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Mental Health (MINOR) New Patient Forms

Please note: information you provide here is protected as confidential information.

Child's Name: _____ Child's DOB: _____

Parent/Legal Guardian Information □ Same as mother's information

Mother: _____ Father: _____

Address: _____ Address: _____

City: _____ City: _____

State and Zip Code: _____ State and Zip Code: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Email: _____ Email: _____

Date of Birth: _____ Date of Birth: _____

Patient resides with: _____ Custody arrangement: _____
*Please provide divorce decree paperwork that is necessary before our first visit.

Names of stepparents, if necessary: _____

Pediatrician / Practice:_____

For what are you seeking help with today?

_____

_____

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Presenting Problems (check all that apply within the last 6 months)

___ Temper outbursts
___Withdrawn
___Daydreaming
___Fearful
___Clumsy
___Overactive
control
___Short attention span
___Distractible
___Peer conflict
___Phobic/fears
___Fire play
___ Cruelty to animals
___ Other: _____

___ Impulsive
___Stubborn
___ Disobedient
___ Infantile
___Mean to others
___Destructive

___ Bed wetting
___ Self-Mutilating
___ Head banging
___ Rocking
___ Runs away
___ Physical Complaints

___Shy
___Strange behavior
___Stealing
___Lying
___School Trouble
___Bowel/bladder

___Eating problems
___Sleeping Problems
___Drug/Alcohol use
___Sexual acting out
___Target of bullying

MEDICAL HISTORY

Has the child ever been hospitalized for illness, mental or emotional issues? Y__N__
If yes, please explain where, when, and what for? _____
_____
_____

Has the child ever taken, or is he/she currently taking any medications? Y___ N___
If yes, please list medication name and frequency of dosage and prescribing doctor's name.
_____
_____
Does the child have any allergies that you are aware of (i.e. latex, peanut, soy, etc.)? _____
_____

LIVING ARRANGEMENTS

Number of moves in child's life____ Ever placed or lived away from family? Y__ N__
Explain: _____

List all members of your household presently and indicate their relation to the child: _____
_____

Describe discipline style used in home:
_____

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DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? Y__ N__ If yes, please explain:
_____

Complications at birth? (Explain) _____

Did mother abuse alcohol or drugs during pregnancy? Y__ N__
Length of pregnancy: _____ Full Term? Y__ N__ Birth Weight _____lbs _____oz

As far as you know, did the child meet developmental milestones at an appropriate age (i.e. rolling over, sitting up, babbling, and eating)? Y__ N__ If no, please explain:
_____

Describe any stressful or traumatic experiences that the child may have experienced in his/her life:
_____

EDUCATIONAL HISTORY

Name of School/Daycare_____ Grade: _____
Types of classes: ____Regular ____Inclusion ____ EDB (Emotionally Disturbed Behavior)
Other (explain):_____

Does the child receive special services at school (504, IEP, BIP)? Y__ N__ If yes, please describe below with frequency and duration of each:
_____

SOCIAL HISTORY
List any activities that your child participates in _____
_____
How does your child get along with other children his/her age?
_____

List three goals that you have for your child in counseling:

1. _____
2. _____
3. _____

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Please tell me how I can support you, as a parent, during this process:_____
_____

Is there anything else that you would like me to know about your child as we begin counseling?
_____
_____
__

Signature (Patient or Guardian)_____

Date_____/_____/_____

LEGAL/CUSTODY INFORMATION CONCERNING YOUR CHILD

_____ I understand that if my child has parents that are divorced and/or part of a joint custody arrangement, I must furnish my counselor with a copy of the file stamped divorce decree and most current child custody arrangement perTexas state law. I also understand that if at any time custody arrangements change, I will notify my counselor and provide them with updated legal papers.

_____ I do understand that in families where there is divorce, pending litigation, and/or contention regarding therapy my counselor will make every effort to include both parties in the care of my minor child.

_____I do understand that my minor child cannot begin counseling services until the current legal paperwork and written consents are received. If both parties are required to give consent, counseling willcommence after all consents are received.

I hereby give full and unconditional authority for Kimberly Hansley, LPC to proceed with clinical evaluation and treatment of my/our minor child as her professional judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal authority to consent to medical, psychological, and mental health assessment and treatment of said minor child.

_____

Parent/Guardian Signature Printed Name Date

_____

Parent/Guardian Signature Printed Name Date

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Therapy with Minors

Confidentiality

As a therapist, I believe in providing a child/teen with a private environment in which to disclose himself/herself to facilitate therapy. It is important for a child/teen to trust the therapist for therapy to be effective. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. As your child/teen's therapist, I will share general information about progress but will refrain from revealing any specific information shared by your child/teen unless your child/teen consents to it. My hope is to support your child/teen in facilitating these conversations to promote open, clear, supportive communication within your family. *When there is a safety risk assessed, I will share information with you as required by law.*

Your child/teen may wish to share about a therapy session but please be aware not to solicit or put any pressure on your child/teen to share information as this will impact our "zone of privacy".

