Child Registration

Child's Name ____ Date______________________

Child's Birthdate _________________ Age ______ Grade ______ School ____________________________________

Address where child lives ____
Street City State Zip

Child lives with ___ mother ____father ______ other (please explain)

Mother's Name: ____ Home Phone ______________Cell Phone ___________

Mother's Place of Work ____ Work Phone ___________________

Fatther's Name ____ Home Phone_____________ Cell Phone _____ ______

Father's Place of Work ____ Work Phone ___________________

Email (optional) ____. Permission to use for appointment reminders and information pertinent to counseling and mental health. ***Your email address will NEVER be shared.***

Are child's parents divorced? ________ For how long? __________

Has either parent remarried? If so,when? ____

List names of children in the family, their ages and who they live with if other than parents. Also list others who live in the home.

1. ____

2. ____

3. ____

4. ____

Who is your child's physician? ____ Last time seen __________________

List any medications your child is presently taking ____

Has your child been hospitalized in last four years? _______ If yes, please describe reason and date of hospitalization.

If someone close has recently died, please explain.

If your child has recently suffered a traumatic event other than death, please describe.

If your child has been to counseling before briefly describe when, who the counselor was and the reason for counseling.

How did you learn of my services?

May I send a written or verbal thank you to this individual or organization?

Family History

Place a mark below each person who has any of these behaviors or symptoms.

	Self	Mother	Father	Brother	Sister	Mother's mother	Mother's father	Father's mother	Father's father	Mother's sister	Mother's brother	Father's sister	Father's brother	Nephew	Niece
Rapid mood swings that change by the minute or hour															
Hot temper															
Impatient															
Unpredictable															
Impulsive behaviors and decisions															
Difficulty paying attention															
Restless															
Lots of energy, hyperactive															
Severe procrastination															
Not completing things (including high school or college)															
Many job losses or job changes															
Dyslexia or learning disabilities															
Had a "nervous breakdown" or difficulty handling stress															
Diagnosed as ADD or ADHD															
Took Ritalin or other medications for ADD or ADHD															
Severe depression															
Severe anxiety															
Panic Attacks															
Serious drinking problems															
Manic depression or bipolar disorder															
Drug abuse															
Problems with the law															
Divorce															
Fears or phobias															
Suicide															
Prison															
Mental hospital															
Eating Disorder															

	Self	Mother	Father	Brother	Sister	Mother’s mother	Mother’s father	Father’s mother	Father’s father	Mother’s sister	Mother’s brother	Father’s sister	Father’s brother	Nephew	Niece
Alcoholism															
Physical abuse															
Fire setting															
Homosexuality or lesbianism															
Soiling pants or wetting bed															
Motor or vocal tics															
Mental Retardation															
Sleeping problems															
Cancer															
Sexual abuse															
Poor appetite															
Shortness of breath															
Rapid heart rate															
Nightmares															
Obsessions															
Obsessive Compulsive Disorder															
Seeing things															
Hearing voices															
Brain Injury															
Schizophrenia															
Low self esteem															
Difficulty concentrating															
Feeling tired most of time															
Crying spells															
Recent death															
Headaches															
Frequent visits or calls to physician															
Sexual problems															
Adoption															
Gambling															
Violence in the home															
Cutting/Self Mutilation															

Patricia A Lee, M.A., M.Ed.
Licensed Professional Counselor, Colorado License #587
2153 Chuckwagon Road, Suite 202 Colorado Springs, CO 80919 719.268.6882

Your Rights as a Client

The practice of both licensed and unlicensed persons in the field of psychotherapy including psychological testing is regulated by the Colorado State Department of Regulatory Agencies. Any questions, concerns or complaints regarding the practice of mental health counseling may be directed to the State Grievance Board, 1560 Broadway, Suite 1340, Denver, CO 80202; (303) 894-7766.

You are entitled to receive information from me about my methods of therapy, techniques I use, duration of therapy, if I can determine it, and my fee structure. Please ask if you would like to receive this information. You may seek a second opinion from another therapist or may terminate therapy at any time.

You should know that in a professional relationship, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

Information provided by a client during therapy sessions is legally confidential except for certain legal exceptions which include: 1) I am required to report suspected child abuse or neglect to the appropriate law enforcement agency; 2) If I receive information from a client concerning a serious threat of imminent physical violence against a specific person, I must inform that person of the threat, and also notify law enforcement authorities; 3) I am required to initiate a mental health evaluation of a client who is dangerous to self or others due to a mental disorder. You should be aware that legal confidentiality does not apply in a criminal or delinquency proceeding. You should also be aware that confidentiality does not apply if I become aware that you are physically or sexually abusing another individual, that you plan to hurt yourself or someone else or that you plan to commit suicide.

I am licensed to practice psychotherapy in the state of Colorado as a Licensed Professional Counselor, Colorado (License #587) and in Indiana as a Licensed Mental Health Counselor (License # 39001913A). I have a Master of Arts in Counseling from the University of Colorado (1989) and a Master of Education Degree from Trenton State College (1975). You should be aware that it is usual and customary for mental health professionals to seek peer consultation on cases and this is done in a manner that protects the confidentiality of the client. You should also be aware that when you sign your request for reimbursement from your insurance company that you give permission for them to obtain information about your diagnosis and the progress of your therapy. In addition, you should understand that if either one of us uses cellular or portable telephones (I use both from time to time), information transmitted by one or both of us may be intercepted by a third party.

