DR. NICCI COUNSELING, LLC.

Client Intake Form – Child/Adolescent

DATE: ____

PERSONAL CONTACT INFORMATION:

CLIENT's NAME: ____

ADDRESS: ____

CITY: ______________________ STATE: ______________ ZIP: ______________

DATE of BIRTH: ____________________ AGE: ______________ SEX: Male ____ Female ______

PHONE: (Cell) ______________________ PHONE: (Home) ______________________

ALTERNATE PHONE: ______________________ E-MAIL ADDRESS: ______________________

EMERGENCY INFORMATION:

In case of an Emergency, please contact: ______________________________

What is the relationship of this person to you? ______________________________

FAMILY INFORMATION:

MOTHER's NAME: ____

ADDRESS: ____

CITY: ______________________ STATE: ______________ ZIP: ______________

DATE of BIRTH: ____________________ AGE: ______________

PHONE: (Cell) ______________________ PHONE: (Home): ______________________

ALTERNATE PHONE: ______________________ E-MAIL ADDRESS: ______________________

FATHER's NAME: ____

ADDRESS: ____

CITY: ______________________ STATE: ______________ ZIP: ______________

DATE of BIRTH: ____________________ AGE: ______________

PHONE: (Cell) ______________________ PHONE: (Home) ______________________

ALTERNATE PHONE: ______________________ E-MAIL ADDRESS: ______________________

What is your **mother's** name and age? ______________________________

What is her occupation? ______________________________

How would you describe her? ______________________________

What is your **father's** name and age? ______________________________

What is his occupation? ______________________________

How would you describe him? ______________________________

What is your **sibling's** name and age? ______________________________

How would you describe them? ______________________________

Are your parents still married? ______________________________

What is your **sibling's** name and age? ______________________________

How would you describe them? ______________________________

What is your **sibling's** name and age? ______________________________

How would you describe them? ______________________________

What is your **sibling's** name and age? ______________________________

How would you describe them? ______________________________

MEDICAL INFORMATION:

Describe current medical treatment, if any: ______________________________

______________________________.

Please list any medications you are currently taking: ______________________________

______________________________.

Have you ever received a mental health diagnosis from a counselor or a doctor? ______________

If so, what was the diagnosis? ______________________________

On a scale of 1 to 10, ten being the highest, how would you rate your distress today? ____________

SYMPTOM CHECK LIST:

Check beside any of these emotional symptoms you are experiencing, or have experienced in the last three months:

	Stress		Nervousness		Panic
	Guilt		Apathy		Verbal Abuse
	Recent Death of a Loved One		Changes in Appetite		Hearing Voices
	Headaches		Grief		Aggressiveness
	Feelings of Low Self Worth		Feelings of Inferiority		Racing Thoughts
	Uneasiness Around Others		Fearful		Loss of Control
	Marriage Problems		Communication Issues		Compulsive Behaviors

	Emotional Abuse		Anger		Abortion
	Shame		Concentration		Eating Problems
	Temper		Memory		Job Troubles
	Nightmares		Self-Control		Indecisiveness
	Unwanted Thoughts		Alcohol Use		Financial Problems
	Impulsive Behavior		Anxiety		Difficulty Breathing
	Sexual Problems		Depression		Sleep Trouble
	Legal Problems		Severe Illness		Tiredness
	Problems with Children		Hopelessness		Stomach Problems
	Recent Loss		Lonely		Dizziness
	Infertility		Drug Use		Adoption
	Suicidal Thoughts		Changes in Body Weight		Physical Pain
	Self-Harm		Physical Abuse		Rapid Heart Rate

SCHOOL INFORMATION:

What school do you attend? ____________________________________ Grade: _____________________

SPIRITUAL/RELIGIOUS BELIEFS:

What spiritual or religious beliefs do you practice? ____

Do you want spirituality incorporated into your therapy? ____

CANCELLATION POLICY:

Please give a 24-hour notice for canceled or rescheduled appointments. If sufficient notice is not given, you will be charged at the regular session fee for the session missed.

By signing below, I am indicating that I understand and agree to the above.

Client: _______________________________________ Date: ___________________________________

Parent/ Guardian_____________________________ Date: ___________________________________

Parent/Guardian: ____________________________ Date: ___________________________________

DR. NICCI COUNSELING, LLC.

Consent to Treat a Minor

I, ____ , am the Parent/
(Print name of Parent/Legal Guardian)

or Legal Guardian of ____
(Print name of Client/Minor)

currently a minor, whose date of birth is ______________________________________.
(Date of Birth of Client/Minor)

I authorize my counselor, **Nicole I. Holloway, PsyD (LMHC)** to provide mental health care to my child named above. I acknowledge that I have had an opportunity to ask questions and receive answers about the type of counseling my child will be receiving. I understand that there may be times when my child's counselor may request to meet with my child alone, times when we may meet together as a family, and times when my child's counselor will request to speak with just myself without my child present.

I do hereby seek and consent to treatment for my child by **Nicole I. Holloway, PsyD (LMHC)**, Licensed Mental Health Counselor with **DR. NICCI COUNSELING, LLC.** By signing this, I acknowledge that I have read this and that I understand this consent and that any questions that I have prior to signing should be directed to my counselor.

____ Date: _________________________________

Client Signature

____ Date: _________________________________

Parent/Guardian Signature

____ Date: _________________________________

Parent/Guardian Signature

DR. NICCI COUNSELING, LLC
446 North Dillard Street, Ste #2
Winter Garden, FL 34787
Phone: (918) 640-8191

DR. NICCI COUNSELING, LLC.

