Shelby Psychological Services

Minor Patient Registration Form

PATIENT INFORMATION

Name	Birth Date	☐ Male ☐ Female	Social Security Number

Street Address	City	State	Zip Code

School	Grade	Patient /Guardian Employer	Work Phone
			( )

Responsible Party's Email Address	Home Phone
	( )

Primary Care Physician Name:	Cell Phone
	( )

How Did you Hear About Us?

☐ Physician ☐ Internet ☐ Yellow Pages ☐ Insurance Co. ☐ Other _____

INSURANCE INFORMATION (Please provide your insurance card for office to copy)

Primary Insurance	Policy Holder's Name

Policy Holder's Social Security #	Birth Date	Employer	Group number

Policy Number	Patient's Relationship to Policy Holder

Secondary Insurance

Policy Holder's Name	Birth Date	Employer	Group number

Policy Number	Patient's Relationship to Policy Holder

Person Responsible for Bill and address if different

Your Signature

Acknowledges:

- Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
- Notice of HIPPA and State of Alabama policy and practices to protect your health information
- Consent for me or my minor child to be evaluated and/or treated by Shelby Psychological Services (SPS)
- Dr. Vance has a small therapy-dog-in-training at SPS – we understand it is our responsibility to inform SPS staff if we do not want to interact with the dog

Authorizes:

- SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
- Consent to release treatment information to SPS providers only in the event of an interoffice referral
- Consent to release requested information to the referring physician/source
- Consent to release information for insurance purposes, when required, with supervising providers

I have read, understand and acknowledge/authorize the above.

Signature of Patient (if age 14 & older)	Printed Name of Patient	Date

Signature of Parent/Guardian	Printed Name of Parent/Guardian	Date

Shelby Psychological Services
FINANCIAL AGREEMENT

Patient/Guardian/Responsible Party Name:
_____

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. **APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE.** Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of $200/hour. A retainer fee of $1000 is required at the time of the request. _____Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____Date _____

Notice of Privacy Practices

Client Name_____

This notice describes how Medical/Mental Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective 01/01/2014. Milkay Counseling Services will only release information in accordance with state and federal laws and the ethics of the counseling profession. The following describes policies related to the disclosure of client's healthcare information. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality of care. State and Federal Laws allow Milkay Counseling Services to use and disclose health information for these purposes.

USES and DISCLOSURES

- *Help manage the health care treatment you receive* – Example: A psychiatrist sends information about your diagnosis and treatment plan so additions or changes in your care can be provided.
- *Payment* – Example: Verifying your insurance coverage or processing claims to collect fees
- *Healthcare operations* – Example: Site review for compliance
- *Other uses and disclosures without your consent* – Example: Mandated reporting for a suspected crime or abuse

CLIENT RIGHTS

- Right to request where to contact or notify you

			Number or email to use:
Home	___YES	___NO	_____
Work	___YES	___NO	
Cell	___YES	___NO	_____
Email	___YES	___NO	
Voice Mail	___YES	___NO	_____

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask to limit the information shared
- Get a list of those with whom your information has been shared
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You can complain if you feel we have violated your rights by contacting Joanna Milkay with Milkay Counseling Services, LLC. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. I will not retaliate against you for filing a complaint. Milkay Counseling Responsibilities include: 1. Required to maintain the privacy and security of your protected health information 2. Let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3. Follow the duties and privacy practices described in this notice and give you a copy of it. 4. Not use or share your information other than as described here unless you inform Milkay Counseling Services, LLC in writing. If you inform in writing, you may change your mind at any time. Inform Milkay Counseling Services, LLC in writing if you change your mind.

Client Signature (*age 14 & up*)_____ Date ____/____/_____

Guardian Signature_____ Date ____/____/_____

Client Name: _____ **Date:** _____

History and Information about your child

Are there any religious, cultural, or spiritual needs or affiliations that need to be addressed in working with your child?

_____

Child's Strengths: _____

Child's Needs: _____

Peer Relationships: _____

What are your child's hobbies, extra-curricular activities, or interests? _____

Treatment History

If your child is currently taking medication, please provide name, dosage, and reason for medication.

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Provider of medication(s) _____

Has child received previous psychiatric treatment or therapy? ____Yes ____No

Dates of service _____ Location _____

Reason for termination of treatment? _____

Why do you think your child is in need of counseling now? _____

Do you consider this an emergency? If yes please explain why: _____

Who in the family encouraged counseling the most? _____

What are the major issues or concerns regarding this child? _____

_____

How long has this been a concern? _____Has the issues changed over time? _____

Is there a time when the problem was not present? _____With whom does the problem arise? _____

How often is the issue concerning? _____How intense is the problem? (1 being not intense and 5 being very intense):_____

Can you think of any event in the child's life that may have caused this problem? If so, what was it?

