Kimball Counseling Associates
1035 S. Semoran Blvd. Suite 2-1029, Winter Park FL, 32792 407-960-3330 www.kca-counseling.com

Child or Adolescent Initial Appointment Form

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

Sibling: _____ Age:_____ DOB:_____

Sibling: _____ Age:_____ DOB:_____

Sibling: _____ Age:_____ DOB:_____

1. Parent's Name: _____

Address: _____

City: _____ Zip: _____

Cell phone: _____ Marital Status: _____

Email Address: _____

Where may I leave a message? ( ) Phone ( ) Email ( ) Neither

2. Parent's Name: _____

Address: _____

City: _____ Zip: _____

Cell phone: _____ Marital Status: _____

Email Address: _____

Where may I leave a message? ( ) Phone ( ) Email ( ) Neither

3. Step Parent's Name, Guardian Name: _____

Address: _____

City: _____ Zip: _____

Cell phone: _____ Marital Status: _____

Email Address: _____

Where may I leave a message? ( ) Phone ( ) Email ( ) Neither

Child Information

Child lives with: _____

School: _____

Teacher: _____ Grade:_____

History of counseling or psychiatric treatment _____

Current or past alcohol/drug use _____

_____

Significant medical problems _____

_____

Accidents or surgeries _____

_____

_____

If additional siblings will be seen:

Child lives with: _____

School: _____

Teacher: _____ Grade:_____

History of counseling or psychiatric treatment _____

Current or past alcohol/drug use _____

_____

Significant medical problems _____

_____

Accidents or surgeries _____

_____

_____

Please describe what concerns you have regarding your child:

_____

_____

_____

How long has the problem existed?

_____

_____

_____

Have there been any significant stressors for the family? (Losses, births, deaths, moves, hospitalizations, financial problems)

_____

_____

_____

What attempts have been made to resolve the difficulties?

_____

_____

_____

Is child adopted? ( ) YES ( ) NO

If adopted, does the child know of adoption? ( ) YES ( ) NO

What was the age of your child at the time of adoption?

_____

_____

_____

Please check the symptoms that the child is currently experiencing. Please indicate duration and severity.

Severity: 0 = None, 1 = Mild, 2 = Moderate, 3 = Severe

SYMPTOM

Sadness or Depression ----------	SEVERITY _____ DURATION _____
Suicidal thoughts ----------	SEVERITY _____ DURATION _____
Sleep Problems ----------	SEVERITY _____ DURATION _____
Changes in Appetite ----------	SEVERITY _____ DURATION _____
Weight Change ----------	SEVERITY _____ DURATION _____
Inability to Concentrate ----------	SEVERITY _____ DURATION _____
Obsessive thoughts ----------	SEVERITY _____ DURATION _____
Anxiety or tension ----------	SEVERITY _____ DURATION _____
Panic attacks ----------	SEVERITY _____ DURATION _____
Memory problems ----------	SEVERITY _____ DURATION _____
Compulsive behaviors ----------	SEVERITY _____ DURATION _____
Feelings of hostility ----------	SEVERITY _____ DURATION _____
Acts of violence ----------	SEVERITY _____ DURATION _____
Social Isolation ----------	SEVERITY _____ DURATION _____
Strange thoughts ----------	SEVERITY _____ DURATION _____
Stomach aches ----------	SEVERITY _____ DURATION _____
Headaches ----------	SEVERITY _____ DURATION _____
Bed wetting ----------	SEVERITY _____ DURATION _____
Phobias ----------	SEVERITY _____ DURATION _____
Others ----------	SEVERITY _____ DURATION _____

Parent Information

Are there any other agencies involved with the family? (ie. DCF, Child Welfare, Courts, etc)

_____

For parents who are divorced, please state custody arrangements. (you may be required to prove legal documentation of custody arrangements.)

_____

_____

Mother's Name: _____ Occupation: _____

Significant medical problems?

_____

_____

Current or past psychiatric treatment or counseling? ( ) Yes ( ) No

If so, regarding what issue/situation? _____

Currently prescribed medications: _____

History of arrests: _____

Father's Name: _____ Occupation: _____

Significant medical problems?

_____

_____

Current or past psychiatric treatment or counseling? ( ) Yes ( ) No

If so, regarding what issue/situation? _____

Currently prescribed medications: _____

History of arrests: _____

Step-parent/Guardian Name: _____

Occupation: _____

Significant medical problems?

_____

_____

Current or past psychiatric treatment or counseling? ( ) Yes ( ) No

If so, regarding what issue/situation? _____

Currently prescribed medications: _____

History of arrests: _____

Is Your Child Highly Sensitive?

Instructions: Please answer each question as best as you can. Check answer if it is true or at least moderately true of your child, or was for a substantial time in the past. Leave unchecked if it has not been very true of your child, or was never at all true.

