EY! EMPOWER YOU! COUNSELING LLC

Child/Minor Intake Form

Please provide the following information and answer the questions below. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

First Name _____ Last Name _____ MI _____
Date of Birth _____ Gender _____

Street Address _____
City _____ State _____ Zip _____

Home Phone _____ May we leave a message? Y ☐ N ☐
Cell Phone _____ May we leave a message? Y ☐ N ☐
Other _____ May we leave a message? Y ☐ N ☐
Email _____

May we email you? Y ☐ N ☐
Please note: Email correspondence is not considered to be a confidential medium

Do you have siblings? Y ☐ N ☐ If yes, please list names and ages:

Name:	Age:
_____	_____
_____	_____
_____	_____
_____	_____

Were you adopted? Y ☐ N ☐ If yes, at what age: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Y ☐ N ☐
If yes, previous therapist / practitioner: _____

Are you currently taking any prescription medication? Y ☐ N ☐
If yes, please list: _____

Have you ever been prescribed psychiatric medication? Y ☐ N ☐
If yes, please list: _____

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Consent for Treatment of Minor

☐ Parent
☐ Guardian

I, _____
Parent or Guardian

give my consent for _____
Therapist

to be conducting art/talk therapy with _____
Name of Minor being treated

I have been notified that all the material discussed during therapy sessions is confidential and can be released only with the permission of the parent/gurdian, I have been informed the limitation to confidentality as discussed with the therapist. In the case of a minor, special sensitivity may be required in releasing information about topics such as drugs, alcohol, and sexual activity. I will accept _____ judgement in reguard to releasing/sharing information obtained during the course of therapeutic sessions with the minor that may endanger or jeopardize the clients well being.
Therapist

Parent/Guardian Signature _____ Date: _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client's Name

First: _____ MI _____ Last _____

Date of Birth: _____ Date authorization initiated _____

Authorization initiated by: _____

Name (client. provider, or other)

☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.}

☐ Other (describe information in detail): _____

_____

Purpose of Disclosure: The reason I am authorizing release is:

☐ My request

☐ Other/Insurance/Billing (describe): _____

Person(s) Authorized to Make the Disclosure: _____

_____

Person(s) Authorized to Receive the Disclosure: _____

_____

Authorization and Signature:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient _____

Signature of Personal Representative _____

Name of Personal Representative (please print) _____

Relationship to Patient if Personal Representative _____

Date: _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

-Tell your mental health professional if you don't understand this authorization. and they will explain it to you.

-You have the right to revoke or cancel this authorization at any time, except: (a} to theextent information has already been shared based on this authorization; or (b) thisauthorization was obtained as a condition of obtaining insurance coverage. To revokeor cancel this authorization, you must submit your request in writing to your mentalhealth professional and your insurance company, if applicable.

-You may refuse to sign this authorization. Your refusal to sign will not affect your abilityto obtain treatment, make payment, or affect your eligibility for benefits. If you refuse tosign this authorization, and you are in a research-related treatment program. or haveauthorized your provider to disclose information about you to a third party. yourprovider has the right to decide not to treat you or accept you as a client in their practice.

-Once the information about you leaves this office according to the terms of thisauthorization, this office has no control over how it will be used by the recipient. Youneed to be aware that at that point your information may no longer be protected byHIPAA.

oIf this office initiated this authorization, you must receive a copy of the signed authorization.

Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical recordsknown as Psychotherapy Notes." All Psychotherapy Notes recorded on any medium{i.e., paper. electronic) by a mental health professional (such as a psychologist orpsychiatrist) must be kept by the author and filed separate from the rest of the clientsmedical records to maintain a higher standard of protection. "Psychotherapy Notes" aredefined under HIPAA as notes recorded by a health care provider who is a mental healthprofessional documenting or analyzing the contents of conversation during a privatecounseling session or a group. joint, or family counseling session and that are separatefrom the rest of the individual's medical records. Excluded from the "PsychotherapyNotes" definition are the following: (a) medication prescription and monitoring. (b)counseling session start and stop limes, {c} the modalities and frequencies of treatmentfurnished. (d} the results of clinical tests, and {e) any summary of: diagnosis. functionalstatus, the treatment plan. symptoms, prognosis, and progress to date.