Also, you authorize with your signature below that in the event of my death or grave disability, one or more of my selected colleagues may review confidential information I have collected about you or your child in order to advise you of options for the continuity of treatment.

I have been informed of my counselor's degrees, credentials and licenses. I have also read the preceding information and understand my rights as a client.

____ ____________
Client Signature (Parent or guardian for minor) Date

____ ____________
Patricia Lee, M.A, M.Ed. Date

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FEE AGREEMENT

In recent years, the confidentiality of psychotherapy has been undermined by medical insurance companies that require therapists to submit information about their patients. People who use their medical insurance or disability insurance to pay for psychotherapy waive some of their rights to confidentiality. When you use your insurance, a psychiatric diagnosis must be assigned and transmitted to your insurance company, detailed clinical information often must be provided by your therapist, and in the case of "in-network-benefits", total access to patient files often must be provided to insurance company employees. Further, insurance companies often attempt to influence the methods or course of treatment so as to save money. That means treatment decisions are taken away from you and your therapist, the two people in the best position to make such decisions. Finally, psychiatric diagnoses may affect your ability to obtain future health or life insurance at a reasonable cost.

There is no way to ensure that confidential information will be treated as private once it is transmitted to an insurance company. For example, employers sometimes are able to obtain personal information from insurance records. In order to protect my client's confidentiality and to provide ethical treatment I encourage you to pay out-of-pocket for your psychotherapy. I am happy to provide you with a simple billing statement that you may submit for "out-of-network" insurance reimbursement and/or tax purposes.

My standard fee is $125 for a full session(50 minutes) and $65 for a short session (25 minutes). Payment is due at the time of service by cash, check or Visa/Mastercard. If you pay by check please have your check written in advance to make best use of our time together. You also have the option of prepaying four sessions at the reduced rate of $450. Sessions purchased in advance may be transferred to another member of the same family, are not refundable and must be used within three months. No shows and late cancellations will be deducted from pre-paid sessions. Telephone time or time spent on written correspondence or a report requested by you or professionals working with you is billed by the minute based on a fee of $125 per 50-minute hour. Time spent with attorneys, court time or any written correspondence or tasks related to legal matters will be billed at $250 per hour.

While psychotherapy may vastly improve the quality of your life, it is also an expensive process. The duration of therapy is affected by the nature of your concerns and what your goals are. It is very important that you feel you are benefiting from treatment. If at any time you feel you are not getting what you want or need out of therapy, I urge you to discuss this with me so that we can find a solution for your concerns.

Appointment Cancellations: My fees are based on the time I commit to work with you in sessions. Any scheduled session not cancelled 24 hours in advance will be charged at the full established fee including pre-paid appointments.

Emergencies: I do not interrupt client sessions and business appointments to answer calls. If your needs are immediate and of a crisis nature you should do one of the following: call Cedar Springs Hospital at 633-4114; call the Pikes Peak Mental Health Crisis Center at 635-7000; visit your nearest emergency room; or call 911. If your needs can wait call me at 719-268-6882, state that your message is urgent, and leave a number where you can be reached in the next few hours. I check my messages on a regular basis during the work day but do not check them on weekends. If you have caller ID on your phone and I am returning your call from my home you should be aware that I will not temporarily unblock my residence phone line to return your call. It is your responsibility to change your caller ID to accept a call from a blocked line. If you have caller ID and do not hear from me within a reasonable time you should use one of the emergency measures listed above. You should also be aware that calls made from cell phones and portable phones may not be secure and confidential.

Financial Contract:
I understand and agree to the professional fees and attendance policy described above. If for some reason charges accrue resulting in an overdue account and attempts to resolve nonpayment are unsuccessful any overdue account may be referred to an attorney or collection agency for collection. I understand that interest will accrue at the rate of 18 percent per year or 1 1/2 percent each month on any unpaid balance. Signature on this agreement indicates acceptance of such referral and responsibility for all costs of collection, including a reasonable attorney fee. I am ultimately responsible for all charges including those denied by my insurance provider. In the unlikely event that check funds are dishonored, I am aware that I will be charged a $25 (or legal limit) processing fee. I agree that, in signing this Fee Agreement, I have read and fully understand the terms contained herein.

Name of Client ____ __________
Date

Signature of Responsible Party ____

Patricia Lee LLC
Licensed Mental Health Counselor
2153 Chuckwagon Road, Suite 202   Colorado Springs, CO 80919
719-268-6882

By my signature below I, ______________________________________, acknowledge that I either received a copy of the Notice of Privacy Practices for Patricia Lee LLC or read the policy at *www.PatriciaLeeLLC.com/PrivacyNotice.htm*.

***Check all of the following that apply to your situation*:**

______ You may leave a message with anyone who answers my home phone.
______ You may leave a message with anyone who answers my home phone but do not divulge the message relates to counseling.
______ You may only leave a message with this person: _______________________
______ You may leave a message on my work voicemail.
______ You may leave a message with someone answering my work phone but do not divulge the message relates to counseling.
______ You may contact me by email at __________________________________
______ You may leave a message on my cell phone #__________________________

____   _________________
Signature of Client (or personal representative)   Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ____

Relationship to Client: ____

For Office Use Only

Patricia Lee LLC attempted to obtain written acknowledgement of the receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented obtaining acknowledgement
_____ Other (Please specify) ____

This form will be retained in your medical record.