My child:

- ○ startles easily.
- ○ complains about scratchy clothing, seams in socks, or labels against his/her skin.
- ○ doesn't usually enjoy big surprises.
- ○ learns better from a gentle correction than strong punishment.
- ○ seems to read my mind.
- ○ uses big words for his/her age.
- ○ notices the slightest unusual odor.
- ○ has a clever sense of humor.
- ○ seems very intuitive.
- ○ is hard to get to sleep after an exciting day.
- ○ doesn't do well with big changes.
- ○ wants to change clothes if wet or sandy.
- ○ asks lots of questions.
- ○ is a perfectionist.
- ○ notices the distress of others.
- ○ prefers quiet play.
- ○ asks deep, thought-provoking questions.
- ○ is very sensitive to pain.
- ○ is bothered by noisy places.
- ○ notices subtleties (something that's been moved, a change in a person's appearance, etc.)
- ○ considers if it is safe before climbing high.
- ○ performs best when strangers aren't present.
- ○ feels things deeply.

Informed Consent

Confidentiality:
The content of your sessions with your therapist is confidential. Your therapist will not release any information about you without your written consent. However, state law mandates that confidentiality be broken in specific situations. These include:

- If you indicate that there is abuse or neglect of children or elderly individuals.
- If you threaten dangerousness to self or others.
- The courts can overrule your right of confidentiality and require me to submit records of your treatment with a court order.
- Insurance carriers often require oral or written case summaries as a condition of reimburse-ment. Choosing to pay privately does help to increase the confidentiality of your counseling experience.
- On occasion KCA therapists also consult with other treatment providers when necessary, in order to provide you with optimal services. If this occurs your therapist will do so without identify-ing you personally. Also, KCA therapists implement a team approach in serving their clients in order to provide the most effective and careful treatment, consisting of consultation and supervi-sion, without personal identification. If you have any objections to your therapist doing so, please notify him/her of your concerns.

Records and Release of Records:
KCA keeps a written record of your therapy for seven years at the office. Your file is confidential and will be maintained for seven years following termination of therapy as required by law. If requested in writing, information in any part of your record can be released to you, or to a person or agency you designate. Your therapist will tell you at the time whether or not in his/her profes-sional judgment disclosing the records could be harmful to you. Florida law does allow for a report of the therapy to be sent in lieu of the full record if necessary and beneficial to you. Records to a third party cannot be released unless every person that has taken part in the session(s) agrees to sign the release. It is helpful for you to understand how your records and privacy are maintained.

Financial Arrangements:
Payment for services are due at the time of service unless arrangements have been made in advance, with a set fee for each therapist per 50 minutes ("clinical hour"). Sometimes, the client or your therapist may find it helpful to plan for a longer session. Fees are adjusted accordingly. Each year KCA's budget and fee structure are re-evaluated. Factors such as overhead expenses and continuing education expenses may necessitate a change in the fee structure. You will be notified in writing and in session 4 weeks in advance of any change to KCA fees. Fees and co-payments are to be paid at the beginning of each session. Cash, checks and credit cards are accepted. Due to the

high processing fee of credit cards, a $4.00 fee will be added to each credit card transac-tion. This option of paying is for your convenience. Please make checks out to KCA or Kimball Counseling Associates.

Insurance:
KCA does not take insurance for a variety of reasons. Private pay offers you privacy and control of your own medical records and diagnoses. Insurance companies require that a mental health diagnosis be given indicating the necessity for treatment. Any diagnosis given to your insurance company will become part of your permanent medical records, which could influence your future insurability. You are able to avoid this exposure by paying privately as no diagnosis is forwarded to anyone without your written permission.

KCA will provide you, the client, with a "Superbill" which includes dates of service, mental health diagnosis, CPT code (type of service) and my credentials. This form is then submitted by you to the insurance company when seeking reimbursement. The insurance company will make the final decision as to what services are to be reimbursed. You can also request a monthly bill to print out, which is sent via secure email through Therapy Partner.

Cancellation Policy:
For all cancellations, a 48- hour notice is requested, and a 24-hour notice is required. The fee for a no show or a last minute (less than 24 hours) cancellation is the same cost as your session fee. This cancellation policy may seem severe, but in reality it is important for our counseling practice. While a medical doctor can see 35 patients in a day, a therapist generally can see a maximum of 6 clients. Your therapist reserves a full hour of his/her time for the session and paperwork. If a client cancels with less than a 24-hour notice, your counselor most likely will not be able to fill that time slot, and thus lose an entire hour from his/her work schedule. Emergencies will be taken into account.

Collections:
You are responsible for any costs incurred should collection proceedings be required. Return checks will be subject to a service charge defined by the bank used by KCA.

Phone Policy:
If you need to speak with your counselor, please call Kimball Counseling Associates at 407-960-3330, or the alternative number your therapist has provided, and leave a message. If it's an emergency, call 911. Your counselor will call you back within 24 hours if message is left Monday through Thursday. Messages left Friday through Sunday may not be returned until Monday. If a call is made to your counselor and the conversation totals more than 15 minutes in a week, the client will be charged for a ½ hour session. If you are calling about an emergency situation and I am not immediately available, please call Life Line of Central Florida 407-425-2624, go to the nearest emergency room, contact your insurance carrier for further instruction, or call the police for immediate assistance.

