

PARENT/GUARDIAN INFORMATION

Name: _____ Date: _____
 Home address: _____ City, State, Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Email Address: _____

For confidentiality, when and where do you prefer to be reached? _____

Marital Status: S M Sep. D W Date of Current Marriage/Separation: _____ Number of Marriages: _____

Child(ren)'s Names: _____ Date of Birth: _____ M F
 _____ Date of Birth: _____ M F
 _____ Date of Birth: _____ M F

Occupation: _____

Name of other custodial parent: _____ Phone: _____

Do you have consent from the other custodial parent for treatment of said child? Y N
If no, this will be required by the therapist before counseling may begin.

How much contact does the child have with his/her biological mother/father? _____

Do you believe in God? Yes No Religious preference: _____

What church do you currently attend? _____ Are you a member of that church? Yes No

How much influence does your religion have on your day-to-day activity? _____

Please list specific days/times for your appointment availability:

Monday	<input type="checkbox"/> morning	Tuesday	<input type="checkbox"/> morning	Wednesday	<input type="checkbox"/> morning	Thursday	<input type="checkbox"/> morning	Friday	<input type="checkbox"/> morning
	<input type="checkbox"/> afternoon		<input type="checkbox"/> afternoon		<input type="checkbox"/> afternoon		<input type="checkbox"/> afternoon		<input type="checkbox"/> afternoon
	<input type="checkbox"/> evening		<input type="checkbox"/> evening		<input type="checkbox"/> evening		<input type="checkbox"/> evening		<input type="checkbox"/> evening

(Limited Friday evening appts. available)

Complete all remaining information according to the child coming for treatment.

GENERAL INFORMATION

Name: _____ Date of Birth: _____ M F

The child is currently living with: _____

School: _____ Grade: _____

Extracurricular activities/interests: _____

MEDICAL HISTORY

How would you rate your child's current physical health? Excellent Good Fair Poor

Is the child complaining of any physical problems? (headaches, stomach aches...) _____

Previous hospitalizations for medical reasons:

Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any medical conditions or disabilities: _____



MEDICATION(S) Over-the-counter or prescription	DOSAGE

Please list any learning disabilities: _____

COUNSELING & PSYCHIATRIC HISTORY

Has the child had any previous counseling? Yes No If yes, for how long? _____

For what reason? _____ Name/location of counselor: _____

Has the child ever been diagnosed with or treated for any type of mental illness? Yes No

If yes, which type? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? Yes No

If yes, which type? _____

PSYCHIATRIC MEDICATION(S)	DOSAGE

REASONS FOR SEEKING HELP

What concerns about the child have led you to pursue counseling? _____

Where are these concerns causing the most problems for YOU? Check all that apply:

- Home Work Marriage Other: _____

Where are these concerns causing the most problems for the CHILD? Check all that apply:

- Home School Friends Other: _____

When did the present concerns begin to be a problem for the child? _____

What concerns about the child have been identified by others? _____

Please indicate which of the following areas are currently problems for the child. Check all that apply:

- Crying spells
- Excessive fears or anxieties
- Difficulty being away from specific family members
- Hearing voices
- Getting into trouble at school/play
- Temper tantrums
- Difficulty falling asleep/inability to sleep at night
- Decreased/increased appetite
- Loss of interest in usual activities
- Hyperactivity
- Bullying/picking fights
- Refusal to respond to authority
- Nightmares
- Obsessions/compulsion with specific activities
- Lack of motivation
- Lack of self-confidence
- Difficulty making or keeping friends
- Other: _____

EMERGENCY CONTACT

Name: _____ Relationship to child: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

What do you hope to gain from counseling? _____

How did you hear about Redeemer Counseling Services? Friend Pastor Church Other: _____

COUNSELING AGREEMENT

In order to be fully informed about the counseling you will be receiving, please read through this following agreement, sign and date it at the bottom. This form must be signed and included with the intake form in order to begin counseling.

Description of Counseling

Redeemer's counseling philosophy is wholistic in that three interrelated perspectives are explored in therapy: the Existential (the person), the Situational (his/her world), and the Normative (his/her God). Although counselors at Redeemer are guided by a Christian worldview, your counselor will be sensitive to your religious/cultural differences and perspectives. Based on your counseling needs, you may be advised to take appropriate tests/inventories or seek medical treatment to facilitate the counseling process. RCS adheres to the Code of Ethics prescribed by the American Association of Marriage and Family Therapy and American Christian Counseling Association. To view our code of ethics, log on to www.aamft.org and to www.aacc.net.

