THE CENTER
PROFESSIONAL COUNSELING

SCREENING APPLICATION - PARENT OF TEEN/CHILD

- ALL PERSONAL INFORMATION IS CONFIDENTIAL -

* To be completed by parent/guardian of client. Please print clearly.

Demographics

Date:_____

Parent/Guardian Name: _____
First MI Last

Address: _____
(NO P.O. Box) Street & Number Apt# City and State Zip

Preferred Phone: ( )_____ ☐ Message ok ☐ No message

E-mail Address: _____

Age: _____ **Birth Date:** _____ **Birth Place:** _____ **SSN:** _____

Gender _____ **Ethnicity** _____

Relationship Status:
☐ Single ☐ Separated ☐ Divorced ☐ Married ☐ Widowed ☐ Partnered

If married, how long? _____ If partnered, how long? _____

If divorced, how long? _____ If widowed, how long? _____

Please list names and ages of your children, if any:

_____ _____ _____ _____

Names & ages of persons living in your home, and your relationship to them:

_____ _____ _____ _____

Name of your local emergency contact: _____

Local Emergency Contact Information: _____ _____ _____
Home Phone **Work Phone** **Cell Phone**

How is this person related to you: _____

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CONSENT FORM FOR MINORS

I hereby give The Center for Professional Counseling my consent to assign a counselor to meet with _____, a minor, on a regular basis
Name of Client
for the purpose of psychological counseling.

I give said consent knowing that the Center for Professional Counseling is a non-profit agency staffed by licensed and unlicensed therapists who are supervised by therapists licensed in the state of California.

Date: _____ Signed: _____
Parent/Legal Guardian

Signed: _____
Client/Minor

Address: _____

_____

Telephone: (_____)_____

THE CENTER
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OFFICE POLICIES & GENERAL INFORMATION
AGREEMENT FOR PSYCHOTHERAPY SERVICES

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions **are confidential** and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; or where a client presents a danger to self, to others, to property, or is gravely disabled.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by the custodian of records. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. The Center for Professional Counseling ("The Center") and all its counselors will not release records to any outside party unless authorized by **all** family members who were part of the treatment.

Emergencies: If there is an emergency during our work together where your counselor becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychological care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, the law permits The Center for Professional Counseling to contact the person whose name you have provided on the intake form as the emergency contact, without your verbal or written consent.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct The Center for Professional Counseling, only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the Psychotherapy Notes will not be disclosed to your insurance carrier. Neither The Center and/or its counselors have any control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

Legal Issues: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), you agree to pay the fee of $125.00 per hour for any expert witness and/or court appearance made by a representative of The Center on your behalf. Further, you agree to pay $25.00 per letter written on your behalf for legal, medical, educational, or social service matters.

_____ _____

Client Initial Counselor Initial

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Consultation: Your Counselor may be an MFT (Marriage and Family Therapist) registered associate or trainee, by law, he/she will consult regularly with licensed mental health professionals regarding his/her clients. We will use your health information to make decisions about the provision coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. **CPC is a general practice counseling agency and is not a crisis or urgent care behavioral health entity.** CPC may refer client(s) in need of a higher level of care to other organizations or private practice therapist who could better treat the presenting issue(s) and diagnosis. Confidentiality is fully maintained.

Considering all of the above exclusions, if it is still appropriate, upon your request, The Center for Professional Counseling will release information to any agency/person you specify after you complete and sign The Authorization to Release Information Form provided by The Center.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your counselor between sessions, please leave a message at (818) 761-2227, your counselor will provide you with their personal and confidential voice mail box number at your first session. Your call will be returned as soon as possible. Your counselor checks his/her messages a few times a day, unless s/he is out of town. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone immediately, you can call Olive View / UCLA Medical Center at (818) 364-1555 or 9-1-1.

PAYMENTS & FEES: YOUR OUT OF POCKET FEE WILL BE DETERMINED DURING THE INTAKE BASED ON YOUR INCOME DOCUMENTS AND ABILITY TO PAY AND IS CONTRACTUALLY AGREED UPON AT THAT TIME TO BE PAID IN FULL AT THE TIME OF EACH VISIT. THE INTAKE FEE IS A NON-REFUNDABLE ONE TIME FEE. Your out of pocket fee will be re-evaluated as your financial circumstances change. The Center's full fee for counseling is $125.00 per session. You will fully cooperate with this process of collection as it pertains to you.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of The Center for Professional Counseling and you. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, California in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, The Center for Professional Counseling can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a **minimum of 24 hours (1 days) notice** is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

RETURNED CHECKS: If the bank returns any of your checks made payable to The Center for Professional Counseling unpaid, you will be responsible for the amount of the check and an additional $25.00 service charge.

