HILLCREST
COMPREHENSIVE PSYCHOLOGICAL SERVICES

Phone: 803-569-3101
www.hillcrestcps.co

Minor Intake and Questionnaire

Welcome to Hillcrest. Thank you for filling out this confidential form. This information you provide is confidential and will be helpful for you and your counselor/life coach when you meet for the first time. Please submit with a copy of your driver's license and insurance card.

Today's Date: _____

Full Name: _____

Date of Birth:_____/____/_____ SSN* ---------- _____ *required for insurance billing

Address: _____

City:_____State:_____Zip code: _____

Sex: Male: ____ Female:____ Non-binary/third gender:____ Prefer to self-describe:_____

Primary phone number:_____Alternative phone number:_____

May we leave a message? Yes:_____No: ____ Would you like text message reminders? Yes:_____No: _____

May we email you? Yes:_____No: ____ email*: _____

*emails may not be confidential

Parent/Guardian (1) Full Name: _____

Relationship:_____ Date of Birth: ____/____/____

Address (if different from patient): _____

City:_____State:_____Zip code: _____

Primary phone number:_____Alternative phone number:_____

Parent/Guardian (2) Full Name: _____

Relationship: _____ Date of Birth:____/____/____

Address (if different from patient): _____

City:_____State:_____Zip code: _____

Primary phone number:_____Alternative phone number:_____

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Emergency Contact Information

Name:_____Relationship: _____

Address: _____

Primary phone number:_____Alternative phone number:_____

Pediatrician:_____Pediatrician's phone number: _____

Do you want us to send a note to your pediatrician to let them know you've come to see us? Yes:☐ No:☐
(This is for referral purposes only; we do not release any details other than your name.)

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Patient Authorization to Disclose Protected Health Information (PHI) to a Third Party

Please contact us if you have any changes in this request. If you need a record to be released to a third party, this form must be signed and filled out.

Patient Information: Individual whose information may be disclosed

Name: _____Date of Birth:___/____/____

I authorize Hillcrest to disclose my protected health information to the following individual/entity:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Important Terms of PHI

I understand that if I have any questions about my clinical records or the content within, I can contact Hillcrest and someone will meet with me to discuss my records. I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 45CFR, Part 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that authorization is ongoing but that I may revoke this consent at any time and that any notice to revoke consent must be in writing. I understand that the information used or disclosed may be subjected to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

Signature: _____Date:_____

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Consent to Treat Minor

Name of minor: _____

Date of Birth:_____/____/_____

Person Requesting Services

First name: _____ Last name:_____

I am the minor's legal parent/custodian: Yes:____ No: ____

I have the legal right to obtain treatment for the minor: Yes:____ No: _____

Divorce

In instances of divorce, the minor's legal custodian must grant permission for services. If you are a divorced parent, step-parent, grandparent, guardian or other, you may be asked to provide a copy of the court order which names you the legal custodian.

Authorization

I authorize the mental health assessment of my minor child. This authorization is in effect until consent is revoked.

As legal custodial parent, I understand that I have the right to information concerning my minor child in therapy, except otherwise stated by law.

I understand that the therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy.

I give my permission to the therapist to use professional discretion, in accordance with state and federal law, in deciding what information is to be shared with me.

This is my written consent to the mental health assessment and treatment of my minor child under the terms stated above.

Signature: _____Date:_____

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Consent and Service Agreement

Welcome to your first session at Hillcrest. Please review this form and feel free to ask any questions.

Our services

Our goal is for you to have a positive, empowering and life-enriching experience. In our confidential sessions, we will encourage you to speak openly and honestly. We will support and guide you during tough times. We can help you learn to cope better and assist you with positive behavior changes.

Confidentiality

Your privacy is very important to us. Hillcrest complies with HIPPA privacy rules. All communications and records with your counselor are held in strict confidence. Information may be released, in accordance with state law, under these circumstances:

- The client signs a written consent to release
- The client expresses serious intent to harm self or someone else
- There is reasonable suspicion of abuse against a minor, elderly person or dependent adult
- For billing purposes
- A subpoena or court order is received

Family, couples and group settings

In compliance with ethical codes, including section 2.2 of the AAMPT Code of Ethics, when providing family, couple or group treatment, your counselor will not disclose information outside of the treatment context without a written authorization from each individual competent to execute a written consent to release information.

