ICF CONSULTANTS, INC.

1524 North Farwell Avenue
Milwaukee, WI 53202

16535 Bluemound Rd, Suite 300
Squires I Building
Brookfield, WI 53005

CHILD/ADOLESCENT INTAKE FORM

Please answer all questions as completely as possible. This will help your therapist better understand your situation and provide the best possible service.

ID# (for Office Use only) _____

Name of person completing this form: _____ Date: _____

Child/Adolescent is (circle one) my biological child adopted child foster child other: _____

IDENTIFYING INFORMATION (for individual receiving services)

Child/Adol.'s Name: _____ Date of Birth: _____

Address: _____ Sex: Male____ Female ____

_____ Home Phone _____

Work Phone _____ Home Phone #2 _____
(Indicate whose number or provide both if joint custody) (If joint custody)

Emergency Contact and Phone #: _____

Who referred you to our agency or the therapist? _____

Do you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity? Please explain:

_____

_____

PRESENTING PROBLEM (current situation and history)

1. Mark the three most urgent problems for which you are seeing help with #s 1, 2, and 3

a. Behavior at home	g. Over activity	m. Grief
b. Family problems	h. Peer problems	n. Abuse or trauma
c. Depression	I. Eating disorder	o. Relationships
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior at school	k. Physical problems	q. Anxiety or worry
f. Self-confidence	l. School performance	r. (Other – explain)

_____

_____

2. How long has the child/adol. had this/these problems(s)? _____

3. Has the child/adol. received treatment for this problem (s) or others in the past? Yes___ No___

If yes with whom, and for how long? _____

_____

FAMILY HISTORY

1. With whom does the child/ adol. currently live (names and relationship)? _____

_____

2. Has the child lived with anyone else in the past? Yes ___No___ If yes, with whom? _____

_____

Please provide the following information about the child (as applicable):

Father's Name: _____ Phone #_____Cell #_____

Address: _____

D.O.B. _____ Occupation: _____

Mother's Name: _____ Phone #_____Cell # _____

Address: _____

D.O.B. _____Occupation:_____

Stepfather's Name: _____Phone #_____Cell #_____

Address: _____

D.O.B. _____Occupation:_____

Stepmother's Name:_____Phone # _____Cell #_____

Address _____

D.O.B. _____ Occupation: _____

Foster Father's Name_____ Phone # _____ Cell #_____

D.O.B. _____Occupation: _____

Foster Mother's Name: _____ Phone #_____ Cell #_____

Address: _____

D.O.B. _____ Occupation: _____

Guardian/Other'sName: _____

Address: _____

D.O.B. _____ Occupation: _____

3. Please provide the following information about the child/adol.'s brothers, sisters and any other children living in the home:

Name (First and Last)	D.O.B.	Relationship (Full, half, step, foster)	Lives with child?	If no, lives where?
			yes_____	no_____
			yes_____	no_____
			yes_____	no_____
			yes_____	no_____
			yes_____	no_____
			yes_____	no_____

4. Does the child/adol. or any other family member have a history of alcohol or drug problems? Yes_____ No_____ If yes, please explain:

_____

_____

5. Has the child/adol. or any other family member experienced any type of abuse (physical, sexual, domestic or emotional)? Yes_____ No_____ If yes, please describe the circumstances:

_____

_____

LEGAL HISTORY

Please describe any involvement the child/adol. has had with the legal system (arrests, convictions, probation, parole, custody issues):

_____

_____

DEVELOPMENTAL HISTORY

1. Were pregnancy and delivery normal? Yes _____ No _____I don't know _____
   If yes, please explain_____

2. Did mother use alcohol or other drugs during pregnancy? Yes _____ No _____I don't know_____

3. Did the child/adol. reach developmental milestones at a normal age?

Developmental Milestones	Yes	No	Don't Know	If no, please explain
Slept through the night				
Sat alone				
Stood alone				
Walked without help				
Said first words				
Spoke in simple phrases				
Toilet trained – day				
Toilet trained – night				

MEDICAL HISTORY

1. Primary Care physician/pediatrician:_____
   Address:
   _____Phone#_____

(Please make a check next to the problems the child/adol. has experienced :)

____ Eye disease, injury, poor vision
____ Ear disease, injury, poor hearing
____ Nose, sinus, mouth, throat problems
____ Head injury
____ Convulsions or seizures
____ Memory problems
____ Extreme tiredness or weakness
____ Thyroid disease or goiter
____ Skin disease
____ Heart disease
____ Back, arm, leg or joint problems
____ Blood disease
____ Stomach problems
____ Premenstrual Syndrome (PMS)
____ Eating disorder
____ Liver, gallbladder disease
____ Cancer
____ Bowel problems
____ Hemorrhoids, rectal bleeding
____ Loss of consciousness
____ Frequent or severe headaches
____ Sleep disturbances
____ Neck stiffness, pain, swelling
____ Marked weight changes
____ Circulatory problems
____ Allergies or asthma
____ Diabetes
____ Encephalitis
____ Meningitis
____ Pregnancy
____ High blood pressure
____ Other

Please explain anything checked above, or other chronic conditions, serious illnesses, surgeries, broken bones, hospitalizations. Give dates. _____

Please provide information about medication(s), prescriptions or over-the-counter drugs which the child/adol. takes regularly:

Medication	Dosage/Frequency	Prescribing Physician	Condition?

