MINOR CHILD INFORMATION & TREATMENT AUTHORIZATION

ANNE MINITER MCKAY COUNSELING, LLC
LICENSE#0701004304
487 B CARLISLE DRIVE, HERNDON, VA 20170
INFO@ANNEMCKAYCOUNSELING.COM VOICE/TEXT: 703-328 4937

First Name: ________________________________ Last Name: ______________________________ Middle Initial: ____

Address: ____

City: _________________________ State: _________ Zip Code:___________

Child Cell Phone: _______________________ Date of Birth: _______________ Age: _____

Referred by: _________________________________
Current Grade in School: _______ Name of School: __________________________ Current GPA Approx: ____________
Current Extracurricular Activities: ____
Prior/Current School Reprimand
Issues:____

Prior Counseling: Yes / No Most recent treatment date: ___________Provider Name: ____________________________

Your Child's Nuclear Family:

Name:	Age:	Relationship to You:	Currently Resides With You?

- Father's Age: _______ Mother's Age: _______ Were you adopted? Yes /No If yes, adoption age? ____________
- Parent's Marital Status (circle one): Married / Divorced / Separated since date: ___________

Please answer the following questions as accurately as possible. <u>All information is confidential</u>:

1. Child's current and/or Past Psychological Behavioral Episodes (e.g. Depression, anxiety, bipolar disorder, etc.):

Condition:	Approx. Dates Start to Finish:

2. Child's current Psychiatric Medication Taking:

Medication Name: Prescribed to Treat:

____

____

3. Child's Biological Family History of Episodes of Behavioral Disorders (e.g. Depression, schizophrenia, bipolar disorder, etc. in siblings, parents, grandparents):

Condition: Biological Relationship to Client:

____

____

- Does your child engage in any types of high-risk or self-injurious behavior?: *Yes No*
- Has your child ever attempted suicide? *Yes No*
- Any family members attempted or completed suicide? Yes No Describe:

____

- Does your child have any suicidal thoughts or plans now? Yes No
- Are there weapons in the home? Yes No
- Have your child ever been involved with the legal system? Yes No Describe:

____

4. Child's Past Major Physical Health Problems and/or Disabilities:

____

____

Your Main Reason for Seeking Counseling for your child:

____

____

____

****

Child Name: ____ DOB: ______________

Mother Name: _______________________________ Cell Phone: __________________

Mother Signature ____________________________ Date __________________

Father Name: _______________________________ Cell Phone: __________________

Father Signature ____________________________ Date __________________

I named below hereby certify that I have sole custody of the above named child and therefor conjoint/dual signature from this child's other parent is not required for authorization for this counseling treatment.

Name: ____
Parent Signature ____ Date __________

Emergency Contact: ________________________Telephone: ______________Relationship: __________________

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Client-Therapist Treatment Agreement

Thank you for selecting me as your therapy provider. I will do all I can to offer you the highest quality care possible. The purpose of this Client-Therapist Treatment Agreement is to provide you with important information about the counseling process and your rights and responsibilities. Counseling is more likely to be successful if we have a mutual understanding of the treatment process.

Within the next few sessions, we will establish goals for our work together and plan a treatment that seems likely to help you achieve those goals. I have found counseling to be most effective if we work collaboratively; I expect you to come to our sessions on time, to complete any tasks we agree upon, and to do your best to talk about the concerns, behaviors, thoughts, and feelings that are bothering you. Although counseling usually results in positive changes in mood, behavior, relationships and other areas, it may also lead to unanticipated and unwanted changes. If anything about our counseling troubles or disappoints you, I strongly encourage you to talk about that in our sessions so that we can address your concerns. You have the right to full information about your treatment and to plan an active part in that treatment. You have the right to receive a copy of the code of ethics that I follow, to ask questions about the counseling process, to express your concerns, to obtain a second opinion, and/or to terminate counseling.

Confidentiality, one of your most important rights, is maintained as part of the counseling process in accord with the ethical standards of my profession. Your written authorization is required for release of information or records, such as to your physician. **Exceptions are made to this policy on confidentiality only in the event of court order, clear and imminent danger to you or another person, or suspected abuse of children, the disabled, or the elderly.** An exception also can be made in the event of nonpayment of fees necessitating the use of a collection agency; that agency will not receive information on the content of our work, but may need to receive dates of sessions and copies of your consent to treatment forms. In addition, I sometimes consult with peers, but will not provide any identifying information about you in the course of consultation. I use an encrypted computer and my email is password protected, but the security of electronic communications can never be completely guaranteed. A note about Facebook: I do not accept friend requests from clients because it jeopardizes your confidentiality. If you are concerned about confidentiality matters with the use of email or other electronic communications, please always call me.

My current fee is $150 for a 45 minute session. Payment should be made at the time of service. I will provide you with monthly statements for your submission to insurance. A

charge of $35 per 15-minute segment also will be made for consultation by telephone. No charge will be made for brief telephone conversations to schedule, change, or confirm appointments.