Referral Policy/Disclaimer

Clients will be referred outside of RCS when treatment required is beyond the scope of care available at RCS. Though Redeemer Counseling Services strives to be responsible and professional in the referral procedure, it is your full right and responsibility to select the professional of your choice. Furthermore, Redeemer is not liable for any services provided or not provided by the referred professional.

Counseling Fees

The fee for a 50-minute session is \$160.00. A sliding scale fee structure is available for those with a qualifying income level. Use of the sliding scale must be accompanied with verification of income, such as the most recent tax return. Payment is due at the beginning or the end of each session and accounts must be kept current in order to continue counseling at RCS. Cash or checks are accepted forms of payment (checks made payable to "Redeemer Presbyterian Church.") *** **Please note that we are unable to accept insurance.** ***

Confidentiality

To release information without your consent would violate commonly accepted codes of counseling ethics. There are situations, however, in which we are required by law to reveal information without your consent. Please see the "**Notice of Policies and Practices to Protect the Privacy of Your Health Information**" given to you at your initial session for details. All counselors at RCS participate in regular peer supervision. During this supervision your personal identity will be concealed. The purpose of supervision is to insure quality of care received at RCS.

Rights As a Client

1. You are entitled to information about any procedures, methods of counseling, techniques and possible duration of therapy.
2. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.
3. You have the right to expect confidentiality within the limits described in the Notice of Policies and Practices to Protect the Privacy of Your Health Information.
4. You have the right to request in writing the release of your records to any person or agency.
5. You have the right to authorize your counselor to consult with another professional about your therapy in writing.
6. You have the right to file a grievance in writing with the Director of RCS if you have concerns that your rights as a client have been violated.

Mediation & Arbitration

All disputes arising out of or in relation to this agreement to provide services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the therapist and client. The cost of such mediation, if any, shall be split equally.

Cancellation Policy

Redeemer Counseling Services requests that you notify your Counselor at least **48 hours** before your scheduled appointment time if you need to cancel a session. Failure to do so will result in charges for the missed appointment. This charge should be paid before or at the time of your next appointment to continue in the counseling relationship. Exceptions are for sudden illnesses and emergencies only.

Contacting Your Counselor

For scheduling and canceling your appointments, you must contact your therapist directly by dialing the RCS main number (212) 370-0475 and then the extension number of your counselor. For general information, please contact the reception desk during regular offices hours of 9:00 AM-5:00 PM at ext. 1365. For emergencies after-hours, please contact 911, your local emergency room, or 1-800-LIFENET.

If these guidelines are acceptable to you, please sign below:

Signed _____ Date _____

Witness _____ Date _____

(Required if under the age of 18)

Application for Reduced Fee

*** Please attach a copy of a recent paycheck stub and/or other income information to this application. ***

Instructions: If you are emailing this application as an email attachment, you may attach a scanned copy of your paycheck to the email or fax all documents to (212) 252-0649. If you cannot email or fax a copy of your income information, submit this application via email and bring all supporting documents with you to your first appointment. Please notify Missy Terrell at missy@redeemer.com that you are doing so and arrive at least 15 minutes early to complete your application process.

Name: _____ Date: ____/____/____

Occupation: _____ Employer: _____

Full-time Part-time

Number of hours/week: _____

Who will be responsible for billing purposes? _____

IF CURRENTLY A STUDENT, please fill out the information below:

School: _____ Full-time Part-time

As a student, how are you financially supported? Self-supported Parents Other

Explain: _____

Income Information

Did you file a tax return for the most recent year? Yes No

If no, please explain: _____

Please enter **Adjusted Gross income** of most recent tax return: \$ _____ Year _____

Single Return Joint Return

Has your employment changed since your last tax return? Yes No

If yes, explain: _____

Has your income changed since your last tax return? Yes No

If yes, explain: _____

Is your income from sources other than or in addition to wages or salaries? Yes No

Gross monthly wages or salaries \$ _____

Other (please itemize on back sheet) \$ _____

Monthly Total \$ _____

Do you have Health Insurance? Yes No

What are your Out-of-Network Benefits for Mental/Behavioral Health Services? _____

What is your yearly deductible? _____

What is the percentage of your reimbursement? _____

What is the maximum number of visits per year permitted under your plan? _____

Is there any additional information you would like us to consider? _____

Signed _____ **Date** _____