Peace of Mind Counseling
Melissa Earls, Ed. D., LPC-S, RPT-S
When you need someone who wants to listen

CHILD INFORMATION/CONSENT FORM

Patient's Name: _____

Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Male __ Female __ Single _Married _ Divorced __ Dating __Separated __ Widowed __ Life Partners ___

Address: _____
City, State, Zip

Occupation: _____

Best Contact Phone: _____ Email: _____

If there is emergency at the office and we must cancel the appointment, where should we call:
_____
In the event of an emergency with you, whom should we contact:
Name: _____ Relationship: _____

Best Contact Phone: _____
Who is responsible for this account/ Who is the Insured?
Name: _____ Relationship to Patient: _____

Birthdate: _____Soc. Sec. # _____

Insurance number:_____ Group Number:_____

Insurance Management Company:_____

Insurance Phone Number for Behavioral Health:_____

Address: _____
City, State, Zip

Employer: _____

Authorization and Release: **I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.** I give Melissa Earls LPC the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him for services rendered and/or for cancelled or missed appointments.

X_____/_____
Signature of patient or parent if minor /Date

3331 Cartwright Rd., STE 125, Missouri City, TX. 77459 *Office*
PO Box 376, Fresno, TX. 77545 *Mailing*
281.788.7975 *Contact*
281.407.6217 fax
www.peaceofmindcounseling.org
peaceofmindcounseling@yahoo.com *email*

ALL ABOUT YOUR CHILD

About Your Child's Education

Age: _____ Grade: _____ Nick Names: _____ Failure or Held Back? _____
What do school personnel tell you about your child? _____

Grade	School	Average Grade	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Does this child receive any remedial or special education services?
_____.
Does this child have frequent absences? _____.
Is this child on appropriate age/grade level? _____.
Please describe this child's attitude toward school.
_____
_____
_____.
How does this child get along with Peers and teachers at school?
_____.

About Your Child's Family

Relatives	Name Age/Grade	Does Child Get Along Well with this Person?
Father		
Mother		
Sister(s)		
Brother(s)		
Step Mother		
Step Sister(s)		
Step Brother(s)		
List all people who live in the home with this child:		

About Your Child's Routine

What kinds of physical exercise does your child get?
_____
How much coffee, cola, tea, or other caffeine does your child consume each day _____
Is your child's eating restricted in any way? How? Why?
_____

Bedtime: _____ Wake-up Time: _____ Hours of sleep on an average night: _____

About Your Child's Health and Physical Development

Who is your child's pediatrician? _____ When was the last visit? _____
Any Concerns shared by the doctor?

_____
_____

Delivery was : on time _____ early_____ late____
Length of Labor _____
Any Complications?_____
Birth Weight_____ Incubator?_____ Needed Oxygen?_____
How would you describe your child as an infant?

_____
Has this child had any problems with motor development (such as difficulty learning to walk; poor coordination; difficulty coloring, cutting, or drawing?

_____
At what age was the child able to:
Smile and recognize people _____ Feed self with spoon_____
Sit up without support _____ Drink from glass/cup _____
Stand Alone_____ Ride a tricycle _____
Walk Alone _____ Tie Shoes _____
Does this child have current problem with soiling or wetting during the day or night? _____
If yes please explain?

_____
_____
Does this child have a current sleep disturbance, such as difficulty falling asleep, getting up in the middle of the night, or being difficult to wake? _____
Describe any allergies your child has: _____
List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please_____
Does this child have any difficulties with vision or hearing? _____

About Your Child's Social Development and Peer Relationships

What special interest, hobbies, sports and games does the child enjoy both in and after school?

When this child chooses playmates are they:
Older_____ younger_____ own age____ all ages_____ boys_____ girls_____ both___
In play activities, is the child a leader_____ follower_____ loaner_____.
Does this child prefer the company of adult to other children? Yes _____ No_____
Does this child have at least one best friend? Yes_____ No_____
What is the friend's age_____

About Your Child's Emotional Development

Has your child even been characterized by family members, teachers or others as being:

	Yes	NO		Yes	No
Restless/inattentive			Forgetful		
Humorous/fun			Quick to anger		
Cheerful			Depressed/sad		
Daydreamer			Disruptive		
Immature			Happy		
Aggressive			Nervous/tense		

Does this child have a great many worries or fears? If so, what are they?

