



PEACE OF MIND THERAPY • 6502 GRAND TETON PLAZA STE 204 • MADISON, WI 53719

PEACEOFMIND-MADISON.COM • 608.338.1786 • fax 608.831.4383

1

CONTACT INFORMATION

NAME OF LEGAL GUARDIAN: _____

NAME OF MINOR CHILD: _____ AGE: _____

CHILD'S DATE OF BIRTH: _____ CONTACT PHONE# _____

STREET ADDRESS OF LEGAL GUARDIAN: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS OF LEGAL GUARDIAN: _____

PLEASE INDICATE: FULL CUSTODY OF MINOR JOINT LEGAL CUSTODY SHARED TIME ONLY OTHER
CAN PROVIDE LEGAL CUSTODY PAPERWORK IF REQUESTED

2

INSURANCE

HEALTH INSURANCE PLAN: _____ CO-PAY AMOUNT FOR OFFICE VISITS: \$ _____

WHAT IS YOUR ANNUAL DEDUCTIBLE? _____ HAVE YOU MET IT? _____

HAVE YOU CONFIRMED THAT YOU CAN USE YOUR INSURANCE FOR MENTAL HEALTH? YES NO

POLICY HOLDER NAME: _____ MIDDLE NAME: _____

BIRTHDATE: _____ PHONE: _____

PRIMARY HOLDER'S INSURANCE ID# (include dash & two digits) _____

IF PRIMARY CARD HOLDER HAS A DIFFERENT ADDRESS PLEASE PROVIDE WITH ZIP CODE:

YOUR INSURANCE ID# (include dash & two digits) _____

GROUP POLICY ID# _____

Please note we ask you to come to your first session with a knowledge of the above information. It will not be Peace of Mind's responsibility to determine your insurance coverage. We will bill you out of pocket (\$160) should insurance deny your claim. In the case of minors, it is the guardian's responsibility to ensure that the co-pay amount is provided at the time of **each session.**

3

ABOUT YOUR CHILD

WITH WHOM DOES THE CHILD LIVE? _____

WHAT IS THE CONCERN THAT BRINGS YOU TO THERAPY? _____

IS THIS A NEW CONCERN? YES NO

IF NOT NEW HOW LONG HAS THIS BEEN OCCURRING? _____

WHAT HAS BEEN THE IMPACT TO YOUR CHILD? _____

PLEASE LIST ANY MEDICATIONS YOUR CHILD CURRENTLY TAKING:

MEDICATION	DOSAGE	PURPOSE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4

MORE ABOUT YOUR CHILD

PLEASE INDICATE IF YOUR CHILD IS EXPERIENCING ANY OF THE FOLLOWING DIFFICULTIES:

- SCHOOL ATTENTION/CONCENTRATION PROBLEMS/GRADE PROBLEMS
- HYPERACTIVE/DIFFICULTY BEING STILL
- IMPULSIVE
- SADNESS OR DEPRESSION
- GENERALIZED ANXIETY
- FEARS/SOCIAL ANXIETY/NIGHTMARES
- PROBLEMS WITH EATING/SLEEPING/FALLING ASLEEP/STAYING ASLEEP
- TANTRUMS
- PROBLEMS SOCIALLY WITH FRIENDS/AUTHORITIES
- PHYSICALLY AGGRESSIVE BEHAVIOR TOWARDS OTHERS (PARENTS/CAREGIVERS/TEACHERS/FRIENDS)
- VERBALLY AGGRESSIVE TOWARDS OTHERS (PARENTS/CAREGIVERS/TEACHERS/FRIENDS)
- STRESS RELATED TO PROBLEMS WITH PARENTS/CAREGIVERS (DIVORCE/CONFLICT)
- ADJUSTMENT TO LOSS (PARENT/FRIEND/PET/NEW CITY/NEW HOUSE/DIVORCE)
- BODY FOCUSED BHEAVIORS
- SELF HARM/SUICIDALITY (CUTTING/THREATS/PLAN)

FOR PARENTS OR CAREGIVERS:

HOW WOULD YOU RATE THE QUALITY OF YOUR PRESENT MARRIAGE/PARTNERSHIP?

- GREAT
- VERY GOOD
- GOOD
- FAIR
- POOR
- VERY POOR

WHAT ARE YOUR CHILD'S THREE GREATEST STRENGTHS?

- 1.
- 2.
- 3.

TELL US ABOUT SOME OF THE THINGS IN YOUR CHILD'S PAST IN WHICH THEY HAVE FELT THEY HAVE BEEN AT THEIR BEST.

WHO IS YOUR CHILD'S BIGGEST SUPPORTER? _____

PARENT/CAREGIVER PLEASE ANSWER THE FOLLOWING QUESTIONS:

- 1. MOST PEOPLE WOULD DESCRIBE MY CHILD AS (PLEASE CIRCLE ONE)
 - a. FEELING CENTERED
 - b. THOUGHT CENTERED
 - c. ACTION CENTERED

- 2. MY CHILD WOULD DESCRIBE SELF AS (PLEASE CIRCLE ONE)
 - d. FEELING CENTERED
 - e. THOUGHT CENTERED
 - f. ACTION CENTERED

- 3. WHEN YOUR CHILD IS UNDER A GREAT DEAL OF STRESS OR TENSION (PLEASE CIRCLE ONE)
 - g. THEY SIMPLY CANNOT SIT STILL; NEED TO BE BUSY
 - h. THEY WILL SOMETIMES DO SOMETHING TO TAKE THEIR MIND OFF THE STRESS
 - i. THEY BECOME IMMOBILIZED

GOALS FOR THERAPY:

PARENT/CAREGIVER PLEASE PROVIDE US YOUR HOPE/GOALS FOR CHANGE FOR YOUR CHILD:



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INFORMED CONSENT FOR TREATMENT

1

CLIENT RIGHTS AND SERVICES

I understand that I have the right to participate in the development and ongoing review of my child's treatment plan. The plan will reflect my child's strengths and respect cultural values, beliefs and traditions. I also have the right to understand the types of services my child will receive as well as the limitation of those services:

1. How these services will operate and options for alternative services;
2. How these services can help as well as any risks associated with these services;
3. The probable consequences of not receiving the proper services.
4. To be provided specific, complete and accurate information about treatment
5. To be free from having unreasonable arbitrary decisions made about me
6. To receive prompt and adequate treatment
7. To have a safe treatment setting, free from sexual, physical and emotional abuse.
8. To refuse to answer any questions or give any information I choose not to give/ answer.