SCHOOL INFORMATION

1. What school does the child/adol. currently attend? _____
2. What is the teacher' name?
   _____
3. What grade is he/she currently in? _____
4. How many schools has he/she attended? _____

   In which cities/towns were they located? _____
5. Does the child/adol. have a written IEP? Yes _____ No _____

   Is the child/adol. in Special Education classes? Yes _____ No _____ Type: _____
6. Is the child/adol. experiencing any problems in school?
   - Academic (grades) Yes _____ No _____
   - Behavior Yes _____ No _____
   - Social (peers or adults) Yes _____ No _____

   Please explain any "yes" responses _____

SOCIAL RELATIONSHIPS/FRIENDS

1. How does the child/adol. Get along with peers? _____

2. How does the child/adol. Get along with adults? _____

3. Does the child/adol. spend more time with (check the closest answer):

___ Same age children
___ Older children
___ Younger children
___ Adults
___ Mostly alone

4. What are the child/adol. 's hobbies and interests? _____

_____

HOME LIFE

1. Is there a behavior problem at home? Yes ___ No ___ if yes, please explain _____

_____

2. What are the child/adol.'s strengths? _____

_____

2. What are the family's strengths? _____

_____

3. What are the child's weaknesses? _____

_____

4. What are the family's weaknesses? _____

_____

5. What kind of discipline is used with the child? _____

_____

Who is the disciplinarian? _____

6. Are there any family circumstances you would us to be aware of? _____

_____

_____

7. What goals would you like to reach as a result of your child/adol.'s involvement at ICF Consultants?

_____

_____

_____

8. How will you know when these goals have been reached? (Describe changes in behavior or functioning)

_____

_____

_____

9. Is there anything else you want us to know about the situation that has brought you to ICF Consultants?

_____

_____

_____

To Parents:

If you are involved in a divorce or custody litigation, you need to understand that the therapist's role is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this document you agree not to call your therapist as a witness in any such litigation. Only court appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

_____ _____

Signature of Child/Adolescent's Representative Date

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CONSENT FOR ADMISSION
For
MENTAL HEALTH/SUBSTANCE ABUSE EVALUATION AND/OR TREATMENT

New Client: Welcome!

Thank you for choosing our agency. ICF therapists aim to collaborate with you to identify and help you achieve your goals. Our mission is respectful understanding and expedient help. Below we will provide you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies. All treatment will be conducted within the boundaries of Wisconsin Law for Psychology, Nursing, Social Work, Professional Counseling or Marriage and Family Therapy.

Benefits and Risks of Therapy

The majority of individuals and families benefit from therapy, but there are no guarantees. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and to assess your progress. You may be asked to fill out questionnaires or do homework. Your open, honest and accurate participation in these activities is vital. Throughout the course of treatment some people experience increased unwanted feelings. These feelings may be difficult, but are a natural part of the psychotherapeutic process and often provide the basis for change.

Your Personal Rights

Under Wisconsin Law (DHS 35) you must be treated with dignity and respect. You must be allowed to participate in the planning of your treatment and care. You are entitled to inspect and make a written request for a copy of your records. You also have the right to ask to amend the medical record.

You have the right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist, or any office policy please inform your therapist or the Director of ICF Consultants, Marilyn J. Bonjean, Ed.D. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

Appointments:

Our office hours are Monday – Friday 9:00 am – 8:00 pm
Saturday by appointment

Appointments are usually scheduled for 50 minutes. Patients are generally seen weekly or more or less frequently depending on what you and your therapist agree on. You may discontinue treatment at any time, but please discuss any decisions with your therapist first. In the event of an emergency, you can call (414) 273-2220 to learn how you can get in touch with your therapist or a therapist on call. In the event of a life threatening emergency call 911 or go to the nearest hospital Emergency Room.

Fees

Our fee schedule is as follows:

Initial visit (Assessment)		$170.00 per 50 min
Subsequent sessions:	Individual	$150.00 per 50 min
	Couple or Family	$165.00 per 50 min

Payment

All payments are due at the time of the session unless other arrangements have been made. If you have insurance coverage, payment is contingent on accurate and current insurance information provided by you. If there is any change in insurance coverage or benefits it is your responsibility to notify ICF Consultants. ICF Consultants will file your insurance claim, but you are responsible for deductibles
and co-payments. I understand that failure to provide current insurance information in a timely manner may result in loss of insurance coverage for services rendered. In the event that you do not respond to our reminders about payments due within ninety days we reserve the right to send your bill to a Collection Agency.
I give permission for ICF Consultants to bill my insurance company.