Email Policy:
Your counselor may communicate with you through email for schedule changes and other business needs. You may choose to email your counselor questions or general concerns. In an effort to maintain your privacy, e-mail contact with confidential and personal information is discouraged by

the HIPPA rules. Your counselor will respond back within 24 hours Monday through Thursday. See your therapist for his/her email policy for weekends.

Your signature(s) indicate that you have read and agree to the above policies, received Privacy Practices document and give your consent for me to do counseling/psychotherapy with you and/or your family. It is necessary that each person receiving treatment, over the age of 14, sign below indicating an understanding and agreement. This is to certify that I have read the above information and that I consent to psychotherapy treatment.

Client Signature _____ Date _____

Client Signature _____ Date _____

Counselor Signature _____ Date _____

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, our other staff] and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

_____ You agree to only keep your in-person appointment if you are symptom free.

_____ If you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, we will not charge our normal cancellation fee.

_____ You agree to adhere to the safe distancing precautions we have set up in the waiting room and therapy room.

_____ You agree to wear a mask in all shared spaces of the office; all of KCA therapists/staff will do so too. If you do not have a mask, we have disposable masks you may use. Please consult your therapist on their in-session mask policy.

_____ Hand sanitizer is available in the lobby and in your therapist's room. Please use as needed.

_____ If you are bringing your child, you agree to make sure that your child follows all of these sanitation and distancing protocols. With young children, the use of masks will be up to the discretion of the therapist and parent.

_____ If you have a job that exposes you to other people who are infected, you agree to immediately let me know.

_____ If a resident of your home tests positive for the infection, you agree to immediately let me know and we will then resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

Our Commitment to Minimize Exposure

Our KCA practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, KCA therapists/staff and all of our families safe from the spread of this virus. If you show up for an appointment and I or another KCA therapist/staff believe that you have a fever or other symptoms, or believe you have been exposed, I am required to ask you to leave the office immediately. We can follow up with services by telehealth as appropriate. If I, test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Client Date

_____ _____

Counselor Date

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INFORMED CONSENT TO TELEHEALTH

Telehealth (or Tele-play for children) allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy and/or in parent consultations via telephone or the internet (hereinafter referred to as Telehealth/Tele-play) with the clinician(s) listed below:

Client Name(s): _____

Birthdate(s): _____

Clinician(s): _____

I understand I have the following rights under this agreement: I have a right to confidentiality with Telehealth/Tele-play under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images (pictures) or information from the Telehealth/Tele-play interaction/session to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth/Tele-play, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth/Tele-play, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, other options will be discussed.

I understand that Tele-play therapy for children may involve parental involvement, parent consultations, and/or modified session frequency and timing, based on needs of the child client.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth/Tele-play communications by providing written notification to Prepare to Change. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Authorized Signature for Client Date

_____ _____

Authorized Parent Signature (for minors) Date

_____ _____

Parent Signature(s) agreeing to using Telehealth for parent consultation sessions Date

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I _____ (parent/guardian) give consent for my child to receive individual, family and/or group therapy services outside of the office setting, a service offered through _____ (name of provider).

Services rendered outside the office include varied nature-based child counseling and play therapy interventions. Although, every reasonable precaution will be used by this provider, I recognize that confidentiality for my child/family cannot be fully guaranteed in an outdoor environment. Therefore, I accept the possibility that other people may hear parts of my child/family's conversation, or see my child/family engaging in therapeutic activities with the therapist.

I recognize that outdoor environments have inherent risks such as exposure to the sun, weather, bugs and animals (such as, mosquitos, ants, etc.). Therefore, this provider recommends that the parent or guardian make available sunscreen, water, and bug spray for health and protection. Please list here any medical concerns for your child/family such as allergies that this provider should be aware of in providing therapy services in an outdoor space.

I hereby affirm that my child/family does not have any conditions or concerns which would prevent or limit participation in outdoor therapy services. I acknowledge that my child/family's involvement in outdoor therapy services is purely voluntary and in no way required.

_____ In consideration of my child/family's participation in outdoor therapy services, I hereby release _____(name of therapist) from any claims, demands, and/or causes of action as a result of my child/family's voluntary participation.

_____ I understand that the therapist will provide the rationale for the treatment.

_____ I can choose not to participate in outdoor therapy services, now or at any time in the future. I can also revoke my consent to any outdoor therapy services at any time.

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature Date

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form is for the release of confidential information to another person or agency at your request.

I _____, authorize KCA therapist _____ to release to, obtain from, or exchange with (include name, practice, agency, and contact information as needed):

_____

_____

_____

_____

I authorize them to release, obtain, or exchange the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ other (specify) _____

For the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, unless stated otherwise.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Name of Client Date of Birth

_____ _____
Signature of Client or Guardian Date

_____ _____
Signature of Witness Date

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ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover. At this time we do not accept American Express.

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Billing Information:

Please indicate the information associated with the card you wish to use:

Name on card: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

I authorize credit card payments for all services and fees at the time they are rendered from the card ending in _____ (last four digits of the card). This credit card may be used for all parties listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

Cardholder Signature: _____ ***Date:*** _____

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): ☐ **Visa** ☐ **MasterCard** ☐ **Discover**

Card Number: _____

Expiration Date: _____ **CVV (3 numbers on the back of the card)** _____