PASTORAL INSTITUTE
2022 15th Avenue | Columbus, Georgia 31901
706-649-6500 | 800-649-6446 | Fax 706-649-6521

For Office Use Only:
Date of Visit:___________
Patient #:_____________
Clinician:_____________
Payment Type:__________

Counseling Center Minor Client Information

Name of Minor: ____ Date of Birth: ___________ Age: ______

Address: ____

City: ____ State: ___________________ Zip: _____________

Social Security #: _________________________ Gender: ________ Race: _________ Ethnicity: _________

School: ____

Parent/Guardian Name:____

Date of Birth: _____________ Age: ______ Social Security #: _____________________________________

Employer: ____

Religion: _______________________ Church: ____

Home Phone: _____________________ Mobile: ____________________ Work: _____________________

Preferred method of contact: ☐ Mobile ☐ Home ☐ Work / ☐ Voice ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Live-In ☐ Married ☐ Divorced ☐ Widowed

Military Status: ☐ Active ☐ Veteran ☐ Disabled ☐ Retired ☐ Dependent

Spouse (if applicable): Name: ____

Date of Birth: _____________ Age: ______ Social Security #: _____________________________________

Employer: ____

Emergency Contact Name: ___________________________________ Relation: _____________________

Home/Cell Phone: ________________________ Work Phone: _______________________________________

Address: ____

Financial and Insurance Information

Primary Insurance: ______________________________ Policy/Member ID #: ________________________

Policy Holder’s Name: ___________________________ Policy Holder’s Social Security #: ________________

Policy Holder’s Date of Birth: ________________ Policy Holder’s Employer: ___________________________

Secondary Insurance: ____________________________ Policy/Member ID #: _________________________

Policy Holder’s Name: ___________________________ Policy Holder’s Social Security #: ________________

Policy Holder’s Date of Birth: __________________ Policy Holder’s Employer: _________________________

In order to file your insurance, we must have a copy of your insurance card(s).

Mental Health Information:

What has happened to cause you to seek counseling for your child? *(continue on back if needed)*

____

____

____

____

____

Has your child received previous mental health care? ☐ Yes ☐ No

If so, what dates did your child receive treatment?

____

____

____

General Health Information:

Is your child presently under the care of a physician? ☐ Yes ☐ No

Name of physician/psychiatrist: ____

Physician's telephone number: _________________________

Types and dates of surgeries: ____

____

Does your child drink alcohol/do drugs? ☐ Yes ☐ No
If yes, how many drinks daily? ____

List medication(s) taken regularly: ____

____

____

____

____

____ ____________________

Parent/Guardian Signature Date

SOCIAL MEDIA POLICY
Pastoral Institute staff will not accept friend requests or contact requests from current or former clients on any social networking site; i.e., Facebook, LinkedIn, etc. Adding clients and/or family members as friends or contacts on these sites can compromise a client's confidentiality and our mutual privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions, please do not hesitate to discuss the issue with your clinician.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the Pastoral Institute or any member of its staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment necessary for payment of insurance claim. The insurance company is hereby authorized to pay the Pastoral Institute, Inc., basic benefits and/or major medical benefits for medical and/or treatment expenses, or to include their name on the check payable to patient for medical and/or expenses.

For Tricare Beneficiaries: **I consent to the Pastoral Institute, as a Military Treatment Facility (MTF) to send a copy of my Protected Health Information (PHI) to referring MTFs for continuity of care.**

____ ____

Client Name (Printed) Date

____ ____

Parent/Guardian Signature Pastoral Institute Witness – Initial/Date

FINANCIAL POLICY AND AGREEMENT

For those with health insurance, the Pastoral Institute will assist in filing claims and seeking reimbursement. The Pastoral Institute cannot guarantee insurance reimbursement. It is the responsibility of the patient to follow up with the insurance company to make sure they pay the claims correctly. If the insurance company does not pay within 90 days, the unpaid balance is due from the Guarantor. Some insurance coverage for mental health services requires pre-authorization. The patient must call for authorization. The insurance company will not pay for services that have not been authorized. All fees charged are the direct responsibility of the client. Payment of any and all services rendered will be expected from the guardian that escorts the patient to his or her appointments. It is the policy of the Pastoral Institute to bill for any appointment cancelled without a 24-hour notice.