The client agrees to this policy regardless of who is paying for services, and regardless of who is listed as the "identified patient" for third party payments.

Electronic communication and online counseling

Telephone, email and video conference are not encrypted methods of communication. There are some confidentiality risks with their use. Our team uses telephone or email for scheduling, billing and quality assurance. If you prefer to not be contacted by email, please inform your counselor. Your preference will be respected. If you are participating in distance counseling sessions, your counselor will abide by the laws and ethical codes of his or her state of licensure. Distance counseling may not be appropriate for some clients and for the treatment of some mental health issues.

Conflicts

We work hard to ensure that you have a positive experience. However, if a conflict occurs, any disputes will be negotiated directly between parties. If the negotiations are not satisfactory, the parties agree to mediate any differences. Litigation will be considered only if these methods are given a good faith effort.

Emergency contacts

Your counselor will establish emergency contacts for you. These contacts may be used if your counselor perceives a need. If you are in crisis and cannot reach your counselor, please go to your nearest emergency room or call 9-1-1.

Scheduling and cancellations
Appointments can be canceled or rescheduled with at least 24 hour notice. If you provide less than a 24 hours' notice, you agree to pay a no show/late cancellation fee of $99. Your insurance will not pay for missed appointments. Please note that we do enforce this policy.

For appointments that are scheduled for a Monday, you will need to notify the office by calling 803-569-3101 and leaving a voicemail 24 hours prior to canceling the appointment, to avoid the $99 fee. For your convenience, our phones are answered Monday- Friday form 9:00 am to 5:00 pm.

By initialing here _____you agree that we can charge your credit card on file for any missed session fee.

Payment
Payment, including insurance copay, is due at the time of service. Clients are fully responsible for all session fees even if insurance or other vendor does not pay for any reason.

In consideration for premium services that our practice provides, clients support our practice by paying a one-time service fee of $99. Client gives the practice to charge their credit/debit card on file for any outstanding fees. To change your payment method, please call our office or email robertcabana@hillcrestcps.com

By initialing here _____I agree to pay all fees associated in the event my account becomes delinquent.

By initialing here _____I agree that this authorization is valid until it is updated or I cancel it in writing.

By initialing here _____I acknowledge that I have read the Notice of Privacy Practices and I agree to honor this agreement.

By initialing here _____I consent to a comprehensive initial assessment, which will result in an individualized treatment plan.

By initialing here _____I consent to treatment and understand that I have the right to refuse treatment at any time.

Signature: _____Date:_____

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Insurance Information

Patient name: _____

Date of Birth:____/____/_____

Policy Holder Information

First name: _____ Last name:_____

Address: _____

City:_____State:_____Zip code: _____

Primary phone number:_____ Date of Birth:_____/_____/_____

Employer:_____SSN*:_____ - ____ - ____ *required for insurance billing

Primary Insurance Company:_____

ID#:_____Group ID#: _____

Secondary Insurance

First name: _____ Last name:_____

Address: _____

City:_____State:_____Zip code: _____

Primary phone number:_____ Date of Birth:_____/_____/_____

Secondary Insurance Company:_____

ID#:_____Group ID#: _____

Self-pay: Yes ☐ No ☐

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Credit Card Authorization

Hillcrest is committed to providing you with exceptional care, as well as maintaining a simple and efficient billing process. To provide a seamless, convenient way for patients to pay their bills, Hillcrest requires all patients keep an active credit card on file with us. **A valid credit card on file is required for all self pay and non-Medicaid patients.**

By signing this form, you give Hillcrest permission to charge your card for the amount required for: self-pay, copays, missed appointments, late cancellations and/or deductibles at the times of your sessions. An active credit or debit card must be on file and an initial **$99.00** service fee (non-claimable) will be necessary to see a clinician. If you have any questions, do not hesitate to ask.

I, _____, authorize Hillcrest to charge my debit/credit card account for any deductibles or copays that may apply at my time(s) of service, including a $99.00 fee for missed appointments. ** Be sure to cancel appointments 24 hours in advance to avoid fees. **

Cardholder Information

Name (as it appears on your card): _____

Billing address:

City:_____State:_____Zip code: _____

Primary phone number:_____email:_____

Visa: _____ Mastercard: _____ Discover: _____ Debit: _____

Card number: _____ – _____ –_____ – _____

Expiration date: _____ / _____ Security Code (back of card): _____

I authorize the Hillcrest to charge the credit/debit card indicated in this authorization form according to the terms outlined above. Payment authorization is for the services described and is valid for all sessions that require payments at the time of service. I certify that I am an authorized user on this debit/credit card. I will not dispute the payment with my debit/credit card company so long as the transactions correspond to the terms indicated in this form.

