Beverly J. Paschal, Ph.D., MFT

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:

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

01/2020
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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 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

Beverly J. Paschal, Ph.D.
Licensed Marriage and Family Therapist
3670 Grant Drive, Suite 103-A
Reno, NV 89509

Phone (775) 827-0404
FAX (775) 827-0404
bjpaschal@aol.com

CLIENT NAME: _____ 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: _____

A receipt will be e-mailed to you at the email you provide: _____

Type of Card: ____Visa _____Mastercard ____American Express ____Discover_____

Name on credit card: _____

Card # 16 Digits_____

Expiration Date: _____ Zip Code You Receive Statement At: _____

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: _____