LIFE ENRICHMENT CENTER
OF VIRGINIA

CHILD/ADOLESCENT INTAKE

*****To Be Completed by Parent or Legal Guardian*****

Appointment Date _____

Name_____ Gender: M F
FIRST MIDDLE INITIAL LAST

Date of Birth _____ Age _____ Grade _____ School _____

Address _____

City, State, Zip Code _____

Home Phone _____ With Whom Does the Child Live? _____

Primary Care Physician _____ Phone # _____

How did you hear about us?_____

MOTHER'S NAME _____ Age _____ Occupation _____

Address (if different from child's)_____

Home Phone _____ Work Phone _____ Cell Phone _____

FATHER'S NAME _____ Age_____ Occupation _____

Address (if different from child's)_____

Home Phone _____ Work Phone _____ Cell Phone _____

PAYMENT INFORMATION: Who will be responsible for payment of this account?

Name _____ Social Security # _____

Address _____ Phone #_____

Signature _____ Date _____
CANNOT SIGN FOR SOMEONE ELSE

INSURANCE INFORMATION

I authorize medical payments from _____
NAME OF INSURANCE COMPANY
to Life Enrichment Center of Virginia and its affiliated clinicians for services rendered.

Name of Policy Holder_____ Policy Holder's Date of Birth_____

Insurance ID# _____ Group # _____

Employer of Policy Holder _____ Co-pay amount _____

Is there a Secondary Insurance Policy? _____ YES _____ NO

_____ ***** **OR INITIAL HERE IF YOU DO NOT WISH TO USE INSURANCE** *****

Signature_____ Date _____

Current Medications _____

Current or past illnesses, injuries, health problems _____
_____

Previous mental health treatment (therapy, hospitalizations, drug/alcohol rehab., etc.)
_____

Briefly describe why you are seeking counseling for your child _____
_____

Please place a check by any symptoms or problems that your child is experiencing

_____ DEPRESSION	_____ ANXIETY	_____ LEARNING PROBLEMS/DISABILITIES
_____ INSOMNIA	_____ EATING DISORDER	_____ HYPERACTIVITY
_____ CHANGE IN APPETITE	_____ CONSTANT WORRYING	_____ POOR GRADES
_____ FATIGUE/LOW ENERGY	_____ PANIC ATTACKS	_____ FAMILY CONFLICT/PROBLEMS
_____ IRRITABILITY	_____ EXCESSIVE FEARS	_____ PROBLEMS WITH FRIENDS
_____ CAN'T MAKE DECISIONS	_____ SHY/WITHDRAWN	_____ INAPPROPRIATE SEXUAL BEHAVIOR
_____ LOW SELF-ESTEEM	_____ STEALING	_____ PHYSICAL ABUSE IN PAST
_____ MOOD SWINGS	_____ LYING	_____ EMOTIONAL ABUSE IN PAST
_____ ANGER PROBLEMS	_____ NIGHTMARES	_____ SEXUAL ABUSE IN PAST
_____ POOR JUDGMENT	_____ PHYSICAL AGGRESSION	_____ RECENT LOSS
_____ CRYING SPELLS	_____ VERBAL AGGRESSION	_____ ABUSING ALCOHOL
_____ SUICIDAL THOUGHTS	_____ ARGUMENTATIVE	_____ ABUSING DRUGS
_____ PAST SUICIDE ATTEMPT(S)	_____ DESTRUCTIVE	_____ LEGAL PROBLEMS
_____ HARM/INJURY TO SELF	_____ DEFIANCE OF RULES	_____ HALLUCINATIONS
_____ IN TROUBLE AT SCHOOL	_____ PICKED ON BY PEERS	_____ POOR ATTENTION/CONCENTRATION

_____ OTHER _____

OFFICE POLICIES

FEES:

Initial Evaluation (45 minutes)…….$125	Missed Session/Late Cancellation…..full fee
Psychotherapy (75 minutes)…….$150	Letters or reports..…….…….$25 per 15 minutes
Psychotherapy (45 minutes)……..…..$100	Telephone sessions…..……...$30 per 15 minutes
Psychotherapy (25 minutes)…..…..…..$65	Returned check fee……..……..$25
Court Appearance/Other legal proceedings……..$650 for the first 3 hours; $185 per hour thereafter	

1. Payment: All fees, co-pays, etc. are due on the date services are rendered. If you should choose to use your insurance, we will file the claim as a courtesy to you. Please be aware that you, not the insurance company, are ultimately responsible for payment of all charges. Please note that there are limits to what information is kept confidential when you use insurance to pay for your child's treatment. Typical information required by managed care organizations includes dates of treatment, type of treatment, a mental health diagnosis, and may include treatment plans and/or periodic review of client records.

2. Cancellation Policy: Your child's appointment time is reserved for him or her. If you need to change your child's appointment, please give at least one full working day's notice; otherwise you will be charged the full fee for the missed session.

3. Confidentiality: The information your child discusses in therapy will be kept confidential unless the therapist believes there exists a serious threat to the child's life or welfare. Additionally, the therapist is legally bound to break confidentiality in cases where the client may be in danger of harming themselves or another person, a client is gravely disabled, there is suspicion of child or elder abuse, and by order of the court. The HIPAA Notice of Privacy Practices and Policies given to you explains in detail the ways in which your child's protected health information may be used and disclosed.

4. In Case of Emergency: If your child is experiencing a mental health emergency, you may contact his/her therapist via emergency pager. In the unlikely event that your therapist does not respond within a reasonable time period (usually within one hour), please call the crisis number that corresponds to the county in which you live or call 911.

5. Collections: If your account is more than 30 days delinquent and prior arrangements have not been made, Life Enrichment Center of Virginia reserves the right to use legal means to secure payment. The cost of any collection services, up to 33.33% of the amount owed will be added to your balance. Additionally, these actions will require disclosure of otherwise confidential information to outside collection agencies.

If you have any questions about the above policies, please discuss them with your child's therapist.

I have read and understand the above policies and agree to abide by the conditions outlined.
I have also received a copy of the HIPAA Notice described above.

_____ _____

Parent Signature Date

PERMISSION TO NOTIFY PRIMARY CARE PHYSICIAN OF TREATMENT

If you would like your child's therapist to inform your child's primary care physician (PCP) that he/she is receiving counseling services, please complete the information below and sign and date the form.

If you would prefer that your child's PCP NOT be notified, please sign under "DECLINE".

If you do not have a preference, please sign under "DECLINE".

Your decision will in no way affect your child's treatment at the Life Enrichment Center. It is simply a courtesy we offer to our clients to enhance coordination of care.

I hereby GIVE my consent for _____ (therapist's name) to inform my child's primary care physician that he/she is receiving treatment and the reasons for treatment. This release is valid for one year unless noted otherwise. I have the right to revoke this authorization at any time by notifying the therapist in writing. However, my revocation will not be effective to the extent that the therapist has already taken action in reliance on the authorization.

Parent's Signature_____ Date _____

Child's Name _____ Date of Birth _____

Primary Care Physician Name and Phone # _____

OR

I hereby DECLINE my consent for my child's therapist to inform his/her primary care physician that he/she is receiving treatment.

Parent's Signature _____ Date _____