Payment for co-pay or deductible is due at the time service is rendered. Accounts that become more than ninety (90) days past due may be forwarded to a collection agency. All returned checks are forwarded to Check Care for collection. Check Care adds an additional fee for collection.

Financial Agreement:

I understand the above financial arrangements. I also understand I will receive a statement each month if there is a balance due from me. I agree that the statements are correct unless questioned within thirty (30) days in writing or by telephone contact with the Pastoral Institute Business Office.

____ ____

Client Name (Printed) Date

____ ____

Parent/Guardian Signature Pastoral Institute Witness – Initial/Date

PASTORAL INSTITUTE BROKEN APPOINTMENT POLICY

Your appointment time has been reserved just for you. If you find it impossible to keep your appointment time, please call us at least 24 hours in advance. Failure to call our office and cancel your appointment 24 hours in advance will result in a charge of $60.00 or more. We offer appointment reminder phone calls and/or texts 48 hours prior to your appointment. However, this is a courtesy and you are still responsible for cancelling your appointment at least 24 hours in advance.

____ ____

Parent/Guardian Signature Date

COUNSELING, CONFIDENTIALITY, PRIVACY PRACTICE AND NON-RECORDING AGREEMENT

I am aware that the practice of counseling is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment by the Pastoral Institute's (PI) staff members. I agree to collaborate with my therapist and other appropriate professional staff members of the PI for the purpose of assessment and evaluation of my current situation to work together to identify appropriate goals and methods of achieving them.

I understand that over the course of therapy, whatever assessments, tests or other clinical care that is recommended will be fully explained to me and that I have the option to accept or reject such care. I understand that the PI is committed to quality care. I may contact the Clinical Director regarding any questions about my therapist or concerns about quality of care. I understand that the PI may call my home or other designated location and leave a message on voice mail or in person to assist the practice in carrying out health care operations, such as appointment reminders, insurance concerns, and any call pertaining to my clinical care. I have read the above and give my consent to the counseling process of the PI. I have also read and understand the Pastoral Institute's statement regarding the limits of confidentiality. In addition, I have had an opportunity to review the Pastoral Institute's Notice of Privacy Practices and have had an opportunity to obtain a copy and ask questions to seek clarification I needed about these important materials.

Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

____ ____

Client Name (Printed) Date

____ ____

Parent/Guardian Signature Pastoral Institute Witness – Initial/Date

E-MAIL CONTACT WITH THERAPIST CONFIDENTIALITY RELEASE AGREEMENT

____

E-mail Address

I understand that confidentiality of e-mail communications with my therapist cannot be guaranteed. I further agree that I will not attempt to extend therapy via e-mails, but only use it to conduct business of information sharing such as cancelling or confirming an appointment. Any therapeutic issues I will handle either during the therapeutic face-to-face meeting or as appropriate, by telephone in emergencies. E-mail is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular e-mail will be read and responded to within a particular period of time. Possible e-mail-related concerns can include, but are not limited to the following:

- E-mails go through several intermediate stations before reaching their destination. Someone at any point along the line could access the e-mail and even store the message contained in it.
- E-mails may remain stored in various places of a computer system and could surface at a later time.
- Computers, particularly those on DSL lines, are vulnerable to electronic eavesdropping.

Knowing the above information and considering other possibilities not yet known that could further jeopardize confidentiality, I give my permission to my therapist to respond to my e-mails according to his/her professional judgment.

____ ____

Client Name (Printed) Date

____ ____

Parent/Guardian Signature Pastoral Institute Witness – Initial/Date

EMAIL RELEASE FOR COMMUNICATION ABOUT PASTORAL INSTITUTE SERVICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have rights to privacy regarding myself or my minor child's (or individual for which I have guardianship) protected health information. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of health information.

This release is strictly designated to give permission to my provider to send educational information, newsletters, announcements of upcoming services/programs and marketing materials via email and/or through the patient portal. My provider will have permission to send information via email and/or patient portal in the manner described above unless I request him/her to no longer use it. A written request form is available to decline permission.

