Leta LaRue LeRossignol, L.C.S.W., B.C.D., RPT-S
3035 Whisper Fern Street
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www.letacounseling.com

PATIENT INTAKE INFORMATION

Please complete the following as completely as possible and let me know if you have questions.

Patient Name _____ Date _____

Patient's Birth Date _____ Age _____

Sex: M / F Parent's Marital Status: Married ___ Divorced ___ Single ___ Other ___

Address _____

City, State, Zip _____

Home Telephone _____May we leave a message? _____

Primary Care Physician _____

Referring physician/pediatrician _____

Permission to share clinical summary with pediatrician? Yes :_____ No: _____

Signed consent: _____

Please initial the following items after reading:

___ All co-payments are due at the time of services rendered

___ **Full session fees are due for cancellations with less than 48 hours notification and less than 72 hours for Saturday (when available) and Mondays appointments.**

___ I have read and agree to Leta LeRossignol's Notice of Privacy Practices (Health Insurance Portability and Accountability Act) describing how medical information about you or your child may be used and disclosed and how you can get access to this information.(The entire Privacy Document can be found online at **www.letacounseling.com under 'Your Privacy '/Privacy Document**

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CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

CHILD'S NAME:_____**SEX**: (M) (F) **DATE**: _____

BIRTHDATE: _____ PLACE OF BIRTH: AGE:

ADDRESS: _____Zip:_____

PRIMARY PHONE: _____ WORK/CELL: _____

EMERGENCY CONTACT: _____PHONE: _____

EMPLOYER: _____SCHOOL: _____

E-MAIL ADDRESS: _____

REFERRED BY:_____

LIVES WITH (*including parent's names and custody arrangements*)
_____
_____

Briefly describe what motivated you to set up this appointment:
_____
_____

What do you expect to accomplish while working in counseling?
_____
_____

HEALTH: Medical Problems (including infectious disease past/present) problems?
_____

Medications: _____

_____

Any allergies? _____

Has your child ever been hospitalized? _____ If so, when and for what reason?
_____

Has your child been seen by a mental health professional? _____If so, by whom and for what purpose? _____

- **What helped? _____**
- **What did not help: _____**

Please rate the severity of your problem at this time (on a scale from 1 to 10): _____

Previous Marriages: _____

BROTHERS & SISTERS (including step)

Name Age lives w/

History of Birth/Infancy:

Problems during pregnancy?: _____ Length of pregnancy _____

Birth weight: _____Birth problems: _____

Did the mother take any medication during the pregnancy? _____

Did the mother take drugs, alcohol or tobacco during pregnancy? _____

Milestones: About what age did/was your child :

Talk? _____

Walk? _____

Toilet trained? _____

Bedtime routine: Does your child: Adhere to bedtime routine**: _____**

Sleep too much ____ Wakes often or early ____ Sleep walks or wanders ___

Sleeps too little ____ Frequent nightmares? ____ None of the above ____

Child sleeps alone: _____ with parent (s) _____ with sibling _____

Wakes parent at night: _____

Eating Habits: Does your child:

Have a special diet ___ Have an eating problem ___ Eat normally ___

Overeat ___ Have poor eating habits ___

Self-Harming Behaviors:

Eating disorders: _____ Cutting behavior: _____

During the first three years of life did your child:

Enjoy being held? _____ Appear overly active? _____

Appear to be a happy baby? _____ Have a change in primary caregiver? _____

Current Fears: _____

_____

Social relationships: ____ individual play ____ group play

____ competitive play

____ leadership role ____ a follower

Friend's first names:

_____

Discipline used: _____

Has your child experienced any of the following?

Parent Miscarriage _____Year _____ child's age _____

death of a significant other?_____ child's age_____

physical abuse? _____ child's age_____

sexual abuse? _____child's age _____

long term financial instability? _____child's age _____

Hospitalization of a parent? _____ child's age _____

Divorce/separation of parents? _____child's age _____

Alcohol/Drug abuse by parent? _____child's age _____

Suicidal/homicidal thoughts/behavior _____ child's age _____

Chemical use/dependency of child such as alcohol, illicit drugs, OTC, etc:

_____

Any pending legal problems related to this child? _____
If so, what are they? _____

Family History: (health problems, mental illness, substance abuse, etc.)