Signature: _____Date:_____

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Statement of Informed Consent – Psychologist or Counselor-in-Training Disclosure from the Department of Clinical Psychology, Social Work and Counseling

This disclosure provides information relative to students enrolled in Social Work, Psychology and Clinical Mental Health Counseling University Practicum or internship in the Department of Counseling and Educational Psychology at the students' university. The counselor or psychologist-in-training must give you written information about student training, the counseling relationship, your rights and responsibilities and the limits of confidentiality. The client or the client's parent/legal guardian must sign this form before counseling may begin.

Student Training

Students in the program have completed core courses in counseling prior to beginning their clinical experience at the practicum or internship site. Examples include courses in ethics, theories of counseling, counseling techniques, group work and other courses relevant to the student's specialty or clinical mental health counseling. The practicum and internship courses are a developmental sequence in which students apply their knowledge under intensive supervision.

Counseling Relationship

Your counseling services will be based on a relationship characterized by trust and respect. You and your counselor will work together to identify goals for counseling and to move toward meeting those goals. The counseling sessions may include exploration of thoughts, feelings, personal history, communication styles, attitudes and beliefs about self and others and personal development needs. The counselor or psychologist-in-training will receive supervision from two sources: a qualified member of the mental health or school setting in which the counseling takes palace and a faculty member who is trained in the area of counseling specialization and has training in supervision.

Client Rights and Responsibilities

Clients have the right to receive counseling in which the individual's dignity, worth and uniqueness are respected. Your counselor-in-training will provide you with quality services under close supervision. The success of the counseling relationship depends on the client's willingness to be open and involved in the process. Individuals who participate in counseling can experience changes in personal views, attitudes and coping skills. Those close to you may need time to adjust to the new perspectives and positive behavioral changes that may evolve during your counseling. Your counselor or psychologist-in-training may ask to record some or all of your counseling sessions. You have the right to either allow or refuse recording to take place. Any recordings will be destroyed at the end of the semester in which services are provided. If you agree to this process, which will both serve the student's training needs and enrich your personal counseling experience via the added perspective of supervisory review, your counselor-in-training will ask for your written permission. Clients have the right to confidential services, with exceptions listed under 'Limits of Confidentiality'.

Limits of Confidentiality

Confidentiality will conform to state guidelines and the ethical guidelines of the American Counseling Association. All counselors-in-training, their supervisors and group supervision members will not disclose information except under the following conditions:

- Client or guardian gives written consent to release information to a designated individual or agency
- Client makes specific violent threats to harm him or herself or to harm an identifiable victim
- Counselor-in-training and/or their supervisors are named as defendants in a civil, criminal or disciplinary action arising from the counseling session
- Counselor-in-training receives an authentic subpoena backed by judicial authority that requires the disclosure of information
- Counselor-in-training has reasonable cause to believe that a child or adult with a disability has suffered abuse or neglect
- Counselor-in-training will discuss the content of counseling sessions in individual and group supervision under the direction of a qualified supervisor who is held to the same professional standards of confidentiality and its limits

If you have questions or concerns about your services, please call us at 803-569-3101, or email us at robertcabana@hillcrestcps.com

By signing this form, client or client's parent or legal guardian acknowledges:

- He or she has read the contents
- Questions regarding the contents have been explained
- Giving consent for counseling services to be provided

Client name (please print): _____

Signature: _____Date:_____

Counselor or psychologist-in-training: _____

Hillcrest staff: _____Date: _____

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Individual Plan of Care

Patient Name: _____

Parent/legal guardian:_____

I will actively participate in developing an individual plan of care (IPOC) to include a sufficient assessment of the strengths and skills I possess as well as the behaviors and skills to be developed as a result of this treatment plan. I have been given a satisfactory explanation of the plan, including my role and responsibilities in the implementation of the plan and continuation of care and treatment.

Patient signature: _____Date:_____

Clinician signature: _____Date:_____