Informed Consent

It is the mission of DR. NICCI COUNSELING, LLC to provide you with the highest quality counseling possible while keeping the content and records of therapy confidential. However, there are certain circumstances when I am legally and ethically required to break confidentiality and make appropriate disclosures. These disclosures are strictly to protect you or someone else from potential harm. These circumstances include serious suicidal or homicidal threats, actions, or ideation of a degree severe enough to warrant medical care, HIV/Aids reporting requirements, Patriot Act reporting requirements, and/or child abuse/elder abuse (physical, sexual, emotional or neglect). Disclosure in these circumstances is rare.

I, ____, understand the limits of confidentiality and I am aware of and give consent that if any of the above situations are discussed in therapy, Dr. Nicole Holloway will be required to make the appropriate disclosures for the safety of myself and those around me. I understand that I am entering into a confidential therapeutic counseling relationship. I understand that I have the right to terminate this relationship at any time upon notice to Dr. Nicci.

____ Date: _________________________________

Client Signature

____ Date: _________________________________

Parent/Guardian Signature

____ Date: _________________________________

Witness Signature

DR. NICCI COUNSELING, LLC
446 North Dillard Street, Ste #2
Winter Garden, FL 34787
Phone: (407) 702-1141

DR. NICCI COUNSELING, LLC.

Cancellation Policy/Financial Agreement

I understand that it is my responsibility to notify my counselor 24 hours in advance of my scheduled appointment time if the need arises for me to reschedule or cancel my appointment. If I fail to give at least 24 hours' notice, I will be charged a regular session fee for the session you missed. Dr. Nicci requires this minimum of 24 hours in order to provide the opportunity for someone else to receive counseling services in the event that I am not able to keep my scheduled appointment.

I understand that payment for each session will be due at the onset of each session. For my convenience, I may pay for my session by cash, check or credit card. I understand that there will be a fee of $50 for any check that is returned due to non-sufficient funds or non-payable.

I understand that Dr. Nicci does not accept insurance and that any arrangements that I may have for reimbursement for mental health care services through my insurance company will be coordinated directly between myself and my insurance company. I also understand that DR. NICCI COUNSELING, LLC, agrees to provide me with a receipt for my counseling sessions for purposes of obtaining insurance reimbursement.

____ ____________________________

Client Signature Date

DR. NICCI COUNSELING, LLC
446 North Dillard Street, Ste #2
Winter Garden, FL 34787
Phone: (407) 702-1141

DR. NICCI COUNSELING, LLC.

NOTICE of PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of *treatment, payment and healthcare operations:*

- ***Treatment*** means providing, coordinating, or managing healthcare and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- ***Payment*** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment by phone or mail or provide you with information about treatment options or other health-related services.

We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATON to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a court administrative order if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law. You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that weI restrict using and disclosing your PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request.
- You may request an amendment to your PROTECTED HEALTH INFORMATION.
- You may request alternative means or locations in which you receive confidential communications.
- You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment payment, and health care operations.

We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our Privacy Practices, please contact:

- The Privacy Officer, Nicole Holloway, PsyD
  Licensed Mental Health Counselor
  DR. NICCI COUNSELING, LLC
  446 North Dillard Street, #2
  Winter Garden, FL 34787
  Phone: (407) 702-1141

For more information about HIPPA or to file a complaint, please contact:

- The U.S. Department of
  Health & Human Services
  Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (877) 696-6775

DR. NICCI COUNSELING, LLC.

Acknowledgement of Receipt of Privacy Practices Notice

I, ____, have received a copy of the NOTICE OF PRIVACY PRACTICES used by DR. NICCI COUNSELING, LLC.

Name:
____;

Address: ____

City: _______________________________________ State: ___________ Zip: ______________

____ Date: ________________________________

Client Signature

____ Date: ________________________________

Parent/Guardian Signature

____ Date: ________________________________

Witness Signature

DR. NICCI COUNSELING, LLC
446 North Dillard Street, Ste #2
Winter Garden, FL 34787
Phone: (407) 702-1141

DR. NICCI COUNSELING, LLC.

Authorization for Credit Card Charges

Dear Client,

By signing this form, you are giving DR. NICCI COUNSELING, LLC permission to charge your credit card with any unpaid balances for services rendered.

Please note that your credit card information will be kept confidential and secure. If you choose a receipt for each transaction, that receipt can be emailed to you. Charges will appear on your credit card statement as DR. NICCI COUNSELING, LLC.

I certify that this is my credit card and I am legally authorized to give permission for its use. My signature authorizes the offices of DR. NICCI COUNSELING, LLC to charge my credit card the amount agreed upon for counseling services. I understand it is my responsibility to notify the office of DR. NICCI COUNSELING, LLC of any changes to my account.

This authorization will remain in effect for one (1) year unless I cancel it through written notice to DR. NICCI COUNSELING, LLC.

Cardholder's Signature: ________________________________ Date: ____________________

****

Name of Client: ____

Cardholder's Name: (as shown on card) ____

Cardholder's Billing Address: ____

City: ____________________________________ State: _________________ Zip: _________

Card Type:

______Visa ______Master Card ______Discover

Credit Card Number: ______________________ Expiration Date: ________________

Code: _________________________________ Billing Zip Code: ________________

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