Family Involvement

In my work with children/teens, I believe the family unit is so important. As part of our treatment, I may ask to include the family in therapy when appropriate. These sessions will support overall goals related to the family. Some family sessions may include only the parents to discuss parenting practices or strategies to support your child/teen's development. Recommendations may be made to make changes in the family unit in order to support changes in your child/teen.

Something that may come up during therapy with children and teens is disagreement between parents regarding the best interests of the child/teen. As parents, it is important for you to be as united as possible to fully support your child/teen in therapy, and it can be difficult for children/teens to be caught between the disagreements of their parents. Thus, if such disagreements occur, I will listen carefully to your concerns and I will attempt to help you find an acceptable resolution. You can choose to resolve such disagreements or you can agree to disagree, so long as this enables your child's therapeutic progress.

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Termination

The opportunity to celebrate the completion of treatment goals is important in the life of your child/teen. As part of the termination process, I may plan a celebration session with your child/teen to acknowledge progress and growth and to review helpful ongoing strategies. If at any time you choose to discontinue therapy for any reason, I will share with you my perspectives on your child/teen's needs given what we have worked on in therapy, and I will offer you any appropriate resources or referrals. I ask that you allow me the option of having a closing session(s) to appropriately end the treatment relationship.

Additional Information Regarding Services With Minor Clients:

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

If either parent decides that therapy should end, then the therapy must stop. I ask that you inform me ahead of time that you are considering stopping therapy and allow me the option of having a closing session(s) to appropriately end the treatment relationship.

CLIENT CONSENT

By signing below, I am indicating that I have read, understand, agree and will abide by the document above.

PATIENT SIGNATURE _____ DATE _____

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Mental health professionals will not share written/verbal information about the client/legal guardian to anyone outside session except in the exceptions outlined below:

Duty to Warn and Protect

If a client discloses intentions/plans to harm themselves/someone else, the mental health professional is required by law to report such information to the appropriate legal authorities, victims, & family.

Abuse of Children and Vulnerable Adults

Mental health professionals have an obligation to protect children, the elderly, or otherwise compromised adults who cannot protect themselves. Should a client state, suggest, or imply that s/he is abusing a vulnerable population, is being abused, is in danger of abuse, the professional is required by law to report the information to the appropriate social services & legal authorities for further investigation. I understand that suspected physical, emotional, or sexual abuse is enough to trigger the professional's duty to report.

Prenatal Exposure to Controlled Substances

Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship/Sponsorship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. In the event that someone other than the client is paying for service, they have the right to dates of service, attendance, & a yes/no answer as to whether the client is using the time appropriately.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

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Digital Media

I understand that the mental health professional cannot protect my confidentiality from whatever I put into writing myself, as well as from non-HIPPA compliant communication providers, such as Google, AT&T, etc. as well as other digital breaches.

Case Consultation

Mental health care professional may consult with or receive supervision from other health professionals regarding the case to ensure the highest and best quality of care for the client. Mental health care professional will make best efforts to protect the identity of the client.

I agree to the above limits of confidentiality and understand their meanings and ramifications. The counseling relationship is intended to be a healing and supportive environment where you can explore issues and concerns. As a counselee I understand that I am a vital part of the overall treatment process and that this process may produce strong and difficult emotions in regard to personal issues. I consent to the mental health treatment knowing that if I need to file a complaint or grievance, I can do so with the LPC board at 1-800-821-3205 if I feel I have been mistreated.

Signature Printed Name Date

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Court Action Policy and Fees

Clients are discouraged from having their mental health care provider/Curis Functional Health subpoenaed or having to provide records for the purpose of litigation. Mental health care providers are trained to work with clients from a non-adversarial position, not forensically, and do not have the expertise to appear in court. Forensics is an area of clinical specialization and we are able to provide recommendations for such outside services.

Even though you are responsible for the testimony fee, it does not mean that the testimony of the mental health care provider will be solely in your favor. S/he can only testify to the facts of the case and her/his professional opinion.

If the mental health care provider is to receive a subpoena then the attorney or office staff will need to call the office and set up a time for the subpoena to be served during office hours. A minimum of 14 days notice of any Court appearance is required so that schedule changes for clients can be made within a reasonable time frame.

Please note: if a subpoena is received without a minimum of 14 days notice there will be an additional $500 express charge.