_____

Does this child have unusual or persistent nightmares? If so, what are they?

_____

Special Concerns

Briefly describe this child's behavior at home?

_____

_____

_____

_____.

List all prior counselors/dates/reasons:

_____

Anything else you are concerned about?

_____

_____

_____

_____

_____

_____

_____ .

Signature of Parent(s) or Guardian(s) Who completed this form.

_____ _____

Name *Date* *Name* *Date*

Child's Informed Consent Form

I understand that when I come to this office I will be playing, drawing, and talking. I can talk about anything that I want to. I can even talk about my worries, if I want to. Sometimes when I come here, I will feel a lot better. Sometimes I might feel a lot worse. During play, I can do anything I want if I follow three rules. I can't hurt myself. I can't hurt my counselor. I can't break any of the toys or objects in the room on purpose.

My parents will know how I'm progressing and may participate during my session at times. My counselor might give my parents ideas on how to help me with Problems. If my counselor wants to talk about me with another person, my counselor will ask my parents and me for our permission.

My counselor will **have to talk to other people if I say that someone is hurting me or doing things to me that they shouldn't. Also, if I say that I want to hurt myself, then my counselor will have to tell someone.**

I am signing my name on this paper to show that I agree to talk and play with my counselor.

Child's signature _____ Date _____.

ABOUT YOUR CONCERNS

Please mark all of the items below that currently apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

Accident-prone	Clowns around	Dawdles
Affectionate	Competition	Daydreams
Aggressive	Complains	Defiant
Argues	Complains of feeling sick	Dependent
Assaults	Compliant	Destructive
Bathroom language	Concern for others	Developmental delay s
Bigoted	Conflicts at school	Difficulties with parent's partner
Bossy to others	Conflicts at home	Disobedient
Breaks rules	Conflicts with friends	Disrupts family activities
Breaks the law	Conflicts with police	Distractible
Bullied by others	Cries easily	Dropping out of school
Bullies others	Cruel to animals	Drug or alcohol use
Cheats	Dares others	Drug sales

- ☐ Eating Issues
- ☐ Failure in school
- ☐ Fantasy life
- ☐ Fearful
- ☐ Feelings are easily hurt
- ☐ Fidgety
- ☐ Fighting
- ☐ Finger sucking
- ☐ Fire setting
- ☐ Friendly
- ☐ Hair chewing
- ☐ Head banging
- ☐ Hitting
- ☐ Hostile
- ☐ Hyperactive
- ☐ Hypochondriac
- ☐ Imaginary playmates
- ☐ Immature
- ☐ Inappropriate sexual behaviors
- ☐ Inattentive
- ☐ Independent
- ☐ Inflicts pain on others
- ☐ Insults others
- ☐ Interrupts
- ☐ Intimidated by others
- ☐ Intimidates others
- ☐ Intolerant
- ☐ Irritability
- ☐ Isolates
- ☐ Lacks organization
- ☐ Lacks respect for authority
- ☐ Learning disability
- ☐ Legal difficulties
- ☐ Lethargic
- ☐ Likes to be alone
- ☐ Loitering
- ☐ Loss of friends
- ☐ Low frustration tolerance
- ☐ Lying
- ☐ Manipulates
- ☐ Masturbation
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Name calling
- ☐ Needs for high degree of supervision
- ☐ Negativism
- ☐ Nervous
- ☐ New school
- ☐ Nightmares

Noisy

- ☐ Noncompliant
- ☐ Obedient
- ☐ Obesity
- ☐ Only younger playmates
- ☐ Oppositional
- ☐ Outgoing
- ☐ Out-of-seat behaviors
- ☐ Overactive
- ☐ Picks on others
- ☐ Poor concentration
- ☐ Pouts
- ☐ Prejudiced
- ☐ Procrastinates
- ☐ Provokes others
- ☐ Rages
- ☐ Recent move
- ☐ Refuses
- ☐ Relationships with friends
- ☐ Relationships with siblings

