Blue Star COUNSELING

Client Information Sheet—Child Client

Client's Name: _____ Client's Date of Birth: _____

Client's Address: _____

City: _____ Zip: _____ Sex: Male Female Trans

Parent's name: _____ Relationship: _____

Parent's Home Phone: _____ OK to leave message? _____

Cell Phone: _____ OK to leave message? _____

Work Phone: _____ OK to leave message? _____

Email address: _____ Email o.k.? _____

Alternate parent's name: _____ Phone: _____ Msg? _____

How did you hear about my therapy services? _____

Insurance Information: (Primary Insurance)

Name of Mental Health Insurance: _____ Insurance Phone #: _____

Mental Health Claims Address: _____

Insured/Sponsor's Name: _____ Insured's Date of Birth: _____

Insured/Sponsor's Address: _____

Insured/Sponsor's ID # (off of insurance card): _____

Group #: _____ ***Client's*** Relationship to Insured: Self Spouse Child

Insured's Employer Name: _____

Do you have other insurance? Yes No

Name of Mental Health Insurance: _____ Insurance Phone #: _____

Mental Health Claims Address: _____

Insured/Sponsor's Name: _____ Insured's Date of Birth: _____

Insured/Sponsor's Address: _____

Insured/Sponsor's ID # (off insurance card): _____ ***Client's*** Relationship to Insured: Self Spouse Child

Group #: _____ Insured's Employer Name: _____

SIGNATURE ON FILE

I attest that all of the information above is correct to the best of my knowledge. I authorize release of any medical or other information necessary to process claims to my insurance companies. I authorize payment of medical benefits to the physician or supplier for services described on insurance claims. I understand that verification of insurance benefits it not a guarantee of payment and that any unpaid balance is my responsibility.

_____ _____

Signature Date

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Developmental/Social History Questionnaire

Child's Name:_____ Age:_____ DOB:_____

School:_____ Grade:_____ Grades Retained:_____

Child currently lives with: _____

Form completed by: _____ Relationship: _____

Family Members

Relationship	Name	Age / Sex	Occupation/ School Grade	Living in the Home? Y / N
Parent 1				
Stepparent				
Parent 2				
Stepparent				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Other Adults Currently Living in the Home:
Name:_____ Age:_____ Relationship:_____
Name:_____ Age:_____ Relationship:_____

If parents are separated or divorced, please describe visitation or co-parenting schedule: _____
_____

Describe any significant conflicts between the parents: _____
_____

Reasons child is being referred for counseling: _____
_____
_____
_____

Any previous counseling (dates/therapist name):
_____
_____

Please complete page 2

Developmental History

Mother's Pregnancy:

Illness or Complications? ( ) Yes ( ) No
C-section? ( ) Yes ( ) No
Premature Delivery? ( ) Yes ( ) No
If so, gestational age at delivery:_____
Length of hospitalization after delivery: _____

Did the mother (during pregnancy):
Smoke? ( ) Yes ( ) No
Use Alcohol/Drugs? ( ) Yes ( ) No
Take Medications? ( ) Yes ( ) No

Was any of the following present during child's early childhood? Please check the appropriate boxes:

_____Did not enjoy cuddling _____Difficult to comfort _____Colic
_____Irritability _____Eating Difficulties _____Excessive Sleep
_____Head Banging _____Seizures _____Difficulty Sleeping
_____Demanding/Clingy _____Developmental delays _____Ear infections

Was the child adopted? _____ If yes, at what age? _____ From what country? _____
Please list what is known about care received before adoption?_____
_____

Major history of learning or behavior problems at home or school?_____
_____

Medical History

Any Childhood Illnesses? Please list:_____
_____
Hospitalizations/Operations? _____
Head Injuries? _____ Eye Problems? _____
Allergies? _____
Present Medical Conditions/Concerns:_____
_____

Current Medications:_____ Reason(s): _____
Doctor Prescribing:_____ Phone #: _____

Current Concerns

Please check any of the following that are concerns for your child:

_____Reading _____Handwriting _____Does not Listen _____Destroys Property
_____Bedwetting _____Forgets Easily _____School Phobia _____Comprehension
_____Distractibility _____Easily Frustrated _____Poor Hygiene _____Soils Pants
_____Math _____Tantrums _____Drug/Alcohol Use _____Poor Peer Relations
_____Aggressive _____Talks Excessively _____Disorganized _____Frequent Accidents
_____Poor Response to Discipline _____Mood Changes

Type of discipline you use:_____
Child's response to discipline:_____
Child's interests/talents:_____
Recent losses or changes in home:_____
Family history of drugs/alcohol/mental illness (describe)?_____
_____
_____
Any other information you feel would be helpful:_____
_____
_____

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Parent Observations and Symptom Check List

