

## **Minor's Get Acquainted Form**

### **Child's Name:**

\_\_\_\_\_  
First Middle Last Prefers to be Called

Street Address: \_\_\_\_\_  
Number Street City Zip

Home Phone: (\_\_\_\_)\_\_\_\_\_ Contact Person & Phone: (\_\_\_\_)\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Are the Child's Parents: Married ( ) Divorced ( ) Separated ( ) Domestic Partners ( )

Other: \_\_\_\_\_

If not living together, who has: Primary Physical Custody: \_\_\_\_\_

Who has: Legal Custody: \_\_\_\_\_

**Dad:** Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: ( ) Same as above, or ( ) \_\_\_\_\_

Employed By: \_\_\_\_\_  
SS# \_\_\_\_\_

Job Title or Position: \_\_\_\_\_

**Mom:** Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: ( ) Same as above, or ( ) \_\_\_\_\_

Employed By: \_\_\_\_\_  
SS# \_\_\_\_\_

Job Title or Position: \_\_\_\_\_

### **Guardian--> If other than parent(s):**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: ( ) Same as above, or ( ) \_\_\_\_\_

Employed By: \_\_\_\_\_  
SS# \_\_\_\_\_

Job Title or Position: \_\_\_\_\_

Family Members (Step-Parents; Siblings)

Name	Date of Birth	Occupation or Grade	Living at home (yes or no)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who May I Thank for Referring You?

\_\_\_\_\_

Any Previous Psychotherapy? ( ) Yes ( ) No If Yes, then when, with who and for what reason?

\_\_\_\_\_

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Date of Last Medical Exam: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for Seeking Treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

## **Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

## **Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

## **Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

## **Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

## **Insurance Providers** (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings.*

---

Client Signature (Client's Parent/Guardian if under 18)

---

Today's Date

*Beverly J. Paschal, M.A.*  
*Licensed Marriage and Family Therapist*

~~~~~  
3670 Grant Drive, Suite 103-A  
Reno, Nevada 89509  
Phone ~ (775) 827-0404 ~ FAX  
(775) 788-4135 ~ Pager  
*bjpaschal@aol.com*

**HIPAA NOTICE SIGNATURE FORM**

You have been provided with a document titled **NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION.**

Your signature below indicates that you have read this document and/or been given a copy for your own records.

\_\_\_\_\_  
Patient Name and Signature Date

\_\_\_\_\_  
Parent or Guardian Name and Signature Date

*Beverly J. Paschal, M.A., MFT*  
Beverly J. Paschal, M.A., MFT Date

Beverly J. Paschal, MA, MFT

## CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of \$175 is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

---

Client Signature (Client's Parent/Guardian if under 18)

---

Today's Date