_____
_____
_____

Educational History:

Present School: _____ Grade: _____

Has your child ever attended a special education program? ___ yes ___ no

Is your child in a special education class now? ___ yes ___ no

How is your child doing with class work and classroom behavior?

_____

	Name of school	City/State	Attended	Grades
Preschool				
Elementary				
Junior high				
High school				

What are your worst fears concerning your child?

Any other comments about your child: _____

_____

_____

_____

_____

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Consent For Treatment

I give permission for myself, or my child/children _____
to receive services from Leta LeRossignol, LCSW

Signature _____ Signature _____
Date _____ Date _____

Special arrangements such as divorce/adoption/legal guardianship:

Custody: ___ Sole Parental Responsibility
___ Joint Custody
___ Other: _____

Custody: ___ Sole Parental Custody
___ Joint Custody
___ Other: _____

Consent for Uses and Disclosures

In the course of providing treatment to you or your child, there may be times when it will be necessary to use or disclose your protected health information (PHI) to carry out treatment, obtain/receive payment, or perform other health care operations on your behalf. This consent signifies your permission for us to use your PHI for these purposes. Some examples of these uses include:

- Billing/receiving payment from insurance companies for services provided to you or your child.
- Obtaining pre-authorizations for treatment or determining your coverage under a health plan.
- Sharing information between practitioners here at the office to provide you with treatment.

There are a number of rights to which you are entitled concerning your protected health information. You have the right to restrict how your protected health information is disclosed, including having it be disclosed by alternative means other than those we would normally use. We are not required to agree with your restrictions, but will consider your requests as binding in the event that we should agree to them. You also have the right to revoke this consent at any time, but must do so in writing. We are not responsible for actions or disclosures taken during the effective time of this consent and any services costs incurred while this consent is active, are subject to payment. Additionally, we may refuse treatment to you, if you do not agree to this consent, and in the event that you revoke this consent, we have the right to discontinue further treatment. A thorough description of our privacy practices posted here in our office and of which you can obtain a copy.

Policies concerning the protection of your health information have always been to take every safeguard possible in protecting your health information. We consider your information as private and take every necessary precaution to see that it is protected.

Signature: _____ Signature:_____
Date: _____ Date: _____

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CLINICAL POLICIES

LENGTH OF APPOINTMENT
A regular clinical session lasts approximately 45 minutes. Please be punctual to assure the full time allotted.

FEES
The fee for a regular clinical session is $138.00. Initial intake sessions are $180.00. Full payment is expected at the time of the appointment unless other arrangements are made. Insurance is accepted as applies. Please check with your insurance company to establish your benefits.

We ask that you provide the following information. Charges will only be made for regular sessions as well as for the case of ***missed appointment/late cancellation (see below: 'Cancellation of Appointment) .***

VISA AND MASTER CARD ACCEPTED

*Credit card #: _____ _____ _____ _____

Name on credit card: _____ Exp date _____

Zip match with card _____ 3 numbers on back of card _____

Signature on file _____ Date _____

CANCELLATION OF APPOINTMENT
The full fee is due for appointments not cancelled at least 48 hours prior to the appointment time, 72 hours for Saturday appointments, or by Friday morning for Monday appointments. *This policy allows for securing your appointment as well as allowing time to offer your appointment time to another client.*

CONSULTS REGARDING LEGAL MATTERS:
This office does not provide forensic (court) work. If your treatment, or your child's treatment may involve the court, please let me know immediately, I am able to provide some names of forensic psychologists who may be more suitable for your treatment. *Services for court appearance are $1,500 minimum cost. Additional hours for preparation as well as consults regarding legal matters cost $400 per hour. These fees must be paid in advance. Legal fees sustained by the legal provider on behalf of the client or legal guardian(s) are the sole fiscal responsibility of the client/guardian(s).*

INSURANCE:

This office does not participate in any insurance networks. Upon request, paperwork will be provided for your submittal to your insurance company.

Please present questions or concerns at any time.

I UNDERSTAND AND ACCEPT THE CLINICAL POLICIES OUTLINED ABOVE:

_____ _____
Signature Date

If Patient is a Minor: I am the legal guardian of managing conservator and grant permission for treatment.

_____ _____
Signature Date