☐ **Yes:** I will allow my provider to send educational information, newsletters, announcements of upcoming services/programs and marketing materials via email and/or through the patient portal.

☐ **No**: I decline that my provider can send educational information, newsletters, announcements of upcoming services/programs and marketing materials via email and/or through the patient portal.

______________________________	______________________________
Client Name (Printed)	Date
______________________________	______________________________
Parent/Guardian Signature	Pastoral Institute Witness – Initial/Date

RELEASE FOR IDENTIFICATION PHOTO

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have rights to privacy regarding my minor child's (or individual for which I have guardianship) protected health information. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of health information.

This release is strictly designated to give permission to my provider to take a photo of my child (or individual for which I have guardianship) for identification purposes only. The photo will be part of their clinical record/chart which can be seen by their Pastoral Institute providers to assist us in ensuring their identification when conducting therapy, evaluations, group activities, etc. The photo will not be released to anyone, will not be used outside of the Pastoral Institute nor used for any other purpose. My provider will have permission to use this photo in the manner described above unless I request him/her to no longer use it. A written request form is available to decline permission.

☐ **Yes:** I will allow my provider to take a digital photograph of my child (or individual for which I have guardianship) for chart identification purposes only.

☐ **No**: I decline that my provider can take a digital photograph of my child (or individual for which I have guardianship) for chart identification purposes only.

______________________________	______________________________
Client Name (Printed)	Date
______________________________	______________________________
Parent/Guardian Signature	Pastoral Institute Witness – Initial/Date

Informed Consent for Therapy with Parents/Guardians Divorce, Custody or Legal Issues

As a mental health treatment practice, our primary focus, responsibility and goal is the treatment and well being of our identified patients. In the case of a minor child as the primary patient, it is essential that parents and legal guardians are in agreement as to the decision to treat, the treatment goals, appointment times and the need to maintain patient confidentiality. This Consent states that you, as the parent and/or any legal guardian with authority over the health care decisions of the child, agree to the terms contained herein and to communicate effectively with any other parent and/or legal guardian as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible for the patient.

Although our responsibility to your minor child, as the primary patient, may require our involvement in conflicts between parents and guardians, you hereby acknowledge that the Pastoral Institute's involvement will be strictly limited to those actions which will benefit and be in the best interest of the patient. Additionally, you agree to the following:

- Anything that is said in any individual or group therapy session is and shall remain at all times strictly confidential;
- The Pastoral Institute's role is limited to providing treatment to the patient, and you shall not attempt to utilize any information related to your minor child's treatment to your benefit or for your advantage in any legal proceeding relating to a divorce or to the custody of your child that is derived from the treatment of your child by the Pastoral Institute. You acknowledge and agree that the use of any such information shall be determined by a court appointed guardian ad litem or by an order from a court with competent jurisdiction;

You shall not request or require the Pastoral Institute, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child; Any communications between the minor patient and the clinician, whether during an individual or group session, are treated by the Pastoral Institute as privileged communications under applicable law. **You acknowledge that, prior to any clinician being required to testify or disclose any confidential and/or privileged communications between a patient and the clinician, a written waiver of the privileged communications shall be delivered to the Pastoral Institute. If you decide to subpoena your therapist, you will be responsible for his/her expert witness fees in the amount of a deposit of $300.00 to be paid at the time we are notified of a subpoena to provide a deposition or appear in court. Any additional time the therapist spends would be billed at the rate of $200.00 per hour including travel time. If your therapist is a licensed psychologist the fees are $250.00 per hour including travel time. You understand that if you subpoena your therapist, he/she may elect not to speak with your attorney, and a subpoena may result in your therapist withdrawing as your counselor.**

- In the event of a group session, a written waiver of all participants shall be received by the Pastoral Institute prior to any disclosure. In the event the patient involves a minor child and the request is in connection with a divorce or child custody proceeding, you agree that a guardian ad litem shall be appointed by the court to make the determination as to whether the minor child should waive the privilege, and that you, as the parent and/or legal guardian, shall not retain the right to waive any privilege on behalf of a minor child under such circumstances;
- Any and all medical records retained by the Pastoral Institute are subject to the applicable Health Insurance Portability and Accountability Act of 1996 ("HIPAA") laws and regulations. Any requests for medical records of a patient shall be HIPAA compliant, and the Pastoral Institute will not disclose any medical records in its possession that would be in conflict with the applicable HIPAA requirements.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor **but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.**

In order for the Pastoral Institute to disclose privileged communications pursuant to any court order, such court order shall explicitly require the disclosure of any privileged communications of the patient.

I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my minor child under these terms and conditions set forth above by signing below.

I accept the responsibility of communicating with my child's therapist after every appointment to be updated regarding any change in the treatment plan related to my child's therapy. However, I acknowledge that I am not entitled to all of the communications and disclosures made by my minor child during any treatment sessions, and that such communications may consist of privileged communications which are afforded protection under applicable law.

I understand that as the custodial parent of the minor child, I am responsible for any and all payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, I acknowledge that the Pastoral Institute will look to me as the sole party responsible for the financial obligations of the account.

Name of Child/Client (Printed): ____

Parent/Guardian Name (Printed): ____

Parent/Guardian Signature: ____ Date: ________________________

PI Witness: ____ Date: _______________________

Pastoral Institute's Child and Family History   Client #_____________

Child's Name: ____ Birthdate: ________________

☐ Male ☐ Female Age: _____ School: ____ Grade:_____

(Does child Sign?______) Race/Ethnicity:________________________________ Handedness: ☐ Right ☐ Left

Referred by: ________________ Form completed by________________ (Relationship?________________)

PLEASE CHECK CURRENT CONCERNS ABOUT YOUR CHILD

☐ Academic/Learning Difficulties
☐ Adoption Issues/Problems
☐ Suspected Alcohol/Drug Abuse
☐ Allegations of Abuse
☐ Anger Issues
☐ Anxiety
☐ Attention/Hyperactivity Difficulties
☐ Autism Spectrum Disorder
☐ Behavior Difficulties
☐ Depression

☐ Eating Problems
☐ Language Difficulties
☐ Health Concerns________________
☐ Home Schooling Issues
☐ Hearing Difficulties
☐ Gifted Assessment
☐ Suspected Intellectual Difficulties
☐ Family difficulties
☐ Grief issues
☐ Gross Motor Delays/Clumsiness

☐ Memory Difficulties
☐ Self-Harm
☐ Suicidal
☐ Visual Motor Coordination Difficulties/Writing; Difficulties
☐ Social Skills Difficulties
☐ Traumatic Brain Injury
☐ Violent behaviors
☐ Other______________________
____

Living Arrangements:

The Child currently lives with ____

How many other children live with child? _________ Ages: _______________________________________

How long has the child lived in the present living arrangements? ________________________________

Does the child have pets? ☐ Yes ☐ No; what types? ____

PARENT/GUARDIAN INFORMATION

Highest Educational Level:

Mother	
Father	
Step Parent	
Adoptive	
Guardian	

Events Producing Family Stress:

☐ Death of a family member
☐ Incarceration of a family member
☐ Custody disagreement
☐ Parent emotionally/mentally ill/ substance abuse
☐ Abandonment by parent
☐ Parental deployments #______

☐ Serious illness of a family member
☐ Loss of employment of a major wage earner
☐ Unsafe home environment
☐ Birth/Adoption of another child
☐ Parental disagreement about child-rearing
☐ Involved with Social Services/Child Protective Services/Juvenile Court

☐ Loss of home
☐ Parental separation
☐ Parental divorce
☐ Sibling conflict
☐ Child neglect/abuse
☐ Financial problems
☐ Single-parent family

☐ Other ____

Prenatal/Birth History

☐ Child was born with no complications
☐ Experienced anoxia at birth/assistance breathing
☐ Experienced in utero exposure to drugs/alcohol
☐ Experienced in utero trauma (e.g. cord wrapped)
☐ Was born past due date
☐ Gestational diabetes
☐ Toxemia
☐ Was born via C-section
☐ Was born premature
☐ Weighed less than 5 ½ pounds at birth
☐ Weight over 9 lbs
☐ Birth weight__________
☐ Rh incompatibility

Which of the following applied to the infant? (Check all that apply)