If you need to cancel or change an appointment, please give me at least 24 hours notice. If that is not done, you will be charged in full price for any missed appointments. *Emergency Cancellations (within 24 hours)* due to a family emergency or some other unforeseeable infrequent circumstance should be made by call or text to my cell number. These appointments will be a courtesy reschedule. You will not be charged for weather-related cancellations if area schools are closed due to the weather at the time of your appointment.

I will provide you with my contact number as well as email address. Texts may be sent and/or messages may be left on my voice mail at any time. I regularly check these contact points and will return your outreach as soon as possible. Please note that I do not respond to counseling related issues via email or text as concerns in these areas are best handled in session. Skyping as a form of ongoing support and/or transitional support, will only be provided at my sole discretion and with prior extensive counseling established via in-person in office treatment.

In the event of a true emergency, please go to the nearest hospital emergency room or call the nearest community mental health center. **If the emergency involves a life-or-death situation or threat of physical harm, contact me AFTER calling public emergency numbers and your psychiatrist's emergency number (if you have one) or proceed to the nearest hospital emergency room.** These could include the following 7 day a week, 24 hour a day numbers: 911 (any area); Colombia Dominion Hospital, 703-536-2000; Fairfax/Falls Church Community Mental Health Center at Woodburn, 703-573-5679; or Inova Fairfax Hospital 703-698-1110. Please do not use email or text for emergency situations. Information regarding my policies on protected health care information as per Virginia law and HIPPA can be found on my website below. If you have any questions regarding this information, please ask me. Thank you. www.annemckaycounseling.com – Click on HIPPA link on the front page.

Please sign below to indicate that you have reviewed, understand, and are in agreement with the policies in this statement. Please keep one copy for yourself and return the other to me.

Child Name: ____ DOB: ______________

Mother Name: ____

Mother Signature ______________________________ Date __________________

Father Name: ____

Father Signature ______________________________ Date __________________

I named below hereby certify that I have sole custody of the above named child and therefor conjoint/dual signature from this child's other parent is not required for authorization for this counseling treatment. Mother

Name: ____

Parent Signature ______________________________ Date __________

Consent for Treatment of Minor

The information contained in this agreement is in addition to the information contained in the Client-Therapist Agreement, a copy of which has been provided. In order for me to provide services to your child, both forms must be read and signed by both parents, unless one parent has sole legal custody.

A copy of any custody agreement relevant to this child must be provided as well before any services can be provided. The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. I will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential.

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist. Therapy is most effective when a trusting relationship exists between the therapist and client. Privacy is especially important in securing and maintaining that trust. The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy are potentially lost. The content of your child's sessions must be confidential in order to enable your child to confide in his/her therapist, and for therapy to be effective. This is especially true for adolescents. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is being respected, at the same time that parents have access to certain critical information. This Consent for Treatment of Minor agreement must have the understanding and signed approval of the parents or other responsible adults and of the child in therapy, and is written verification of this agreed upon arrangement. If your child is an adolescent, it is likely that he/she will reveal sensitive and personal information, and possibly information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. Unless your child is at serious risk of harming him/herself or another, I will not share with you what your child has disclosed to me without your child's consent. Information regarding my policies on protected health care information as per Virginia law and HIPPA can be found on my website below. If you have any questions regarding this information, please ask me. Thank you. www.annemckaycounseling.com – Click on HIPPA link on the front page.

Child Name: ____ DOB: ______________
Mother Name: ____
Mother Signature _____________________________ Date __________________

Father Name: ____
Father Signature _____________________________ Date __________________

I named below hereby certify that I have sole custody of the above named child and therefor conjoint/dual signature from this child's other parent is not required for authorization for this counseling treatment. Mother

Name: ____

Parent Signature ____ Date ____________

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Consent for Treatment of Minor Agreement Addendum

The information contained in this Consent for Treatment of Minor Agreement Addendum is in addition to the information contained in the Client-Therapist Treatment Agreement, a copy of which has been provided. In order for me to provide services to your child, both forms must be read and signed by both parents, unless one parent has sole legal custody. A copy of any custody agreement relevant to this child must be provided as well before any services can be provided.

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. I will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential. Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist. Therapy is most effective when a trusting relationship exists between the therapist and client. Privacy is especially important in securing and maintaining that trust. The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy are potentially lost. The content of your child's sessions must be confidential in order to enable your child to confide in his/her therapist, and for therapy to be effective. This is especially true for adolescents. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is being respected, at the same time that parents have access to certain critical information. This Consent for Treatment of Minor Agreement must have the understanding and signed approval of the parents or other responsible adults and of the child in therapy, and is written verification of this agreed upon arrangement. If your child is an adolescent, it is likely that he/she will reveal sensitive and personal information, and possibly information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. Unless your child is at serious risk of harming him/herself or another, I will not share with you what your child has disclosed to me without your child's consent. Information regarding my policies on protected health care information as per Virginia law and HIPPA can be found on my website below. If you have any questions regarding this information, please ask me. Thank you. www.annemckaycounseling.com – Click on HIPPA link on the front page.

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[*SIGNATURES OF THIS DOCUMENT ARE ON FILE WITH THIS OFFICE. FOR A SIGNED COPY PLEASE CONTACT THIS OFFICE AND WE ARE PLEASED TO PROVIDE]**

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