Relationships with teachers

Resists

- ☐ Responsible
- ☐ Restless
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad
- ☐ School avoiding
- ☐ Self-harming behaviors
- ☐ Sexual preoccupation
- ☐ Sexually active
- ☐ Shy
- ☐ Slow-moving
- ☐ Slow-responding
- ☐ Smart-alecky
- ☐ Smoking
- ☐ Social
- ☐ Speech difficulties
- ☐ Stealing
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing
- ☐ Talks back
- ☐ Talks out
- ☐ Teased
- ☐ Teases others
- ☐ Temper tantrums
- ☐ Threatens
- ☐ Thumb sucking
- ☐ Tics-movements or noises
- ☐ Timid
- ☐ Truancy
- ☐ Uncooperative
- ☐ Uncoordinated
- ☐ Under-active
- ☐ Unhappy
- ☐ Unprepared
- ☐ Vandalism
- ☐ Violent
- ☐ Wastes time
- ☐ Wetting/soiling of bed/clothes
- ☐ Withdraws
- ☐ Work problems
- ☐ Yells

Any other characteristics: _____

_____

_____

_____

_____

_____

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Acknowledgement of Receipt of Disclosure, Consent & of Notice of Privacy Practices Form for Melissa Earls, LPC

- I understand that **Melissa Earls, LPC** is a Licensed Professional Counselor in the state of Texas and holds a B.A. in History and Sociology and an M.A. in Psychology from Houston Baptist University, Texas and has earned a Doctorate in Education in the Field of Counseling from Texas Southern University.
- I understand that **Melissa Earls, LPC** works with children, adolescents, and adults in individual, group, and family counseling.
- I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.
- I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.
- I understand that if I am concerned about slow progress or lack of progress I have the right to speak to **Melissa Earls, LPC** about this.
- I understand that **Melissa Earls, LPC** does perform formal testing but may refer individuals for additional testing.
- I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- I understand that there are some occasions when confidentiality can/must be breached. Those are: **a*) I direct Melissa Earls LPC to tell someone else in writing or verbally, b) Melissa Earls LPC determines that his client poses a threat to them self or others, c) he is ordered by a court to disclose information, or d) He suspects that child abuse has taken place, at which time he will notify Child Protective Services.***
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that if I have a complaint I cannot resolve with **Melissa Earls, LPC** and I wish to file a formal complaint I may contact the **Texas State Board of Examiners of Licensed Professional Counselors** at 1-800-942-5540.
- I understand I am responsible for all fees that my insurance denies, rejects, or fails to pay to **Melissa Earls, LPC**.
- I understand that there is a returned check fee of $35.00 and that if a returned check is not cleared up in 30 days Melissa Earls LPC will file a suit with the Fort Bend County District Attorney's Office.
- I understand that all co-pays are due at the time of service.
- I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of $40.00 that must be paid at my next scheduled appointment.
- I understand that the rate for an initial session is $125.00 and for subsequent sessions is set based on the scheduled session as posted in the Client Information Binder in the Lobby. These fees are for 30, 45 or 60 minute sessions.
- I understand that although **Melissa Earls, LPC** has earned a Doctorate in Education in the Field of Counseling, she is not a psychiatrist and as such can not recommend or prescribe medications but can encourage clients to see an M.D. for a medication evaluation.
- I acknowledge that I have received and understand the Notice of Privacy Practices for this office:
- I hereby permit **Melissa Earls LPC** to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.
- **You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.**
- Please see our Notice of Privacy Practices for more complete description. You will find this Notice of Privacy Practices in a notebook in our office. This Notice of Privacy Practices is also provided to you in your intake packet. If this consent is revised in the future, you may obtain a revised copy from this office.

By signing below I confirm that I have read agree to and received the above information:

_____ _____

Client/Parent of Client *Date Received and Read*

(Parent or Guardian if Patient is a Minor)

Disclosure, Consent & of Notice of Privacy Practices Form for Melissa Earls, LPC

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

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by it's terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services.

You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of April 14, 2003