



## MINOR INTAKE FORM

### **General Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### **Mother's Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

### **Father's Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_



Parent Marital Status (please circle): Married      Divorced      Widowed      Never Married

Who has legal/physical custody? \_\_\_\_\_

*Please provide legal documentation if necessary for the custody information above.*

### **Insurance Information**

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder's DOB (mm/dd/yyyy): \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### **Mental Health History**

What are your concerns/expectations for your child?

Has your child ever engaged in self harm and/or experienced suicidal ideation? Please explain.

Has your child ever received counseling or psychotherapy? If yes, when and by whom?



Please list any psychiatric medication your child has taken or is currently taking:

<u>Medication</u>	<u>Dates</u>	<u>Benefits/Side Effects</u>
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### **Medical History**

Primary Care Physician:

Please list any medical problems and/or serious procedures your child has had:

Please list any medication your child has taken or is currently taking for medical problems:

<u>Medication</u>	<u>Dates</u>	<u>Benefits/Side Effects</u>
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Are you concerned about your child consuming alcohol or recreational drugs? If so, please explain:

Please list any history of mental health issues, medical issues, and substance abuse among your child's blood relatives:

**Mother's Side**

**Father's Side**

Please list any allergies you have:



## **Social History**

Has your child had any developmental problems? If so, please explain.

Has your child been a victim of any form of emotional, physical and/or sexual abuse?

As a parent, are you experiencing any issues with your marriage or parenting? If so, please explain

## **School History**

Where does your child go to school?

Grade Level: \_\_\_\_\_ Typical Grades: \_\_\_\_\_

Where are your child's academic strengths?

Has your child ever had an IEP/504 plan implemented? If so, please list any relevant accommodations:



## MINOR CONSENT TO TREATMENT

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

I give Healing Minds, LLC my consent to treat my child. If we are treating your child, we will do our best to accurately diagnose your child and design a comprehensive treatment plan that will enable your child to continue with a typical emotional development. This may include recommendations of therapy, medications, and/or contacting your child's school to help coordinate optimal education. This is all part of the service of a mental health professional. We can also work with your child's primary care physical to assure coordination of care.

\_\_\_\_\_ (Initial)

Your child is our client and has confidentiality rights. Confidentiality does not apply under the following situations: reporting suspected child abuse, and anyone suspected in danger of harming themselves or someone else. Except in these situations, your child has a right to keep particular topics confidential from even his/her parent or guardian. Please respect this confidentiality. If there is any concern of harm, suicide or other dangerous behavior, we will inform you.

\_\_\_\_\_ (Initial)

If we require or believe it is in your best interest to communicate with an outside source, such as your child's school, we will request that you complete a release of information. **We do not perform custody evaluations.** If there is a question of custody, there will need to be a separate, neutral evaluation that both parties can agree on. To assure best therapeutic care, frequent appointments are recommended. Clients who have not been seen in 6 months will be considered inactive and will be required to complete a new evaluation.

\_\_\_\_\_ (Initial)

I, \_\_\_\_\_, (parent/guardian), do hereby seek and consent for my child to take part in the treatment provided by Healing Minds, LLC. If my child is attending group services, I also understand and consent that confidentiality still applies and that Healing Minds, LLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with my child's provider and regularly reviewing their work towards the treatment goals are in my child's best interest. I agree to play an active role in this process. I understand that no promises will be made to me regarding the results of my child's treatment or any other procedures provided by my mental health provider.

\_\_\_\_\_ (Initial)



While treating your child, we may consult other team members inside the Healing Minds practice regarding your child and his/her treatment. Consulted practitioners are required to keep all information discussed confidential and are held to the same level of ethical standards as the primary therapist.

\_\_\_\_\_ (Initial)

I am aware that I may stop treatment for my child with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment for my child. (For example, if my child's treatment has been court-ordered, I will have to answer to the court).

\_\_\_\_\_ (Initial)

Healing Minds, LLC and all of our clinicians do not participate in custody proceedings.

\_\_\_\_\_ (Initial)

I, \_\_\_\_\_ (parent/guardian) understand that Healing Minds, LLC works in connection with the Collection Services of Nevada. If for any reason my child's account is not paid in full after three months of the date I was billed, I understand that my contact information and statement may be released to the Collection Services of Nevada.

\_\_\_\_\_ (Initial)

Healing Minds and/or your therapist have the right to terminate services for non compliance/non committal to treatment at any time not deemed effective for treatment.

\_\_\_\_\_ (Initial)

If your therapist is an intern and you need case management services outside of therapy sessions, you will be responsible for these charges. This will be determined by your therapist as to what will be considered case management "outside of sessions." The charge will be \$30.00 per 15 minutes.

\_\_\_\_\_ (Initial)

I am aware that if I attempt to contact my child's provider through phone, email, text or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, Healing Minds is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_ (Initial)

**DISCLAIMER:** By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

**Client signature (or Representative):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent/Guardian (sign or print):** \_\_\_\_\_ **Relationship:** \_\_\_\_\_



## **INSURANCE AUTHORIZATION/RELEASE OF INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

I, the subscriber named below, authorize Healing Minds, LLC, to release any and all information pertaining to my treatment to any third party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and diagnosis.

Please note that insurance is considered a method of reimbursing the client for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, while others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time, and not to exceed 90 days

Parent/Guardian Name (please print): \_\_\_\_\_

*DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.*

**Parent/Guardian Signature (sign or print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

Insurance Company: \_\_\_\_\_



## HIPAA NOTICE/PRIVACY PRACTICES

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. **Please review this carefully.**

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you, and to enable us to meet our professional and legal obligations to operate this practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our office.

Parent/Guardian Name (please print): \_\_\_\_\_

*DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.*

Parent/Guardian Signature (sign or print): \_\_\_\_\_





## APPOINTMENT CANCELLATION AGREEMENT

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

We understand that things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, Healing Minds requires **24 business hours notification (Monday through Friday, 8:00am to 5:00pm)**. If you fail to cancel within the 24 hours prior to your appointment, **a \$100 fee for the initial appointment will be charged to the card below or to the credit card on file, or a \$75 fee for any follow-up appointments**. In addition, if you do not show for your appointment within 15 minutes of the start of the session, this fee will be charged. While our system reminds you of your appointment, it is your responsibility to call the office at (775) 448-9760.

### **My signature acknowledges:**

- In the case of a psychiatric emergency, I will call 911 or go to the nearest hospital
- I will adhere to the guidelines above
- I understand that Healing Minds will attempt to bill my insurance and that if my insurance does not pay for any reason, I am responsible for any remaining balance. This may include deductibles, copays, or out of pocket expenses.
- I authorize Healing Minds to charge all fees to the card kept on file if not paid within a timely manner
- If I have any questions regarding charges to my account, I will contact Leigh Miller for assistance at [lmiller@healingminds.com](mailto:lmiller@healingminds.com)
- I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Healing Minds, LLC.

***DISCLAIMER:** By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.*

**Parent/Guardian Signature (sign or print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I authorize the following card and any card swiped into the system to be used for co-pays and fees for services provided to:**

Client Name (please print): \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV: \_\_\_\_\_

**Parent/Guardian Signature (sign or print):** \_\_\_\_\_ **Date:** \_\_\_\_\_