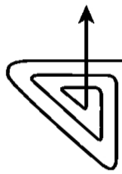

1301 E. 13th - Hays, Kansas 67601
Office (785) 628-3575 - Fax (785) 621-2257

Child Intake Form

Today's Date: ____________________

Office Use Only:(DX) Axis I:__________________
Axis II:__________________
GAF: __________

Identification

Your Name: ____

Your Relationship to Child: ____

Child's Name: ____ _____
First MI Last Jr, Sr, etc.

Child's Date of Birth: _________________ Age: ____ Sex: _____

Home/Mailing Address: ____

City: ____ State: _________ Zip: __________________

Home Phone: ___________________________ Cell Phone: ___________________________

Permission to leave voice message: □ Yes □ No Permission to leave text message: □ Yes □ No

Insurance Information

Insurance Company:____

Member ID:____

Group ID:____

Insured's Name:____

Insured's Date of Birth:_______________

Copay: □ Yes □ No Amount:$___________

Relationship to Patient: □ Parent/Guardian □ Self □ Other

Back of Card

Mail claims to address:

____

Checklist of Concerns/Characteristics

Person completing this form:_____________________________________

Parents: Please mark all of the items that describe or apply to your child.
Child: Please mark the concerns/positive traits you feel describe or apply to you.
Feel free to add additional concerns at the bottom.

- ☐ Argues, talks back, smart-alack, complains, interrupts, talks out, yells, swearing
- ☐ Bullies/intimidates, teases, is bossy to others, picks on, provokes, inflicts pain on others
- ☐ Conflicts with parents
- ☐ Cries easily, feelings are easily hurt
- ☐ Dawdles, procrastinates, wastes time, lacks organization, unprepared
- ☐ Difficulties adjusting to divorce, issues with one parent, disagrees with custody/visitation
- ☐ Dependent, immature
- ☐ Developmental delays: ____
- ☐ Disability: ____
- ☐ Disobedient, uncooperative, refuses, defiant, doesn't follow rules, lacks respect for authority
- ☐ Distracted, inattentive, poor concentration, daydreams, slow to respond
- ☐ Dropping out of school
- ☐ Drug, tobacco or alcohol use
- ☐ Eating: appetite increase or decrease, poor manners, refuses, odd combinations, overeats
- ☐ Extracurricular activities interfere with academics
- ☐ Fighting, hitting, violent, aggressive, hostile, threatens, temper tantrums, rage, destructive
- ☐ Friendly, outgoing, social
- ☐ Gets in trouble at school:____
- ☐ Grief, loss, death of family member/peers
- ☐ Independent
- ☐ Overactive, restless, hyperactive, restlessness, fidgety
- ☐ Recent move, new school
- ☐ Relationships with siblings or friends/peers
- ☐ Responsible, reliable, conscientious
- ☐ Runs away
- ☐ Sad, unhappy, likes to be alone, withdraws, isolates
- ☐ Self-harming behaviors: cutting, scratching, punching self/objects
- ☐ Sleep: too much, too little, nightmares, wetting or soiling the bed/clothes
- ☐ Sexual: sexual preoccupation, masturbation, inappropriate sexual behaviors
- ☐ Shy, timid
- ☐ Suicidal thoughts or actions
- ☐ Thumb sucking, finger sucking, hair chewing
- ☐ Teased, picked on, bullied
- ☐ Truant, avoiding school
- ☐ Under active, slow-moving or slow-responding, lethargic
- ☐ Other characteristics:____

Please look over the concerns you have checked and choose the one(s) that you or your child want to be helped with the most:____

____

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Updated March 2019

Turning Point
Professional Counseling Services

1301 E. 13th - Hays, Kansas 67601
Office (785) 628-3575 - Fax (785) 621-2257

Consent to Treatment and/or Evaluation

PLEASE INITIAL to the left of each paragraph after you have read through it.

______ I do hereby seek and consent to take part in the treatment by therapist ______________ _____________________. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

______ I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

______ I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand I am responsible for anything my insurance does not cover. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

______ I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

______ I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

______ I understand that ___________________________ is not authorized to practice medicine and surgery and is not authorized to prescribe drugs. I understand that certain mental disorders can have medical or biological origins and I have been advised to consult with a physician.

My signature below shows that I understand and agree with all of these statements.

____ __________________
Signature of client Date

____ __________________
Signature of parent/guardian if client a minor child Date

Internal Use Only: The above signed has stated that he/she has an understanding of the rights and meet the signature requirements. Per K.S.A. 59-2949, I have determined that he/she has the capacity to make the decision for treatment.

Signature of Therapist Date

Fee Agreement

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I ____, agree to pay an intake fee of $160.00 and an hourly fee of $145.00 for each counseling/therapy session held.

I agree to the fee schedule for additional services as stated below.

I agree to pay any fee not covered by insurance. I agree to pay the insurance co-pay the day of the appointment, if applicable.

Counselors Bill Davis does not accept BCBS.

Sliding-scale fees are available to patients who qualify with proof of income, and at the discretion of the therapist.

We do not accept credit or debit cards. Please mail checks to the Hays office.

I have read and understand the office and financial policies, and agree to those terms.

Service	Fee
Initial Assessment and Evaluation	$160.00
Individual Therapy	$145.00
Family Therapy	$145.00
Report/Letter Preparation	$50.00
Telephone Calls/Consults with Client/Guardian(s) Exceeding 10 minutes in Length	$50.00
Consultation with Other Professional (Lawyers, Doctors, Therapists, etc.) as Requested and/or Approved by Client/Guardian(s)	$50.00
No show fee or Cancellation of less than 24 hours	$25.00
Returned check fee	$20.00

____   ____________________

Client or Guardian's Signature   Date

____   ____________________

Therapist's Signature   Date

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