Court action fees are as follows:

1.	Correspondence & Letter of Opinion:	$300 per hour (billed in 15-minute increments)
2.	Preparation Time:	$300 per hour (billed in 15-minute increments)
3.	Phone Calls:	$300 per hour (billed in 15-minute increments)
4.	Travel to court	$300 per hour, minimum 1 hr each way
5.	Depositions	$300 per hour
6.	Minimum charge for court appearance	$1500.00 ≤ half day $3000 for full day

Attorney fees: I, the client, agree to pay all attorney's fees and costs that are incurred by the mental health care provider & Curis Functional Health as a result of any court action. Reimbursement is due in full at time of appearance.

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Retainer: A retainer of $1,500 is due within 48 hours of subpoena. The remainder of the costs will be billed at the court appearance and will be due upon receipt the same day.

If the mental health care provider is subpoenaed and the case is reset with less than 72 hour notice prior to the beginning of the day of the scheduled subpoena and or testimony is not given, then the client will be billed $1500.

Bills for court related actions are presented to clients on a weekly basis and payment is expected upon receipt. A zero balance will need to be kept at all times.

_____

Signature Printed Name Date

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PATIENT AUTHORIZATION For Use And Disclosure Of Protected Health Information

I _____, hereby authorize Curis Functional Health to:

Circle One: Obtain information from **OR** Disclose information to

Name / Facility: _____

Mailing Address: _____Phone / Fax: _____

The following specific protected health information: ___ Diagnostic Assessment ___ Psychological Evaluation ___ Treatment Plan ___ Progress Notes ___ Other ___ All as needed

For the purpose of: ___ Verbal Communication ___Treatment at Curis ___ School Assistance ___ EAP ___ Coordination of Care ___ Payment/billing ___ Utilization Review ____ Other: _____

I understand that this authorization is valid until ___/___/_____ or until stated in writing by patient/guardian.

I expressly acknowledge that this authorization is voluntary. The following is/are other criteria or limitations that I make regarding this authorization:

I understand that the office _____ will _____ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. I understand that this authorization may be revoked by the authorizer, in writing, at any time. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form. I understand that I may see and copy the information described in this form if I ask for it and that I will get a copy of this form after I sign it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

This authorization is valid as of ___/___/_____, the date I have signed below.

Name of Individual (Printed) _____ Signature _____

DOB _____

Signature of Legal Guardian/Attorney Requesting Records: _____

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Federal law requires that we obtain your written acknowledgement of receipt of the Notice of Privacy Practices. Please sign or initial below.

I acknowledge that I have received the Notice of Privacy Practices.

_____

Patient Name (Print)

_____

Patient Signature

_____

Patient Date of Birth

_____

Legal Representative Name (if patient is unable to sign) (Print)

_____

Legal Representative Signature

Date: _____

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Teletherapy Consent to Treatment

I, _____(client) hereby consent to engage in teletherapy with a Curis Functional Heath Provider. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In Texas mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.

3. You understand that this teletherapy occurs in the state of Texas, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the clinician in his/her Texas office. It is the responsibility of you, the client, to inform if this is not the case, in which teletherapy services cannot be offered.

4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my mental health clinician, my condition may not improve, and in some cases may even get worse.

6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

7. Teletherapy is not recommended for children under the age of 12 given that the services are often interactive and play based. However, children can vary in levels of emotional development and maturity, therefore appropriateness can be evaluated for children in the 10-13 age range.

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8. I accept that teletherapy does not provide emergency services. During our first session, the clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

9. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure, and (5) I should show up to therapy dressed appropriately, as if I were being seen in office.

10. I understand that while email may be used to communicate with the clinician, confidentiality of emails cannot be guaranteed.

11. I agree that my telehealth session happens live and will not be recorded, reproduced, or published. I understand that misuse and or mismanagement of my session by recording it compromises my own integrity and could bear significant damages to the clinician. Should this occur, I bear sole responsibility for these actions, including but not limited to legal fees, damages, etc. I waive the right to confidentiality under these circumstances.

12. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand, and agree to the information provided above.

Client (or Guardian's) Signature _____

Date _____

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Late Cancellation / No-Show Policy

Session times are reserved exclusively for me, and I understand that if I cancel a session with ***less than 24 business hours' notice***, or do not show for my appointment time, I will be charged $130 - OR – (the Therapist's full hourly Cash-Pay rate for the session). Business days are Monday through Friday, except holidays. Please note that for Monday appointments, an early cancellation would occur the Friday prior. For example, a 3pm Monday appointment must be cancelled by 2:59pm on the prior Friday to prevent a late cancellation charge. This charge does not apply to those on government health insurance plans.

