MINOR INTAKE FORM

Child's General Information

First Name: _____ Last Name: _____

Gender: _____ Date of Birth (mm/dd/yyyy): _____

Social Security Number (optional): _____

Name of person completing this form: _____

Relationship to patient: _____

First Parent's/Guardian's Information

First Name: _____ Last Name: _____

Gender: _____ Date of Birth (mm/dd/yyyy): _____

Social Security Number (optional): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone: _____ Other Phone: _____

Email Address: _____

Second Parent's/Guardian's Information

First Name: _____ Last Name: _____

Gender: _____ Date of Birth (mm/dd/yyyy): _____

Social Security Number (optional): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone: _____ Other Phone: _____

Email Address: _____

Parent Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Never Married

Who has legal/physical custody? _____

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

Emergency Contact

First Name: _____ Last Name: _____

Phone: _____ Relationship: _____

Do you authorize this person to discuss care or treatment with the clinic in case of an emergency?

◯ Yes ◯ No

Insurance Information

Will you be using insurance? ◯ Yes ◯ No

(We offer a $150 self-pay rate for uninsured clients.)

Primary Insurance: _____ Policy Holder: _____

Policy Holder DOB (mm/dd/yyy): _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Group Number: _____

Will you be using a secondary insurance or supplement? ◯ Yes ◯ No

Secondary/Supplement: _____ Policy Holder: _____

Policy Holder DOB (mm/dd/yyy): _____ Relationship: _____

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?

Has your child ever been diagnosed with a mental health condition or learning disability?

Has your child every received outpatient treatment by a psychiatrist/nurse practitioner? If yes, when and by whom?

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

Medication	Dates	Benefits/Side Effects

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:

Medication	Dates	Benefits/Side Effects

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:

Maternal Side	Paternal Side

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: _____

What 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.

Initials: _____

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.

Initials: _____

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.

Initials: _____

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.

Initials: _____

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)

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.

_____ (Initial)

At Healing Minds, LLC, we strive to provide consistency in your therapeutic care. However, there may be times when a change in therapist is necessary due to scheduling, availability, employment changes, or other clinic needs. Should this occur, we will notify you in advance and work closely with you to support a smooth, thoughtful transition.

_____ (Initial)

Client signature (or Representative): _____ Date: _____

Signature of Parent/Guardian: _____ 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): _____

Parent/Guardian Signature: _____ Date: _____

Primary Insurance: _____

Secondary Insurance: _____

HIPAA NOTICE/PRIVACY PRACTICES

First Name: _____ Last Name: _____

This notice describes how medical information about your child 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 child's 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): _____

Parent/Guardian Signature: _____

Date: _____

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 7:00pm).** If you fail to cancel within the 24 hours prior to your appointment, a **$100 fee will be charged to the card below or to the credit card on file.** In addition, if you show for your session more than 15 minutes late, 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 the front desk for assistance at health@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.

Parent/Guardian Signature: _____ 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: _____ Date: _____