PLEASE INITIAL: _____

For Self-pay clients: I request that ICF Consultants, Inc. does <u>not</u> inform my health plan that I am receiving treatment.

PLEASE INITIAL: _____

Cancellations and Missed Appointments

You will be billed for a session that you cancel with less than 24 hours notice. You may leave messages 24 hours a day. You will be billed the amount your insurance company pays us plus the co-payment. Insurance companies generally do not reimburse for failed appointment.

Discharge Policy

A client may be involuntarily discharged from treatment because of his or her behavior that is reasonably a result of mental health symptoms that cannot be met by the clinic or that endanger the safety of staff or other clients. The client must be notified in writing of the reasons for the discharge, given sources for further treatment, and has the right to grieve the discharge.

Limits of Confidentiality Statement

We are required by State and Federal law to maintain the privacy of your personal health information. We can not release your medical information for reasons other than those necessary for treatment (e.g. consulting with a supervisor), payment (e.g. billing your insurance company) or business operations (e.g. a billing service). Any associates used for business operations have a contract with us that require them to safeguard the privacy of your personal information.

ICF is legally mandated to release your personal health information only under the following circumstances:

1. prevention or control of disease, injury or disability;
2. threat of injury to yourself or others;
3. to report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse;
4. in response to a valid court order.

All other release of personal information requires a written authorization by you specifying who the information is to be released to, how much of it, and for what period of time. You have the right to revoke this authorization any time.

You have the right to request how you want written, telephone or e-mail reminders of appointments or any other notifications to be handled by ICF Consultants in order to protect your privacy.

If you believe your privacy rights have been violated you may file a complaint with your insurance carrier, or with the Secy. of the Department of Health and Human Services. To file a complaint with ICF Consultants contact the Privacy Officer, Ronald Bonjean, Ph.D. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

Consent for Treatment

I accept, understand and agree to abide by the contents and terms of this agreement. I have been given a summary of my rights and a notice of ICF Consultants, Inc.'s Privacy Practices. I consent to participate in evaluation and/or treatment, and I understand that I can withdraw this consent at any time.

Name of patient (please print) _____ ID# _____

Signature: _____ Date: _____

General Consent for Child or Dependent Treatment

I am legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Patient's Name_____ ID#_____

Name of Legal Guardian/Rep._ (please print) _____

Signature of Legal Guardian/Rep._____

Relationship to Patient_____ Date: _____

ICF Consultants, Inc.
Notice of Privacy Practices
Receipt and Acknowledgment of Notice

ID# (for office use) _____

Patient/Client Name_____DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of ICF Consultants, Inc. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ronald Bonjean, Ph.D. at ICF Consultants, Inc., 1524 N. Farwell Avenue, Milwaukee, WI 53202, or by calling 414-273-2220.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

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CLIENT CONSENT FOR E-MAIL, CELL PHONE & TEXT COMMUNICATION

Name: _____ ID# (for office use only) _____

I hereby request that my therapist and/or the staff of ICF Consultants, Inc. communicate with me via cell phone, e-mail or text messaging in addition to US Mail and land-lines, and I therefore acknowledge and accept the conditions listed below:

Check one or more options: __cell phone __e-mail __text messaging

1. The privacy and security of e-mail, cell phones or text communications using a non-secure Web messaging system cannot be guaranteed.

2. ICF Consultants, Inc. is not liable for breaches of confidentiality caused by a client or third party. I am responsible for protecting my password, or other means of access to my e-mail, cell phone or text messaging.

3. E-mail to, and from me, may be printed in full and made part of my medical record. Office staff and billing personnel will have access to records.

4. ICF Consultants, Inc. cannot guarantee a response to your e-mail, cell phone or text message although your therapist and the ICF Consultant staff will endeavor to read and respond as promptly as possible.

5. If your e-mail or text has not been responded to within a reasonable time period it is your responsibility to follow up to determine whether the e-mail or text was received, and to inquire when you can expect a response.

6. E-mail, cell phone and text messages are not to be used for communication of sensitive medical and mental health information, or for emergency situations. In an emergency please contact your therapist or the on-call emergency therapist to whom you will be directed by the telephone message when you call the office at 414-273-2220. You can also call 911 or go to the nearest hospital Emergency Room.

7. ICF Consultants is not responsible for information loss due to technical failure.

I have read and I understand the information above, and any questions I had were answered to my satisfaction. I know that I can withdraw this consent in writing at any time.

_____ _____ _____

(Signature) (E-mail address) (Cell phone number)

Relationship to client if other _____ Date_____