_____ _____

Client Initial Counselor Initial

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Acknowledgement

I have read a copy of the Office Policies and General Information Agreement for Psychotherapy Services and the Informed Consent. I have received a copy of the Client Handbook.
Will receive after intake

Client name (print)	Client Signature	Date
Parent / Guardian (if client is a minor)	Parent / Guardian Signature	Date
Parent / Guardian (if client is a minor)	Parent / Guardian Signature	Date
Therapist name	Therapist Signature	Date

5445 Laurel Canyon Blvd., North Hollywood, CA 91607
Tel (818) 761-2227 Fax (818) 761-2959 www.TheCenterPro.org

THE CENTER
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FINANCIAL INFORMATION – CONFIDENTIAL

*PLEASE PROVIDE PROOF OF INCOME (check stub, W2 tax form, etc.)

WEEKLY COUNSELING FEE DETERMINATION:

Household Income ~ Annually or Monthly (specify) $_____

ACKNOWLEDGEMENT OF FEE ARRANGEMENT: I understand and agree that The Center for Professional Counseling provides fee for service counseling. I understand that my fee per session is $_____ and I am contractually obligated to pay this agreed upon fee before the start of each session.

Signature of Client_____ Date_____

Comments on fee_____

CLIENT AVAILABILITY FOR WEEKLY APPOINTMENTS

* ***Please circle all hours you can be available to come to counseling.***

Mon: 9 10 11 12 1 2 3 4 5 6 7 8

Tue: 9 10 11 12 1 2 3 4 5 6 7 8

Wed: 9 10 11 12 1 2 3 4 5 6 7 8

Thu: 9 10 11 12 1 2 3 4 5 6 7 8

Fri: 9 10 11 12 1 2 3 4

Sat: 9 10 11 12 1 2 3 4 5

Sun: 9 10 11 12 1 2 3 4 5

Comments related to availability and counselor preference: _____

_____

_____

_____

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INFORMED CONSENT

PLEASE INITIAL EACH ITEM TO ACKNOWLEDGE THAT THE INTAKE COUNSELOR HAS THOROUGHLY EXPLAINED THE FOLLOWING ITEMS DURING THIS INTAKE SESSION:

_____ I understand that **the intake fee is a non-refundable one-time fee**. If my treatment plan requires a higher level of care than what can be offered at CPC, I may be referred to an organization or private practice therapist who could better treat my presenting issue(s) and diagnosis. Completion of the intake appointment does not guarantee acceptance or automatic enrollment into our counseling program.

_____ I understand that CPC is a marriage and family training facility which uses pre-licensed trainees and associates to provide counseling services to its clients.

_____ I understand that CPC is a general practice counseling agency and is not a crisis or urgent care behavioral health entity.

_____ I understand CPC's 24 hour cancellation, and I am aware that I am responsible for any fees accrued due to a cancellation **less than 24 hours before my appointment**.

_____ I am aware that CPC's phone number is 818 761 2227 where I may leave my counselor messages in case of a cancellation of appointment or an emergency.

_____ I agree to CPC policy to refrain from attending my therapy sessions while under the influence of any mind or mood altering substances, i.e., marijuana, cocaine, alcohol, or any other illegal nonprescription medication, which would impair my ability to fully and actively participate in the counseling session. I understand that if I break this agreement and arrive to my session while under the influence, my counselor will not see me for that session and that I will, nonetheless, be charged for the session.

_____ Fee acknowledgment: I understand that my fee based on my ability to pay is $_____. I understand that CPC has an annual fee re-evaluation and my fee may change depending on my ability to pay.

_____ I understand the California law regarding client confidentiality and the limits to confidentiality in the event of harm to self or others, child or elder/dependent abuse.

_____ I understand that my appointments are weekly for a 50 minute session at an agreed upon day and time, with either a Registered Associate Marriage and Family Therapist or Trainee.

_____ I understand that I must pay $25 for all progress and attendance letters and/or copies of medical records.

_____ The Office Policies & General Information Agreement page explains in writing what has been verbally explained regarding the items on this checklist.

_____ My email address will not be shared with a third party, nor will it be sold or used for purposes other than scheduling and receiving information about future events at CPC.

_____ _____
Client's Signature Date Intake Counselor Signature Date

Parent Questionnaire

1. Please describe the problem(s), symptoms or behaviors that your teen/child is presenting with:

2. Have you ever had a problem like this before?

3. What behavioral techniques have been attempted with the child? Have any been helpful?

4. Have you had to make any special accommodations for the child?

5. Has your teen/child ever been in psychotherapy before?

6. Does your teen/child have any medical conditions we should know about?

7. Is your teen/child taking any prescription medications?

8. Has your teen/child ever experienced physical, sexual or emotional abuse?

9. Has your teen/child ever been arrested for a crime?

10. Has your teen/child ever attempted suicide?

11. Has anyone in your family ever attempted suicide?

12. What is your current household living situation?

13. List any and all family stressors that may be impacting your teen/child's behaviors:

14. List any and all of your personal stressors you may be having direct or indirect effect on your teen/child: