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: ______________________________

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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, M.A.
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 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