_____

Child's Development (normal pregnancy, age appropriate milestones): _____

Family History

Parent's marital status *(circle one)*: Single Married Separated Divorced Deceased

Father's name _____ Mother's Name _____

Names of Step Parents _____

Siblings included stepsiblings, give names and ages _____

Names of all the people living in your child's home:

Any mental illness in the family? If so, please describe the family member's relation to child and the diagnosis and/or treatment that was prescribed _____

Has your child or any family member been hospitalized for a mental illness? If YES, please explain what happened and where _____

Has your child or a family member ever had suicidal ideations, if so please explain _____

Is there a history of substance abuse in the family? If yes please explain: _____

Is there a history of sexual abuse in the family? If yes please explain: _____

Has your child ever been a witness to domestic violence? ____ When? _____

Support system for child and family: _____

Educational History

Child's current school:_____ Grade_____ Teacher:_____

School performance:_____ Favorite subject:_____ Least favorite:_____

School behavior:_____ Have any grades been repeated _____

Does child have learning disabilities? ___Yes ___No IEP with the school? ___Yes ___No Copy of the plan? ___Yes ___No

DHR History

Is the family involved with DHR or receiving support services through DHR? If so please briefly explain: _____

Judge: _____ DHR Worker & Phone #: _____

Has your family participated in an Individualized Service Plan (ISP) with DHR? _____Yes _____No

Are there any in home services? With who?_____

Do you or your family have history with DHR? If so, please explain _____

Legal History

Is the family involved in the court system? If so please briefly explain: _____

Have you been involved with the court system before? _____ Judge: _____

Have you retained a lawyer, if so who? _____

Are there any in-home services? _____ Who is the provider?_____

Does the child have a court appointed specialist (CASA) or a special attorney or lawyer for your child (GAL – guardian ad litem)? Their name and number:_____

Next court date (if applicable): _____

Parent's legal history (incarcerations, community service/probation, charges, plead guilty): _____

_____

Is there anything else that you would like me to know about your child that has not been asked?

_____

What goals would you like for your child to achieve through therapy? Or, What final outcome would you like to see for your child upon completion of therapy?

_____

Behavioral Indicators

Please rate each behavior that your child has displayed in the last 3 to 6 months. Rate each behavior on a scale of 0 – 4.

0 = none (never)	1 = little (2 x's a month)	2 = some (1 – 2 x's a week)	3 = much (2 – 3 x's a week)	4 = most (almost every day)

___ Gives in easily
___ Unprovoked crying
___ Acting out, aggressive
___ Withdrawal, depressed acting
___ Nonparticipation in school and social activities
___ Extraordinary fears of specific persons or things
___ Sudden drop in school performances
___ Sleep disturbances, nightmares
___ Drug or alcohol problems
___ Mood Swings
___ Poor peer relationships/inability to make friends
___ Persistent & inappropriate sexual play with peers, toys, or self
___ Secretive behavior: "I can't tell you" responses regarding secrets
___ Regressive behavior: wetting pants, thumb sucking, rocking

___ Suicidal feelings
___ Unexplained anger, irritability, or crankiness
___ Bedwetting
___ Lack of trust, particularly with significant others
___ Seductive behavior
___ Change in dress habits
___ Running away from home
___ Harmful behavior to self/others
___ Loss of appetite, problems with eating or swallowing
___ Extreme Worry

Comments: _____

What is the most significant concern? _____

How long has this been a concern? _____ Has this changed over time? _____

When and where does the problem occur? _____

With whom does the problem arise? _____

Client Informed Consent, Limits of Confidentiality, and Treatment Agreement

BACKGROUND
Welcome to my practice. I have provided services to clients since 2003, after receiving my Master's degree from The University of Montevallo. I became licensed in 2006. My experience includes couples counseling, family counseling, child and adolescent counseling with play therapy modalities, individual and group counseling, and specific training with trauma and abuse. I am trained to provide evidence based therapy in Trauma Focused Cognitive Behavioral Therapy and Eye Movement Desensitization and Reprocessing (EMDR) therapy.

