Authentic Healing and Counseling
9432 Katy Freeway, Suite 400 | Houston, Texas | 77055
713-376-9500
Email: info@authentichealingandcounseling.com
Therapist: Gina Baiamonte, MS, LPC

CONFIDENTIAL REGISTRATION PACKET - Child Development Inventory

The information requested below should be completed by the parent(s) and returned at your child's first session. The information requested is confidential and will not be released without parent or guardian authorization. This form is intended to provide information about the child's growth and development that will be useful to the therapist. Many things contribute to a child's growth, success in school and becoming a confident individual. Please answer all questions as accurately and as fully as possible (all information is strictly voluntary). If you prefer to discuss any questions rather than writing an answer your child's therapist will be pleased to set up an additional meeting with you for a personal conference.

Date: _____ Person completing form: _____

IDENTIFYING INFORMATION:

Child's complete name: _____

Date of Birth: _____/_____/_____ Birthplace: _____

Address: _____City: _____ Zip: _____

School: _____ District: _____ Grade: _____

HOME BACKGROUND:

Father's full name: _____ Email: _____
Permission to send confidential information to the above email address? ☐Yes ☐No

Address (if different from the one listed above): _____

Occupation: _____ Employer: _____

School level completed: _____ Cell Phone # _____ Texting ☐Yes ☐No
Dad's Preferred form of contact: ☐Email ☐Call ☐Text

Work phone #: _____

Mother's full name: _____ Email: _____
Permission to send confidential information to the above email address? ☐Yes ☐No

Address (if different from the one listed above): _____

Occupation: _____ Employer: _____

School level completed: _____ Cell Phone # _____ Texting ☐Yes ☐No
Mom's Preferred form of contact: ☐Email ☐Call ☐Text

Work phone #: _____

What is the primary language spoken in the home? _____

Other languages used frequently around your child? _____

HEALTH HISTORY

Explain any complications with pregnancy. Was your child born full term or pre-mature? If premature, how many weeks? _____

_____

Infancy Concerns: ☐Allergies ☐Frequent crying ☐Poor sleep habits ☐Eating concerns
Has your child met developmental milestones within the appropriate ranges of times: i.e.: rolling over, sitting up, crawling, walking, talking, potty training, etc.: _____

_____

Which hand does your child prefer to use? ☐Left ☐Right ☐Either ☐Not yet determined

Please list any childhood diseases/serious injuries and/or hospitalizations:

Childhood diseases/Serious injuries/illnesses	Age:	Treatment – completed/ongoing

Physical disabilities that might interfere with learning/playing/etc.: _____

_____

Speaking difficulties (such as mispronouncing of words, specific letters sounds, stuttering): _____

_____

Hearing Concerns: _____Vision Concerns: _____

Unusual Spells: ☐Now ☐Past Upset Stomach: ☐Now ☐Past Soiling pants: ☐Now ☐Past

Bedwetting: ☐Now ☐Past Seizures: ☐Now ☐Past Nightmares: ☐Now ☐Past

Current medication your child is taking now: _____

In the past: _____

Has your child ever received previous counseling or therapy? When (age of child and month/year) _____

Where: _____ By whom: _____ How long did it last: _____

Is the child receiving any form of therapy at this time? _____ When did they begin? _____

Where: _____ By whom: _____ Do you plan to continue it? _____

Has the family ever received family therapy? If so, when (month/year) _____

Where: _____ By whom: _____How long did it last: _____

What was most helpful? _____

What did not work well with previous therapy? _____

SCHOOL HISTORY

☐Full time Childcare ☐Mother's Day Out ☐Preschool ☐Kindergarten ☐1st grade ☐2nd grade ☐3rd grade ☐4th grade ☐5th grade ☐6th grade ☐7th grade ☐8th grade

Has the child changed schools recently? ☐Yes ☐No What grade/age? _____

Reason/s _____ Was it an easy transition for the child? _____

Has the child skipped or failed a grade? ☐Yes ☐No **IF Yes please give details:** _____

_____

Explain any specific academic concerns with: Reading: _____ Math: _____

Special tutoring: _____ Other: _____
Subject with highest grade: _____Subject with lowest grade: _____

Child's attitude about school: _____

School activities the child enjoys most: _____ Least: _____

Social Adjustment of the child

Is the child active in any **children's groups**?
☐Scouting (cub/boy scouts, campfire girls/bluebirds/brownies/girl scouts) ☐Religious groups
☐Team Sports (baseball, soccer, cheerleading ☐Community Activities
☐Other: _____