☐ Required Oxygen/Breathing problems
☐ Required incubator
☐ Sleeping problems
☐ Infections
☐ Placement in the NICU, if so how long? _____________________
☐ Feeding problems
☐ Rash
☐ Bleeding into brain
☐ Excessive crying
☐ Seizures/convulsions
☐ Did the infant require: ☐ X-rays ☐ CT scans ☐ Blood Transfusion
☐ Unusual appearance, describe: ____
☐ Jaundice (were bilirubin lights used?) ☐ Yes ☐ No How long: ___________________________________
☐ Length of stay in the hospital: _________________ Mother: _________________ Infant: _____________
☐ Other concerns____

Developmental Milestones	Early	Typical	Late	Not Yet
Sitting Alone				
Crawling				
Fed self				
Fed self with spoon				
Gave up bottle				
Started solid foods				
Standing Alone				
Walking Alone				
Speaking First Words; age ______				
Speaking Short Sentences; age ______				
Using Toilet When Awake				
Staying Dry at Night				
Dressed Self				
Rides tricycle				
Rides Bike				

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

☐ Time out ☐ Loss of allowance/privileges ☐ Physical Punishment ☐ Yelling

☐ Ignoring ☐ Grounding ☐ Other, describe:____

Who is mainly in charge of discipline? ____

What do you find most difficult about raising your child? ____

____

____

Sensory Motor Skills:	**Date of Last Testing**	**Results Normal Y/N**
Vision Testing		
Hearing Testing		

Medical/Psychiatric/Neurological Concerns:

☐ No major medical/psychiatric concerns ☐ Asthma ☐ Depressive disorders

☐ Attention deficit/hyperactivity disorder ☐ Diabetes ☐ Fetal alcohol syndrome

☐ Chronic ear infections ☐ Lead poisoning ☐ Severe allergies

☐ Seizure disorder ☐ Spina bifida ☐ Stomach problems

☐ Surgeries ☐ Other____

☐ Family History of Mental or Emotional problems ____

☐ Food allergies ____

Neurological Status:

☐ No signs of neurological concerns ☐ Episodes of head banging ☐ Seizures or convulsions

☐ A serious head injury ☐ A motor tic ☐ Periods of unconsciousness

☐ An unusual number of accidents ☐ Other____

Medication:

Is he/she currently on any medications? ☐ Yes ☐ No If so, names of all medications: ______________________

____

____

Education:

Did he/she attend a formal pre-kindergarten? ☐ Yes ☐ No | ☐ Fulltime ☐ Halftime

Did he/she attend a formal kindergarten? ☐ Yes ☐ No | ☐ Fulltime ☐ Halftime

Has he/she been in the same school since initial enrollment? ☐ Yes ☐ No

Has he/she ever been held back? ☐ Yes ☐ No If yes, what grade(s)?__________________________________

He/she is currently in:

Attendance:

☐ full time classes ☐ part time classes ☐ regular classes

☐ gifted/talented courses ☐ special education classes ☐ homeschooled

He/she has:

Attendance:

☐ an excellent attendance record ☐ no significant attendance problem

☐ frequent excused absences ☐ frequent un-excused absences

Conduct:

☐ exemplary conduct record ☐ only minor disciplinary problems ☐ frequent disciplinary problems

☐ enrolled in correction program ☐ severe disciplinary problems ☐ suspension from school

Academic Performance:

☐ an outstanding academic record ☐ no serious academic difficulties

☐ some academic difficulties ☐ many academic difficulties

Academic Testing:

	Above Average	Average	Below Average
Reading			
Math			
Language			

Describe School Issues:

____

____

Services Received:

☐ Speech ☐ Occupational Therapy ☐ Physical Therapy ☐ ABA Therapy ☐ Social Skills ☐ Early Child Special Edu.

Extracurricular Activities

☐ Sports Clubs/Hobbies: ____

☐ Spiritual Affiliation/Church: ____

How does your faith impact these concerns? ____

____

Strengths: What are the child's greatest assets? ____

____

What are the family's strengths? ____

Level of family stress related to child's condition:

Low Moderate High

1	2	3	4	5	6	7	8	9	10