REGISTRATION INFORMATION

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Client/child:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth: \_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_M \_\_\_\_F

**Name of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: mother

Address: (circle if:) Same as above

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Other Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children with whom the child resides/relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Information:

Please initial one of the following:

\_\_\_\_ In case of emergency my child may be released to the following people:

Please list at least 1 person other than parent(s)/guardian(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your child’s last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please schedule a physical with your PCP to order bloodwork to test vitamin levels (B & D, particularly) which can impact mental health. Want further testing to see what neurotransmitters may be high or low, causing mood or regulatory issues? Ask this provider for more details.**

**Are familiar with TBRI (Trust-Based Relational Intervention)? Yes Somewhat No**

**This therapist uses concepts from the following books. Please CIRCLE those which you have read: *The Connected Child* by Dr. Karyn Purvis, *Parenting without Power Struggles: Raising Joyful, Resilient Kids While Staying Cool, Calm and Connected* by Susan Stiffelman**

**INSURANCE VERIFICATION**

Outpatient Mental Health Benefits

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Managed Care Co**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check those that apply:**

Network: In \_\_\_\_\_\_\_\_ Out \_\_\_\_\_\_\_

Pre-Authorization required \_\_\_\_\_\_\_\_\_\_

Referral required \_\_\_\_\_\_\_

Copay amount \_\_\_\_\_\_\_\_\_

Deductible \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Limited number of sessions? If so, please provide the number of sessions allowable \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Limited types of sessions (individual only, etc.)? If so, fill out the information below.

90801 (eval) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

90806 (ind) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

90862 (rx mgmt) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

90804 (Ind 20-30) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

90847 (fam) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your insurance require a treatment plan? If so, please provide the address and time requirement.

**TP Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fax#:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I acknowledge my responsibility for my insurance deductible and for any non-covered services.*

*I understand that these fees are subject to change with 30 days notice. I understand that any cancellations made less than 24 hours in advance will be charged directly to me, at a rate of $50 per hour.*

Special provisions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature and date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party (if different than client)

**CONSENT FOR CHILD/ADOLESCENT TREATMENT**

I, the undersigned, am the legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, date of birth \_\_\_\_\_\_\_\_\_, a minor child. I agree to his/her treatment with Sara Rodriguez, LCSW-C. I understand that this may include the intake and diagnostic assessment process as well as any therapies or recommendations for psychiatric evaluations and/or medication. I understand that in the course of my child’s assessment or treatment services, we may be asked to participate in a number of expressive arts or play projects such as sand tray, arts/crafts, puppetry, etc.

I also understand that children in counseling progress much more quickly when their parents are involved. I agree to attend a minimum of monthly parent meetings.

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SERVICE AGREEMENT**

I agree to correspond with the Sara Rodriguez, LCSW-C regarding my child’s mental health treatment and well-being via electronic mail (e-mail). I agree that I am the sole recipient of email communication; therefore, am able to receive responsibility for maintaining my own confidentiality.

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature | x | Date |  |

Client Parent / Guardian

Client and/or client’s guardian agrees to mediation as a source of resolution if a conflict regarding treatment service delivery, fees, theory, technique, or client progress should arise. The parties agree to refrain from pre-emptive maneuvers and adversarial legal proceedings (except in the case of an emergency necessitating such action), while actively engaged in the mediation process.

I have received a copy of the privacy summary notice and am informed of my rights and responsibilities.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician/Witness Signature Date

INFORMED CONSENT FOR TREATMENT AND/OR EVALUATION

**Child Client**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(parent or guardian) (child name) (DOB)

hereby give my permission and consent for treatment to Sara Rodriguez, MSW, LCSW-C. I understand that this may include the intake and diagnostic assessment process as well as any therapies or recommendations for psychiatric evaluations and/or medication. I understand that in the course of my child’s assessment or treatment services, we may be asked to participate in a number of expressive arts projects such as sand tray or arts and crafts.