Does your child seem to genuinely enjoy these activities? _____

What are the child's **major interests** right now? Check all that apply and give brief details below of any area of concern, pride, obsession.
☐Listening to music ☐Creating music ☐Watching TV ☐Reading ☐Telling stories
☐Collecting things ☐Drawing/coloring ☐Movies ☐Pets ☐Building/making things
☐Playing alone ☐Playing with adults ☐Playing with siblings ☐Playing with friends ☐Other

Give details about types of Music/TV shows/Reading your child enjoys _____

Hobbies: _____

Describe the child's relationship with his/her mother: _____

_____

Describe the child's relationship with his/her father: _____

Please give a complete list of addresses where the child has lived in his/her lifetime:

Moved From	Moved To	Child's Age & School Grade	Month/Year

List Child's brothers (last name if different from child) **Age** **School level completed**

_____ _____ _____

_____ _____ _____

_____ _____ _____

List Child's sisters (last name if different from child) **Age** **School level completed**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Others who live with the family **Age** **Relationship**

_____ _____ _____

_____ _____ _____

In the child's lifetime:
Anyone else who has lived with the family, Age **Relationship** **Date when person moved out**

_____, _____ _____ _____

_____, _____ _____ _____

Who resides with the child at this time?

☐Both Birth Parent (s) ☐Birth Mother Only ☐Birth Father & Stepmother
☐Adoptive Parent (s) ☐Birth Father Only
☐Foster Parent (s) ☐Birth Mother & Stepfather

☐Relatives (list names and relationships): _____

☐Other (Give Details) _____

If either/both parents are deceased, how old was the child at the time of death(s)? _____

If birth parents are divorced, how old was the child at that time? _____

How did the child react to either of the above situations? _____

Describe the child's relationships with other adults: _____

Describe the child's relationships with his/her siblings: _____

Describe the child's relationship with other children: _____

Disciplining of the child: ☐Strict ☐Lenient
☐More-strict than used with other children? ☐More-lenient than used with other children?

What discipline works best and in general how does your child respond to this form of discipline? _____

_____

Major difficulties at home: _____

When were you first aware of these difficulties: _____

Major difficulties at school _____

When were you first aware of the difficulties _____

Has the child attended a camp or spent an extended time away from parents/guardians? ☐Yes ☐No

Were any of the above-mentioned difficulties or others exhibited during these times away from parents/guardians? _____

Check any of the following that describe the child's behaviors

- ☐ Talks Constantly
- ☐ Talks only when needed
- ☐ Never talks to others
- ☐ Seldom completes tasks
- ☐ Finishes tasks
- ☐ Dislikes meals
- ☐ Enjoys meals
- ☐ Concerned about safety
- ☐ Looks forward to school
- ☐ Dreads school
- ☐ Friendly with playmates
- ☐ Fights with playmates
- ☐ Cannot control temper
- ☐ Dresses self
- ☐ Takes care of self
- ☐ Wants own way
- ☐ Good humored
- ☐ Slow movements
- ☐ Not much help at home
- ☐ Helps at home
- ☐ Learns easily
- ☐ Resists going to bed
- ☐ Restless, overactive
- ☐ Takes criticism
- ☐ Lacks self confidence
- ☐ Feels inferior
- ☐ Easily discouraged
- ☐ Upset by criticism
- ☐ Aggressive, hostile
- ☐ Easily injured
- ☐ Healthy
- ☐ Active
- ☐ Easily upset
- ☐ Selfish
- ☐ Patient
- ☐ Imaginative
- ☐ Inquisitive
- ☐ Anxious
- ☐ Impatient
- ☐ Patient
- ☐ Impulsive

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INSURANCE INFORMATION (Skip if self-pay):

Primary Insurance: _____Phone: _____

Name of Insured: _____Employer: _____ DOB: _____ / _____ / _____

Policy ID #: _____Group #: _____ SSN: _____ - _____ - _____

Secondary Insurance: _____Phone: _____

Name of Insured: _____ Employer: _____ DOB: _____ / _____ / _____

Policy ID #: _____Group #: _____ SSN: _____ - _____ - _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to Patient: _____

Address: _____City: _____ Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department.
AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize the release of any information regarding my condition or treatment to insurance company.
AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

_____ _____

Patient / Legal Guardian Signature Date

GENERAL INFORMATION AND PROCEDURES (Office Copy)

This form provides information about our counseling relationship, procedures involved, and your authorized consent to treatment.

Length of Session: Sessions are scheduled for 45-50 minutes. This conversation was established by insurance companies. Greater flexibility is possible and desirable, but may not be covered.

