions.

We may disclose your protected health information in a civil proceeding with your permission or if a court or judge has ordered me to do so. In a criminal proceeding against you, our records are discoverable.

We or our Administrative Services Provider may use your information to remind you about upcoming appointments.

Complaint Process

You have the right to complain to us about our privacy practices (including the actions of our Administrative Services provider) at 972.335.3933 with respect to the privacy of your health information. You have the right to complain to the Secretary of the Department of Health and Human Services at 1-800-369-1019 about our privacy practices. You will not face retaliation from us for making such complaints.

Please sign below indicating that you understand the terms of this Agreement and have either received or downloaded a copy.

_____	_____	_____
Child	Parent Signature	Date

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Credit Card Authorization

I, _____, authorize Amy Allen Meyer, P.A.,
(print name)

to charge my credit card for payment of services and/or 24 hour cancellation policy fees unless otherwise paid for by me at the time of service.

_____VISA _____MC

Card Number _____ _____ _____ _____

Expiration Date_____ 3 Digit Code_____

Name on Card_____

Card Billing Address_____ Zip_____

Email address_____

Signature of Card Holder_____ Date_____

Receipts for each session will be emailed to you.
By signing this, you are giving us permission to do so.

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Communication Agreement

As a courtesy to our clients, we and/or Administrative Services Provider will confirm your appointments one to two days prior to your scheduled session. By giving us permission to do so, we can better protect your privacy. Please be advised that even though your appointment is confirmed, it is your responsibility to keep the appointment or cancel it by calling our office at 972.335.3933, at least 24 hours prior. Otherwise, you will be charged the regular session fee.

I authorize **Amy Allen Meyer & Associates and/or Administrative Services Provider** to confirm appointments by:

Phone Number

Text: _____

Voice Mail: _____

In addition to myself, I authorize **Amy Allen Meyer & Associates** to leave confidential information and/or speak to the following people regarding my child's treatment.

Name	Phone number	Circle one
_____	_____	Home Work Cell
_____	_____	Home Work Cell

Correspondence may be mailed/and or emailed to:

_____
Name

_____
Street

_____
City, State, Zip

_____
Email address

_____ _____ _____
Child's Name Parent Signature Date