Child' name: _____ Age: _____

Parent's name: _____ Date: _____

Behavior	None	Mild	Moderate	Severe
Poor impulse control				
Aggression toward others (physical/verbal)				
Inappropriately demanding and clingy				
Deceitful (lying, conning) behavior				
Sleep disturbances				
Hyperactivity				
Persistent nonsense questions, incessant chatter				
Difficulty with novelty and change				
Perceives self as victim (helpless)				
Intense displays of anger (rages that can't be soothed)				
Frequently sad, depressed, hopeless				
Extreme mood changes				
Lack of eye contact				
Cannot tolerate limits and external control				
Lacks trust in others				
Manipulative, controlling, bossy				
Lack of remorse or conscience				
Does not like to be touched				
Accident prone				
Poor hygiene				
Victimizes others (bully), seeks revenge				
Blames others for own mistakes or problems				
No stable peer relationships				
Indiscriminately affectionate with strangers				
Poor self-esteem				
Does not seem to listen when spoken to directly				
Victimized by others				
Learning disorders/problems in school				
Lack of cause and effect thinking				
Cruelty to animals				
Inappropriate sexual conduct and attitudes				
Pre-occupation or obsessions with an object				
Frequently defies rules (oppositional)				
Abnormal eating habits				
Destruction of property				
Consistently irresponsible				
Stealing				
Unusually fearful				
Grandiose sense of self-importance/entitlement				
Poor organization and planning skills				

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COUNSELING

Consent for Treatment of Minors

Client's Name:_____ Date of Birth:_____

I give permission for Kathryn Zentner, LCSW to provide mental health services for the above-named client and any family members who may be participating in a family therapy session. I understand these services may include assessment, and/or brief or long-term family therapy or individual counseling/psychotherapy.

- All records related to the client will remain confidential unless otherwise authorized by the client (or parent/legal guardian), a court order, or an emergency necessitating release of client-related information.
- Parents have the right to request information contained in their child's records. However, if the record includes contact with a parent (such as family therapy or family assessment sessions), the parent(s) participating in the session must provide consent before the content of the sessions can be shared.
- Please list all the child's legal guardians: / Please list all legal guardians' phone numbers:

  _____ _____

  _____ _____

  _____ _____
- I understand that in signing this form I give Kathryn Zentner, LCSW permission to notify all legal guardians of the above therapy services.

The parent responsible for payment of any outstanding balances from services provided by Kathryn Zentner, LCSW is:

Parent/Guardian Name: _____

Street/Mailing address: _____

City/State/Zip: _____

I hereby certify that I am the managing conservator for the above named minor child and have the right to seek mental health services for my child.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

Blue Star COUNSELING

Kathryn Zentner, LCSW *8701 Shoal Creek Blvd, Ste 403, Austin, TX, 78757*

OFFICE POLICIES

Sessions are 45 minutes long. Family or child play therapy sessions require extra preparation time and may be 30-40 minutes long, with the possibility of a parent "check in" time afterwards. You are expected to arrive at your appointment time.

My fee is $150 for the initial interview and/or assessment appointments, $125 for family therapy, and $125 for individual therapy. Longer sessions will be prorated based on the basic fees. Payment or co-payment is due at each session. Costs for court testimony are $600 per half day (or portion of a half day), payable in advance. Separate office policies are required for parents involved in custody proceedings.

Regular attendance at scheduled appointments is one of the keys to a successful outcome in counseling. When you make an appointment, I reserve your appointment time for you. You are expected to notify me at least 48 hours in advance if you cannot attend a scheduled appointment. **Any cancellations within 24 hours of your appointment time will assess a $75 cancellation fee *regardless of the reason for the cancellation***. If you fail to keep an appointment without notice, I will charge you the entire session fee of $125. These fees cannot be billed to insurance. You may cancel an appointment by calling or texting (512) 497-2177.

I am aware of this cancellation policy: _____ (initials)

I will bill your insurance when applicable and as requested by you. It is your responsibility to make sure I am a participating (in network) provider on your plan and to know the limitations of your coverage. Your insurance company may limit the number of sessions based on their assessment of medical necessity or other factors. **Benefits quoted by your insurance company are not a guarantee of payment.** You are responsible for any co-pays, deductible amounts, and any other fees that are not covered by insurance. Payment is due at the time of service unless you have made special arrangements with me. In some cases I may ask you to supply a credit card as a secondary form of payment in case your claim is denied or you have not met your deductible.

Insurance companies routinely ask for patient information, including diagnosis and treatment plans to authorize payment. When you request that I bill your insurance company for my services, you are agreeing that I can release this information to them.

If you have an emergency or have an urgent need to speak with me, you may leave a message in my confidential voice mail box by calling (512) 497-2177. I attempt to return all calls within 24 hours. If I am not able to return your call within a reasonable amount of time, or I am unavailable for a longer period of time (i.e. on vacation), you are responsible for seeking help from community resources or the local emergency room or psychiatric hospital.

Texting and email are permitted, but as they are not guaranteed forms of confidential communication, I ask that they be used sparingly. If you let me know that you would like for me to contact you via texting or email, you should be aware that electronic communication is preserved, may be compromised, or may be viewed by people who have access to your personal device. At the same time, I recognize that checking in, contacting me regarding scheduling matters, etc, might be most effectively accomplished by texting or email. If you would like for me to communicate with you on a limited, as needed basis, with the understanding that there are limits to the privacy and confidentiality of this form of communication, please initial here: _____

Throughout our time together we will discuss your treatment goals for therapy. Therapy is a joint effort between the therapist and client, the results of which cannot be guaranteed. Progress depends on many factors, including motivation, effort, and other life circumstances, such as interactions with family, friends, and other associates. Unfortunately, there are no instant cures and therapist and client must work together to move the client in the direction the client wants to go. You are encouraged to discuss any concerns and/or questions about treatment with me at any time.

I agree that I will be responsible for the payment of all professional fees. I have read and understand the policies listed above. I have received a copy of these policies for my records.

Signature of client (or parent/guardian) _____ Date_____

Printed name of client (or parent/guardian) _____

Name of client (if client is a minor) _____