Cancellations: Your session time is reserved for you and is taken seriously. **Except for emergencies, cancellations must be made 24 hours in advance to avoid being charged. You will be charge $75.00 for no shows and late cancellations.**

Fee Structure: The client is financially responsible for payment of fees, which will be collected at the time of service. The client will also be responsible for any portion of fees not reimbursed of covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, the client and therapist can negotiate a payment schedule.

Confidentiality: Information shared in session is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony requires by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is as minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent.

Client Privacy: Recent laws have been enacted for client privacy. It is important to know that emails and mobile phone conversations are not secure or guaranteed of privacy because they can be potentially intercepted. Therefore, by signing this document you understand that if we have correspondence by email or mobile phone, there is a potential for confidentiality to be comprised.

Counseling Approach: To get the most of counseling of therapy, it is important to assume responsibility for your experience. Therapists can only help you based on the information you provide. If you are like most people, you probably have some sensitive issues you are not comfortable discussing with others. Those are usually the things you most need to talk about with your therapist. Regular, consistent participation in treatment sessions, as well as any "homework" assignments will help facilitate the process, but no therapist can ethically guarantee achievement of your goals. Please feel free to ask questions about the process and let your therapist know if you are not satisfied with how it is progressing. Because of the nature of the therapeutic process, you may experience periods of emotional discomfort on the way to your goals. No single therapist is the best one for every client. If you do not feel your therapist is the right fit for you, we will be happy to help you with another referral in this or another office. You are free to discontinue treatment at any time.

As a client, I have read, understood and agree to the terms and conditions of the information presented in this form as I enter into therapeutic process.

_____ _____

Patient / Legal Guardian Signature **Date**

CLIENT RECEIPT OF PRIVACY NOTICE (Office Copy)

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOUSURES

We may use and share your information as we

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers compensation, law enforcement and other government requests
- Respond to lawsuits and legal action

By signing below, I acknowledge receiving a copy of the "Privacy Notice" of Authentic Healing and Counseling describing my right to privacy of my protected health information (PHI) under the Federal HIPAA Privacy Law, as follows:

- **How my PHI may be used and disclosed,**
- **My privacy rights regarding my PHI**
- **The medical practice's obligations concerning the use and disclosure of my PHI**

Print Client Name/Guardian: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment of this notice but was unable to do so as documented below:

Date:	Initials:	Reason:

Authentic Healing and Counseling
No Show Pre-Authorized Charge Form

I authorize Authentic Healing and Counseling to keep my signature of file and to charge my Credit Card listed below for:

☐ **The one-time amount of $65.00 in the event that I fail to cancel my scheduled appointment and failed to provide 24-hour notice.**

I understand that this from is valid for one year unless I cancel the authorization through written notice to the service provider.

Customer Name: _____

Cardholder Name: _____

Card Type: ☐Visa ☐MasterCard ☐Discover ☐American Express

Account Number: _____

Expiration Date: _____ Card Verification Number: _____

Cardholder Signature: X_____ Date: _____

USE OF PRE-AUTHORIZED CHARGE FORMS

This form is s pre-authorization to charge credit card payments to your clients. You must sill complete the actual credit card charges, including getting an authorization from each transaction.

The information on this form is to be used to fill out your charge slips, as is authorized by the cardholder for payment of future or ongoing visits.

1.) The name of the service provider-your practice or business (as it appears on your card imprinter) must be filled in the top line.

2.) The cardholder must choose one of the three payment schedules indicated by each of the three boxes
   a. Charges not paid by insurance, not to exceed a designated amount, for either the current visit, or for all visits within a year.
   b. Recurring charges of a specific amount, to be charged on a scheduled-bases between two designated dates.
   c. A total fee, of a designated amount to be charged to the customer's card one time.

3.) Personal information must be completed by the provider, stating the customer's name, cardholder's name, card type, account number and expiration date. Please be careful to note that the cardholder's date does not extend beyond the "ending date" for any recurring charges.

4.) The cardholder must sign and date the form at the bottom.

5.) The cardholder receives the top copy, and the bottom two copies are returned by the service provider. (If there is any discrepancy regarding the chargers, the provider has the second copy to supply to the cardholder's bank.)

6.) The form is valid for use for one year, or until the cardholder cancels authorization through written notice to the service provider.

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As a client, I have read, understood and agree to the terms and conditions of the information presented in this form as I enter into therapeutic process.

_____ _____

Patient / Legal Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES (Client Copy)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of our medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice oat any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person an exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take an action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filling a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to.

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these case's we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

- We are allowed or requires to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We use or share your information for health research

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government request

We can use or hare health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We ae required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.