I have been informed that consultation and supervision will be obtained via a senior clinician as protocol for mental health professionals. I also consent that Sara Rodriguez, MSW, LCSW-C can use and disclose Protected Health Information for treatment, payment and healthcare operations upon notice or request from parent. I understand that Sara Rodriguez, MSW, LCSW-C is committed to preserving the confidentiality and privacy of all individuals served. Strict rules are followed from the United States and Maryland Governments about the use and disclosure of medical records/protected health information. Parents may authorize Sara Rodriguez, MSW, LCSW-C to disclose specific protected health information to a specific person/agency via the use of *Authorization for Release of Information* forms.

Limitations in Confidentiality:

Parents of child clients have access to progress updates and information regarding their child and his/her treatment. However, the child client has all rights to confidentiality in order to preserve a trusting therapeutic relationship. Mental health professionals are mandated reports; therefore, all reports of abuse, neglect, and intents to harm must be reported to the police or to the local Department of Health and Human Services.

I understand that all evaluation and treatment is voluntary, and that services will end:

1. When the therapist and I decide that sufficient progress has been made  
    or
2. At any time I so choose

or

1. After there has been no contact for 90 days.

I have read and/or had the above explained to me, and voluntarily give my informed consent to treatment and/or evaluations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Relationship to client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician/Witness Signature Date

**Explanation of Fees & Policies**

Sara Rodriguez, LCSW-C

Creative Counseling Connections

Adult, Child and Family Therapist



|  |  |
| --- | --- |
| Cancellation Policy & Attendance | * **Cancellations less than 24 hours in advance are billed at the rate of $75.** * Exceptions to the cancellation policy will be made for emergency situations or for client who are ill upon awakening if notice is received by 8 a.m., or with a doctor’s note. Please try to give as much notice as possible. * **Treatment occurs weekly. One excused cancellation is allowed per month. (Regular attendance is essential to the client’s progress)** * Please make every attempt to reschedule missed appointments. * Please inform your therapist of vacations as soon as they have been planned. |
| Illness | Please be mindful of spreading illnesses. If you are ill, especially with a contagious condition, please call in advance to reschedule your appointment. CCC will do the same. |
| Payment | Payment is due at the time of service. Unpaid services that are sent to collections will be charged plus 40%. |
| Insurance | This practice does not have the internal structure to support insurance policies. Insurance reimbursement is your responsibility; however, we are willing to support you in this process. Please be aware that many insurance companies require preauthorization and/or limit the number of sessions per preauthorization period or year. Please contact your insurance company prior to the first session. |
| Service Provision | Client or client’s guardian agrees to mediation as a source of resolution if a conflict regarding treatment service delivery, fees, theory, technique, or client progress. |

By signing below you confirm that you have read, fully understand, and agree to abide by the above policies of the practice. You also confirm that you fully understand that health insurance policies and reimbursement are between you and your health insurance company, that all services rendered to you or your child are charged directly to you, and that you are personally responsible for payment to Sara Rodriguez, LCSW-C. **If insurance coverage is denied, the client or client’s guardian is responsible for that payment.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (date)

# *Complete this form if you would like Creative Counseling Connections to be in contact with any pertinent people in your child’s life. If not, please write “declined” across the page and sign/date below.*

# Authorization for Release of Information

I hereby give my informed consent to:

Sara Rodriguez, LCSW-C

19215 Wheatfield Terrace

Gaithersburg, MD 20879

\_\_\_\_\_ to disclose information to: \_\_\_\_\_ to obtain information from:

\_\_\_\_\_ to exchange information with:

The Records of:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patient name: |  | | | | | |
| Patient Date of Birth: | |  | | Telephone: |  | |
| Patient Address: |  | | | | | |
|  |  | |  | | |  |

For the Following Purpose: collaboration for Treatment Dates: \_\_\_\_\_\_\_\_\_(Today’s date) Through\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1 year from today)

|  |  |  |
| --- | --- | --- |
| Relationship to Child | Name  Organization | Address |
| Guidance Counselor |  |  |
| Teacher |  |  |
| Psychiatrist |  |  |
| Special Education Teacher |  |  |
| Doctor |  |  |

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this *Authorization of Release of Medical Information*. This consent expires one year from the date signed by the client or legal representative and may be revoked, in writing, by the undersigned at any time.

**x\_\_\_\_\_\_\_\_\_\_\_ x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Patient/Parent/Guardian/Conservator Relationship to Patient