Detail of Informed Consent

Process, Benefits, and Risks of Psychotherapy: Participating in individual psychotherapy may result in a number of benefits including a reduction of problematic behaviors, a greater understanding of the child's strengths and weaknesses, improved awareness of emotional issues, improved self-esteem, and increased availability within the learning environment. However, such progress cannot be guaranteed. Working towards these goals requires efforts from the patient and support from the family is essential.

Confidentiality: The laws and standards for mental health professionals require that records be kept regarding the treatment of your child. All information disclosed within sessions and the written records pertaining to those sessions are completely confidential and cannot be revealed to anyone without your written permission, except where disclosure is required by law. Disclosure is required by law in the following circumstances:

When there is reasonable suspicion of child or elder abuse or neglect
Where the client presents a danger to him/herself or to others
When disclosure is court-ordered

The reason for such requirements is that mental health professionals have legal and ethical responsibility to take action to protect endangered individuals from harm when there is indication that such a danger exists. Such actions may include notifying the parent/guardian, notifying the potential victim, contacting the police, or seeking hospitalization for the child.

When working with children, the issue of confidentiality is often complicated. In order for children to relate well to the mental health professional and thereby address their social, emotional, and behavioral goals, children must feel a sense of privacy about the information they decide to share. However, mental health professionals understand and acknowledge that there may be types of information that would be important for the parent or guardian to know, even if it does not fall under the categories listed above.

In addition, children are made aware from the onset of treatment that regular communication with the parent/guardian will occur. They are told that relevant themes and issues will be shared with the parent/guardian, when it seems in their best interest to do so.

Availability and Emergency Procedures: I have voicemail that I check periodically throughout the day. In addition, I carry an emergency pager throughout the day and after hours. This pager is for emergencies only, e.g. if the child is experiencing an emotional or behavioral crisis and you feel that he or she is out of your control and at risk of hurting him/herself or someone else. In the event of a life threatening emergency and I cannot be reached, **the parent should immediately call 911 or immediately proceed to the nearest emergency room.**

If you have any questions or concerns regarding your Informed Consent, please feel free to discuss them with us directly.

The Clinical Staff
The Child and Family Counseling Group, P.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or Guardian of the Patient acknowledges that he or she personally received a copy of The Child & Family Counseling Group's Notice of Privacy Policies on the date indicated below.

Signature of Patient/Guardian _____ Date _____

Patient Name (Printed) _____

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

Treatment. Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.

Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.

Health Care Operations. Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or

CFCG ~ THE CHILD & FAMILY COUNSELING GROUP, P.L.C.
Comprehensive Diagnostic & Therapeutic Services

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____

DOB: _____

I authorize: _____

The Child & Family Counseling Group, P.L.C.
3959 Pender Drive, Suite 320
Fairfax, Virginia 22030

_____ to exchange information with
_____ to release to
_____ to receive from

_____
NAME OF PERSON, ORGANIZATION, OR INSTITUTION

_____
ADDRESS

The following information:

_____ Medical Records
_____ Education/Academic Records
_____ Psychiatric Records
_____ Psychological Evaluation
_____ Neurological Evaluation
_____ Behavioral Report
_____ Teacher's Report
_____ Verbal Exchange
_____ Other Information

Approximate Dates of Service: _____

For the Purpose of: _____

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE

RELEASE IS VALID FOR: **ONE YEAR** **TERMINATION OF TREATMENT**

REVOKED (Please circle one)

CFCG ~ THE CHILD & FAMILY COUNSELING GROUP, P.L.C.
Comprehensive Diagnostic & Therapeutic Services

AUTHORIZATION FOR RELEASE OF INFORMATION

The Child & Family Counseling Group, P.L.C. is an outpatient mental health facility which has an interdisciplinary staff. Occasionally, staff members need to consult with each other in order to provide the best possible care for their clients. This may necessitate the sharing of client information. When this pertains to you, we require your written permission. By signing this page you will be authorizing us to exchange both verbally and in written form any information we have obtained from you and which we have available to us here at the Child & Family Counseling Group, P.L.C. We assure you that all information used and shared will be done so judiciously and in the service of providing you better treatment.

_____ _____

Date Signature

_____

Witness

3959 PENDER DRIVE #320 • FAIRFAX VA 22030 • (PHONE) 703-352-3822 • (FAX) 703-385-8353

THE CHILD & FAMILY COUNSELING GROUP, P.L.C.

The Child & Family Counseling Group, P.L.C.
3959 Pender Drive, #320
Fairfax, Virginia 22030

(703) 352-3822
Fax (703) 385-8353

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____ ☐Male ☐Female

RESPONSIBLE PARTY: _____

BILLING ADDRESS: _____

_____

HOME PHONE NO: _____

CELL PHONE NO: _____

NAME & WORK PHONE NO: _____

REFERRAL SOURCE: _____

REFERRED TO: _____

CURRENT/PRIOR PSYCHIATRIST NAME: _____

CURRENT/PRIOR THERAPIST NAME: _____

EMAIL ADDRESS (OPTIONAL): _____

DOES PATIENT HAVE: MEDICARE? TRICARE?

