Pleaase provide the following information and aswer the questions below. Please note: All information you provide here is protected as confidential information.

Minor's Get Acquainted Form

Name:____
First Name Middle Last Name Prefers to be called

Street Address: ____

Date of Birth: Age: Grade: School: ___________

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

Other:____

____

If Not Living Together - Who Has Physical Custody?___________

Who has Legal Custody:____

Dad or Parent 1: Date of Birth:___________

Employment: ____

Address Same as Above Or:____

Mom or Parent 2: Date of Birth:___________

Employment:____

Address: Same as Above Or:____

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?______**No**_____**Yes: If Yes, when, with whom and for what issue?**____

____

Emergency Contact:___________________________**Phone:**__________________

Child's Physician:___________________________**Last Exam:**__________

Current Medications:____

____

Reason for Seeking Treatment:

____

____

____

____

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Beverly J. Paschal, Ph.D., MFT

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, Ph.D.

Licensed Marriage and Family Therapist

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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 entitled **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 have been given a copy for your own records.

Patient Name and Signature   Date

____ ____________________

Parent or Guardian Name and Signature   Date

*Beverly J. Paschal, Ph.D., MFT*____________________ ____________________

Beverly J. Paschal, Ph.D., MFT   Date

05/2020 bjp
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Beverly J. Paschal, Ph.D., 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, no show and cancellations with less than a24 hour notice unless due to illness or an emergency. Your credit card on file will be billed directly if you do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

____

Client Signature or Guardian Signature **Date**

FEE AGREEMENT AND FINANCIAL POLICY

Print Name of Person Financially Responsibility:________________________________

Signature of Person Taking Financial Responsibility:_____________________________

Relationship to Patient if Other Than Self:_______________ DATED:________________

Type of Card: Visa MasterCard American Express Discover____

Name on credit card:____

Card # (16) Digits: ____

Expiration Date: ______ Zip Code You Receive Your Statement At:________________

Beverly J. Paschal, Ph.D. will send you a receipt every time your card is charged.

INSURANCE PAYMENTS

Please also fill out the Insurance Form if you want me to bill your insurance for you. Your Insurance Payments will come directly to you.

I authorize Beverly J. Paschal, Ph.D., to charge this credit card as needed according to the terms specified in this agreement and policy.

Signature____ Date_______________