I also understand that in certain circumstances in which the therapist is unable to meet my child's needs where specialized treatment, psychiatric care or additional services are warranted, I will be given names and phone numbers to appropriate agencies that will be able to meet those needs. I understand this will be decided within the first three sessions and will be discussed with me within the first three sessions if needed.

2

FEES AND PAYMENT POLICY

I understand that I will be charged **\$160.00 per session (per hour)**, unless I am using insurance or I have agreed upon a sliding scale hourly fee provided by Peace of Mind Therapy. I understand that I will be obligated to pay immediately after each session. I understand that cash, personal checks, and charge cards are acceptable methods of payment. I understand that if I should use insurance, I am responsible to pay the agreed upon co-pay set forth by my insurance and **if insurance should deny my claim I will be responsible for the out-of-pocket hourly fee.**

Peace of Mind Therapy's payment policy is to collect payments at each therapeutic session. This includes co-payments for insurance. **Any charges not covered by insurance or a health flex account will be the responsibility of the client. It is not uncommon to submit to insurance and have a waiting time of a month or more before learning that reimbursement is not an option.** All sessions incurred at the time of learning this will be, again, the responsibility of the client.

3

CONFIDENTIALITY OF A MINOR

I understand that every effort will be made to insure that information obtained through working with my child will be kept confidential. Confidentiality about my child's care is protected by the therapist and by state and federal regulations. It has been explained to me that legal and ethical requirements specify certain conditions that make it necessary for confidential information about my child's care to be discussed with persons outside the client / therapist relationship. These conditions include:

1. Situations that involve danger to my child or posed by my child
2. Neglect or abuse of children, elderly or disabled persons.
3. Court ordered release of records.

I understand that when treating a minor, their confidentiality will be maintained by the treating therapist. As the legal guardian, I have a right to treatment status updates, collaborative treatment planning when appropriate, and to be informed of imminent harm.

4

CLIENT RESPONSIBILITIES & CONTACTING THE THERAPIST

In order for work in therapy to be successful I understand that it is essential that my child attend sessions and make a sincere effort to work on the issues that therapist and child are addressing. If for some reason my child cannot attend a scheduled session, I will make every attempt to call at least **48 hours** before the session to cancel. I understand that 3 missed sessions without adequate prior notice may result in termination of therapy. **I understand that without adequate notification of cancellation I will be charged a fee of \$120.** I also recognize that all Monday appointments require a Thursday notice of cancellation otherwise I will be charged \$120.

We contract with our clients to either bill their insurance after each session or collect payment out-of-pocket after each session. We ask that clients using their insurance understand their plan, if there is a co-pay, if there is a deductible and how much/has it been met and if we are a covered provider. It is the responsibility of the client to come prepared with such information so that we can minimize and all together avoid having to make phone calls about your coverage. We also do not want to have an accruing amount of out-of-pocket expenses should insurance not cover our work. **We ask that you attest below that you are understand your current insurance policy and in the event that we cannot use your insurance you will pay any out-of-pocket fees.**

Signature _____

Therapist's office hours are **Monday through Friday 8:30 a.m. to 4:30 p.m.** The main phone number is **608-338-1786**. If no one answers, I understand that I may leave a message and my call will be returned as soon as possible. To schedule or cancel an appointment, I will phone the main phone number listed or visit the online booking portal to make changes. In cases of emergencies, I should first call 911. If my emergency is not appropriate for immediate medical care, I may phone my therapist at the above listed number.

I consent below to giving my child's therapist permission to: **1)** leave a voice message. I understand that confidentiality cannot be guaranteed when leaving a message. **2)** I give permission to therapist to communicate, when appropriate, using email. I understand that with email, there is information about my child being transmitted electronically and without guarantee of confidentiality. Please sign your name below on each line issuing your consent.

Signature for phone message: _____

Signature for email correspondence: _____

I prefer therapist does not correspond with me using either of these means: _____

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SIGNATURES

I have read and understand this document and I have asked any questions I have regarding the above information. I agree to my child's participation in treatment under the conditions described.

By signing this form I:

1. Give consent for services and acknowledge that I have been informed about my rights and responsibilities.
2. I understand that I am responsible to pay the above listed fees at the end of each session.
3. I understand that consent is valid for one year from the date I sign and that I may withdraw consent at any time.

Client Signature _____ Date _____

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Please refer back to section 4 and make sure you have signed all three areas of acknowledgment/consent.

6

HIPAA ACKNOWLEDGEMENT

I, **(please print your name)** _____, am aware of the HIPAA Acknowledgment on Peace of Mind Therapy's website and that I am entitled to a copy of that should I request one.

For Office Use Only:

- I obtained written acknowledgement of receipt of Notice of Privacy Practices
- I attempted to obtain written acknowledgment of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:
 - Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgment
 - An emergency situation prevented me from obtaining acknowledgment