REASON FOR REFERRAL: _____

_____

_____

_____

_____

_____
Intake Completed By

CFCG ~ THE CHILD & FAMILY COUNSELING GROUP, P.L.C.
Comprehensive Diagnostic & Therapeutic Services

PATIENT HISTORY ADULT

This form is to be completed by the named individual. Please feel free to provide additional information on the reverse side. If you have any problems with this form, please discuss with your therapist.

Name: _____ Date of birth: _____

Date form completed: _____

Reason for seeking treatment: _____

_____

_____

How long has this problem existed? 1-3 mos. 6-12 mos. 1-2 yrs. 2-5 yrs. 10+ yrs.

Prior therapy: Yes No

If Yes: What was the duration? Brief Long-term

In what environment? Periodic Sessions Day Treatment Inpatient

Was it: Helpful Not Helpful Not Sure

Current marital status: _____

Current primary physician: _____

Occupation: _____

Current employment: _____

High School graduate: Yes No GED

College graduate: Yes No

If Yes: Degree(s) or number of credits: _____

Field of study: _____

Occupational training (please explain): _____

_____

Military service: _____

Religious affiliation: _____

Recreation (list some usual activities): _____

_____

Have you ever been married? Yes No

If Yes: How many times? _____

How long did the marriage(s) last? _____

Please explain: _____

_____

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List all of those with whom you reside, and designate the relationship(s) and age(s):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have children who do not live with you? Yes No
If Yes, please provide the name(s) and age(s):

_____ _____
_____ _____
_____ _____
_____ _____

Have there been deaths in your family or among your friends? Yes No
If Yes: Who: _____ When: _____
_____ _____
_____ _____

Have you moved recently: No Yes
If Yes: When: _____

Have you moved often: No Yes If Yes, please explain: _____
_____

Do you plan a move in the near future? No Yes
If Yes, please explain: _____
_____

Work History for the Past 10 Years

	Employer	Job Title	Date Started	Date Left	Reason for Leaving
1.					
2.					
3.					
4.					
5.					

6. *Your Family of Origin*

Please provide data on your mother, father, siblings, and any step or half-family members.

Name and Relationship	Age	Health Status	Occupation	Where Resides	Frequency of Contact
(Example: Mary Doe, mother	*60*	*Heart problems*	*Housewife*	*Oregon*	*Once/year)*

Have you ever been separated from family members for a prolonged period? No Yes

Were there any separations from your family or either parent when you were a child (e.g., mother hospitalized for 3 weeks when you were 5)? No Yes

If Yes, please explain: _____

Is there any history of mental, emotional, or psychiatric problems in your family? No Yes

If Yes, please explain: _____

Health History

List any medications taken…

On a Regular Basis Now	Previously

Hospitalizations:

Date	Medical or Psychiatric	Purpose	Outcome

Please provide a history of each pregnancy, miscarriages or abortion,

Please list any chronic health conditions (e.g., Asthma, high blood pressure).

Please list any serious accidents or illnesses for which did not require hospitalization.

What is your current general state of health? _____

Symptoms and Behaviors Checklist

Please answer every question, even if the response is "No". Indicate the severity of the symptom, if known, for the past year.

SYMPTOM	SEVERITY			
	No	Mild	Moderate	Severe
Depression				
Tearfulness				
Feeling lonely				
Feeling sad				
Withdrawn				
Spending more time alone				
Moody				
Avoiding friends				
Concerned about injury				
Eating more				
Eating less				
Weight change				
More exercise				
Less exercise				
Decreased interest in sex				
Decreased interest in usual activities				
Tired				
Sleeping more				
Sleeping less				
Waking during the night				
Waking early in the morning				
Sleepwalking				
Nightmares/Bad dreams				
Headaches				
Careless about dress/hygiene				
Having trouble concentrating				
Confused				
Distractable				
Impulsive				
Disorganized				
Hearing things others don't hear				
Seeing things others don't see				
Trouble following directions				
Perfectionistic				
Anxious				
Worrying				
Feeling panicky				
Obsessive/ritualistic behaviors				
Critical of others				
Have few friends				
Low self-esteem				
Disappointed in appearance				
Disappointed in achievements				
Disappointed in social life				
Legal problems				
Problems at work				

SYMPTOM	SEVERITY			
	No	Mild	Moderate	Severe
Problems in daily life				
Arguing				
Defiant				
Destroying/damaging property				
Irritable				
Angry				
Easily frustrated				
Giving away belongings				
Threats to oneself				
Wishes to be dead				
Suicidal thoughts				
Suicidal intent				
Homicidal thoughts				