In order for a medical provider to release Psychotherapy Notes to a third party the clientwho is the subject of the Psychotherapy Notes must sign this authorization to specificallyallow for the release of Psychotherapy Notes. Such authorization must be separate froman authorization to release other medical records.

EY! EMPOWER YOU! COUNSELING LLC

Missed Appointment Policy

In an effort to provide all of our clients with quality care in a timely manner Empower You! Counseling, LLC., has updated it's missed appointment policy. This new policy is effective immediately.

Faliure to show for a scheduled appointment or *notify our office / therapist of cancellation within 12 hours of your scheduled appointment time* will result in a $75 missed appointment fee. Moving forward we will be billing this fee directly to a credit card we will keep on file. We will send you a receipt (via, UPSP, email, or text) notifying you of the missed appointment charge. If you decline to provide Empower You! Counseling, LLC., with a valid credit card and you incur a $75 missed appointment charge, we will notify you (via, USPS, email or text) with a missed appointment invoice and a 20% surcharge added for a total amount of $90.

Please note that the missed appointment fee is charged at your therapists' discretion.

Please fill out attached Credit Card Authorization Form

Our missed appointment policy enables us to better utilize available appointment time for all of our clients who are in need of care.

Thank you for your consideration of this policy. We are honored that you have chosen Empower You! Counseling, LLC., as your provider!

To be respectful of other patients, please be courteous and call our office / or your therapist if you are unable tomake your scheduled appointment. This will allow us reallocate your appointment time to another client in needof care. Please provide us with a minimum of 12 hours notice if you need to cancel your appointment. To cancelor reschedule your appointment please call our office (248-289-1894) or your therapist. Please understand thatoccasionally we cannot answer the phone and you will be connected to our voicemail. If you are calling to cancelor reschedule your appointment please leave your full name and the time of your appointment. Please note, ifyou call our office and are connected to voicemail and you choose not to leave a message and/or fail to contactyour therapist, this will also result in a missed appointment fee.

Any amount owed by a client at the end of the month will be sent an invoice for the amount due. Should payment or payment arrangements not be made within 60 days of appointment date, any unpaid balance will be sent to a collection agency for non-payment. At this time you understand and agree that the money owed to Empower You! Counseling, LLC., will be collected by a collection agency plus an additional 45% collection fee.

☐ I accept this policy and will complete the credit card authorization form.

☐ I accept this policy and decline to complete the credit card authorization form

Client/Parent/Guardian Signature _____

Client/Parent/Guardian Name (please print) _____ Date: _____

EY! EMPOWER YOU! COUNSELING LLC

Card Authorization Form

I, _____ , give permission to Empower You! Counseling, LLC to charge my card for the following purchases. My card details will be stored in my profile and will only be used for approved purchases.

Amount Authorized _____ Product/Service Co-pay / Deductible / No Call No Show / Counseling

Card Information

Card Type

- ☐ Mastercard
- ☐ Discover
- ☐ VISA
- ☐ AMEX
- ☐ Other

_____

_____
Cardholder (Name on Card)

_____
Card Number

_____ _____ _____
Expiration Date CVV Code (3 digit on back) Zip Code (billing address)

Recurring Payments Information

Charge Every:

- ☐ Week
- ☐ Month
- ☐ Quarter
- ☐ Other

_____

☐ Email reciepts to: _____

☐ Snail mail receipts to:

_____

_____

_____

Charge on what day of the month (monthly or quarterly billing) _____

Payment Amount _____

Products or Services Individual and/or group therapy sessions performed by a Licensed Professional Counselor

****Cancellations Must Be Received At Least 1 week Prior To Expected Billing Date****

Signature _____ Date: _____

Be sure to keep cardholder data safe by storing completed forms in a secure room or filing cabinet, and restrict access only to employees who require it to fulfill their job duties