There is no exception to this policy, even in the event of personal illness or emergency. In the event of contagious illness, I understand and agree that I will not come to the office despite the late cancellation policy. My therapist may be willing to see me via telehealth in this case. Please inquire about this as an option.

If the card is declined, payment isn't processed, or the charge is disputed - I understand that I will not be allowed to carry a balance and my fee must be paid prior to rescheduling. If unresolved, this matter will be turned over to our financial team and may be subject to being sent to collections.

_____

Signature Printed Name Date

Curis Functional Health • klitwiler@gocuris.com • (817) 453 - 0430
221 Regency Pkwy, Unit 101 • Mansfield, TX 76063
GoCuris.com

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Credit Card Authorization Policy & Signature Form

This form authorizes Curis Functional Health to keep my credit card on file and manually charge the fee for service to this credit card number in the event that:

(a) Payment was not rendered at time of service
(b) I am not present to pay for my minor child at the time of service
(c) Therapist provides consultation outside of sessions (billed per 15 minutes)
(d) I missed my scheduled appointment
(e) I cancelled with less than or equal to 24 hours of notice
(f) I'm on a therapy payment plan, in which case debits will be made on the agreed upon dates
(g) My account has an outstanding balance and has been delinquent for 10 business days

I, the undersigned, have read and agree to the credit card authorization policy.

Client Signature Printed Name
Date

Card Type: VISA MC AMEX DISC OTHER

Card Number: _____

Expiration Date: _____

3 Digit Code on the back of Card: _____

5 Digit Billing Zip Code: _____

Name of Credit Card Holder: _____

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Insurance/Billing Information

Insurance Policyholder:_____ DOB: _____ Relationship To Patient: _____

Insurance Member ID#: _____

I understand it is my responsibility to keep my insurance information current to prevent billing errors and or delays. _____(initials)

Communication

I agree that Curis may communicate with me via:

□ Phone _____

□ Email _____

□ Text _____

I understand that these forms of communication could compromise my confidentiality and accept that risk.

_____(initials)

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Curis Functional Health is an Integrated Wellness Center

At Curis, we believe that they body is an interconnected system that is best addressed as a whole. Your health is our top priority!

Please check all areas of interest so we may best serve your health needs:

_____ **I'm interested in scheduling an appointment to see a Curis chiropractor.**

Chiropractors help with spinal alignment, overall nervous system function, back pain, neck pain, headaches, bulging/herniated disc and much more.

_____ **I'm interested in making an appointment with a Mental Health professional**

Anxiety, depression, ADD, relationship issues, stress management, parenting, trauma relief, anger management, childhood challenges, teen issues, etc.

_____ **I'm interested in scheduling a FREE Consult with a Curis Dietitian, Nutritionist, or Weight Loss Coach**

Our DNA-based metabolic program removes the guesswork and provides you with a personalized, sustainable plan for weight loss and control. The average client loses 20+/- pounds in the first 40 days! Coaching, support and accountability helps you achieve your goals big or small - according to YOUR genetics.

_____ **I'm interested in scheduling a consultation to discuss adding supplements to enhance my overall health.**

Brain optimization, digestive issues, immune support, allergy relief, stress management, sleep optimization, pain relief, anti-inflammatory responses, joint and disc support.

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Provider Name
NPI:, TIN:
Provider address
Provider phone number

Good Faith Estimate

Patient Name:	Date of Birth:

Estimated Services and Items		**Date of Appointment**	**1/1/2023- Recurring weekly**	
Description	**Diagnosis Code (ICD-10 Code)**	**Service Code (CPT)**	**Quantity**	**Expected Cost**
Initial Intake session or Parent session		90971	P	$180
45 Minute Therapy Session		90834	weekly	$180
15 Minute session extension			As needed	$60
15 Minute outside of session consultation			As needed	$60
Work completed outside of a formal session will be billed at a rate of $360/hour in 6 minute increments. (texting, emailing, phone contact, written communication, treatment summaries, calls with attorneys, teacher/school calls, FMLA paperwork, etc.) Courtroom testimony estimates are not included in this Good Faith Estimate.			As needed	$360/hr billed in 6-minute increments
P - Primary Service (initial reason for visit) C – Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)		**Total Expected Charges $**		9,360.00
		Date of Good Faith Estimate:		1/1/2023

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Disclaimers:

*There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

*The information provided in this good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time this good faith estimate was and actual items, services, or charges may differ from the good faith estimate.

*You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are $400 more than the expected charges included in the good faith estimate and the dispute is initiated within 120 days after the date of the bill for the items or services. To start the process, you may contact us at the phone number or address listed above to let us know the billed charges are higher than the Good Faith Estimate. You can ask us to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services within 120 calendar days (about 4 months) of the date on the original bill and if the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises.

*This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

Signature: _____ Date: _____