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	☐ FAIR
☐ VERY GOOD	☐ POOR
☐ GOOD	☐ VERY POOR

5

STRENGTHS AND GOALS

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:* _____

5 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

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MATURE MINOR DOCTRINE FOR MINOR CHILD 14 TO 17 YEARS OF AGE

Peace of Mind Therapy honors the **Mature Minor Doctrine** for minors 14-17 years of age. This doctrine protects and affords minors the ability to legally consent to their own mental health treatment, reject treatment, and make decisions about their treatment without the involvement or consent of their legal guardian. The minor is legally owed full confidentiality and they have the protection, under the law, to choose whether they release any information/treatment records about their care by doing so with written consent. The exceptions to this doctrine are: If the minor is in imminent danger (self-harm or threat of harm from another), physical or sexual abuse of or by the minor is learned, if the minor is not competent to make informed decisions about their care, or if the court should request release of the minor's record.

During our initial session, the minor's clinician will address and explain Mature Minor Doctrine. In order for the legal guardian to inquire about, make changes to, the minor's therapy schedule, a release of information will need to be signed by the minor. In order for the parent to have any involvement in the ongoing care of the minor, the minor will need to sign a release of authorization. Below, we ask that you, the legal guardian, sign the acknowledgment of this doctrine. We will require the signature of the minor during the first session, as well, to acknowledge that we have discussed this with them and answered any questions they may have regarding the rights afforded to them under this legal doctrine.

In addition to preliminary signatures of the legal guardian below, and the minor's signature **after** our first session, we have included our Release of Information for a Minor document that your minor child can review **ahead** of our appointment and sign if they choose.

Signature(s) requested **ahead of the first session** is that of the legal guardian:

I, _____, have read and understand the legal rights my minor child age 14-17 years has under the law. I recognize that unless my minor child gives me permission, in writing, to make appointments on their behalf, discuss treatment progress with the clinician, and/or collaborate with other providers, my minor child must fill out and sign a release of information.
Signature: _____
Date:_____

*Signature of minor **after first session**: Please **DO NOT** have your minor child sign this document before their first session.*

I, _____, have discussed with my clinician and understand my legal rights under the Mature Minor Doctrine. I understand that I have to provide written consent for a parent, legal guardian, or other provider to receive information about my mental health care. I understand that my clinician will need to release information about my care, without my consent, in the event that I am in danger of harming myself or another, that I am experiencing physical or sexual abuse or that I am perpetrating physical or sexual abuse of another minor, or if the court should order my records released.
Signature of minor client:_____
Date:_____

Signature of Clinician: _____
Date:_____

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Authorization to Release Confidential Records and Information **of a Minor (14-17Years)**

I, (Minor Client Name) _____ hereby

authorize: (Therapist) _____ to Release information to (Legal Guardian

or other Provider Name) _____

For the following Purpose(s) please check all that apply:

o Making Therapy Appointments and Coordinating with Administrative Staff Around Appointments and Payments

o Coordination of Care (my progress, discussing resources/suggestions, coordinating between parties for my care)

o Treatment Planning

o Other _____

The information to be disclosed:

o Information for making or changing appointments on my behalf
o Discussion of my treatment, progress, specialized treatment needs
o Information to help assist in the transfer of care to another clinician
o Other _____

Minor Client's Signature _____ Date: _____

Therapist's Signature _____ Date:

I have had it explained to me, and fully agree to the release of the above stated information. I understand that this release is only valid for one year from the date signed above. I understand that I can re-evaluate and change my consent for future purposes at any time.