COUNSELING RISKS and EXPECTATIONS
It is natural to want change, to expect change, but it is hard to make change. Counseling is not a quick fix. Counseling requires desire, work, and trust. It is my belief that every person deserves the highest quality of counseling services possible without prejudice to race, gender, religion, physical challenge, ethnic origin or level of income. You may be uncomfortable or have feelings of distress during phases of the relationship. This is normal and part of the process of counseling. It is important for you to know that this may occur, so that you will maintain contact with your counselor long enough to benefit. Counseling is not always successful; some benefit and others do not. Counseling can be productive with an outcome that is beneficial. Please be aware that counseling is a choice and you may choose whether or not to participate. If you choose to participate in counseling, you may choose to terminate at any point in the process. I may choose to terminate the relationship too if there are ethical or other professional situations that warrant termination. This type of termination may not be in agreement but in the best interest of one or both parties. There are some requirements and expectations that we will discuss and agree upon before beginning services. Initially, I will assess the needs and issues for counseling and we will determine the goals. If at any point I determine that I am not able to provide the services that will meet your needs and goals then we will discuss referral sources that may better serve you.

CONFIDENTIALITY/PRIVACY
Another essential aspect of counseling is confidentiality. You need to know that the things discussed in counseling are private and confidential and that your counselor is ethically bound to protect your right to privacy. There are, however, a few circumstances under which details about your counseling will be discussed.

1. **Client Safety**

    - Risk of suicide
    - Risk of hurting others
    - Risk to the client by someone else (Suspected abuse mandates a report)

2. **Court Order**

Note: I do not believe that counseling records belong in court. Counseling is confidential and should be honored as confidential and protected. I do not provide custody evaluations or evaluations for court deposition. If you choose to have records subpoenaed and/or require my professional time with your court case, I will charge the legal fees to you in order to get it quashed or before a judge for in court review. Records that are court ordered by a judge require release of records and fees for court include time with paperwork, travel time, time in court and legal fees.

3. **Client consents for the release of information to another provider or individual**

If a third party pays for your care, such as Blue Cross/Blue Shield or any other insurance company, then that 3rd party has the right to review your record of treatment. By electing to use your insurance, you are choosing to disclose limited information (diagnosis required by insurance companies) to your insurance for the purpose of payment to Milkay Counseling Services, LLC. Release of records or sharing of information requires your consent and documentation as to whom the information can be released or shared. Records are secured for at least 7 years before they are destroyed.

TECHNOLOGY

You may elect to use technology such as email and I take every precaution to protect you and your information from the public. I cannot guarantee unauthorized access with electronic communications. I do not accept friend requests of any clients on Facebook.

CANCELLATION
Your insurance may or may not pay for counseling services. You are responsible for copays and denied insurance submittals. You are responsible for all fees at the time of each appointment. I accept cash, checks, and credit cards. If you refuse to pay your debt, I reserve the right to use an attorney of collection agency to secure payment.

I ask that you please call with a **24 hour** notice to cancel your appointment. Any missed session without cancellation is subject to payment (unless we both agree that the absence was due to circumstances beyond your control). Insurance companies do not reimburse for missed sessions or coming late; you will be responsible for fees incurred, which is the charge of the regular rate for counseling services. An automatic electronic system will remind you of your appointments but sometimes these systems malfunction. You are still responsible and agree to scheduling and cancellation, which can be done through phone and/or email.

AFTER HOURS
Milkay Counseling Services, LLC does not provide on-call services directly. I am available during normal business hours. I check my email and phone regularly to respond to calls that can be attended to within a 24 to 48 hour period. Immediate crisis are directed to THE CRISIS CENTER at **(205) 323-7777** or 1 800 273-8255.

MINORS (children under the age of 14 or adult that can't consent and has a legal guardian)
If you are signing for a minor for whom you are the legal guardian, you are stating that you have the legal right to sign this consent for them and agree to counseling/treatment. The minor is the client. The confidentiality of the session is important. As the custodian, you are entitled to know if the minor is progressing, declining, unstable, in need of further services, or in an unsafe or concerning situation. If you are actively involved in a custody dispute or have legal counsel, I will not speak to an attorney that does not represent the minor client. I will collaborate or consult with a Guardian Ad Litem, representing a minor client, to whom I am counseling and to support the best interest of the minor.

By signing below, you agree to the above conditions and acknowledge that these conditions have been discussed and explained fully to you for the counseling relationship between

_____ and Joanna Milkay, NCC, LPC-S
CLIENT Milkay Counseling Services, LLC

_____ _____
Client Signature (14 years of age or older) Counselor Signature

_____ _____
DATE DATE

Custodial Care

_____ _____
PARENT/GUARDIAN SIGNATURE PARENT/GUARDIAN SIGNATURE

_____ _____
DATE DATE