THE HOUSE OF HOPE
Phone: 715-483-3000
www.thehouseofhope3.com

Afton Location:
3411 St. Croix Trail South
Afton, MN 55001

St. Croix Falls Location:
2070 Hwy. 8
St. Croix Falls, WI 54024

Child Intake

To best meet your needs, the information below will maximize your time here. Please allow 30-60 minutes to complete this survey prior to your first appointment. Write "N/A" for anything that does not apply.

Child Name: _____ Date: _____

Birth Date: _____ Age: _____ School Name: _____ Grade: _____

Mother's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Secondary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Email Address: _____ OK to Email? Yes _____ No _____

Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Secondary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Email Address: _____ OK to Email? Yes _____ No _____

Emergency Contact: _____ Phone #: _____

Primary Insurance: **Secondary Insurance:**

Health Plan		Health Plan	
Policy Holder		Policy Holder	
Member ID#		Member ID#	
Group/Policy #		Group/Policy #	

Responsibility Party: _____ Relationship to Client: _____

Please summarize the reasons that led you to seek our services:

_____

_____

_____

_____

_____

_____

_____

Child's Counseling Focus
CIRCLE any problems your child is experiencing or stressors within the child's environment:

Depression	Emotional	Employment	Housing	Disability
Anxiety	Grief/Loss	Anger/Violence	Physical health	Mental health
Emotional	Health	Spiritual health	Sexuality	Relationships
Education	Finances	Legal issues	Military issues	Cultural issues
Social Life	Housing	Addiction—self	Addiction—other	Abuse
Trauma	Disability	Lifestyle	Self-harm	

What previous or current counseling/therapy or treatments has your child experienced?

Name of Practitioner	Year	Approximate # of Sessions

What goals would you like to see your child achieve in therapy?

1. _____

2. _____

3. _____

What are your child's strengths?

What are your child's areas of need/what primary concerns do you have?

What is the current living situation/custody agreement for the child? Who does the child live with?

List all siblings, half-siblings, step-siblings, or individuals living with the child:

Name: _____ Gender: _____ Current age: _____ Related how: _____

Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____

Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____

Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____

Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____

Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

How does your child get along with other children at home, at school, and in the community?

What role does God and spirituality play in your child's life?

What is your child's health history?

Was the pregnancy planned? _____ Yes _____ No

Were there complications with the pregnancy or birth? If so, what?

Is child adopted? If so, age when adopted?

Problems with: feeding/eating/sleeping? If so, when did they start? How long have they been going on?

Were there any physical separations between the child and a parent (i.e. death, extended travel, hospitalizations)? ____ Yes _____ No If yes, please describe:

Any traumas or tragedies? If so, describe:

Please briefly describe any other significant events from early childhood:

Current medications your child is taking: (please indicate under the frequency column if medication is daily, several times a week, etc).

Medication	Frequency	Dosage	Prescribing Doctor

Previous testing or therapy:

What	Where	When	Result

Has your child been the victim of or have they been exposed to physical, emotional, verbal, or sexual trauma ever in their life? Please describe the nature of the abuse, when it occurred, the duration of the abuse, who was involved, and the harm it caused you or others:

_____

_____

_____

_____

_____

Assessment of Abuse

Abuse	Current	Past	Perpetrator, Victim, or Witness	Please describe any outside intervention such as: treatment, child protection, the legal system, etc.
Mental				
Emotional				
Spiritual				
Physical				

Family History of Mental Health Concerns

Note any "blood" relatives who have or had problems with any of the following:

Check Problem		Which Family Member	Current Status
Substance Abuse			
Depression			
Bi-polar Disorder			
Schizophrenia			
Other Emotional Problems			

What does your child enjoy doing with their free time?

Please include any helpful information that you would like for me to know:

House of Hope Waiting Area Rules:

1) Please keep conversations and children quiet.
2) Please clean up any messes made before leaving.
3) The waiting area is not supervised; therefore, children under the age of 12 may not be left unattended at any time. House of Hope staff are not responsible for children who are left unattended.
4) If you drop off your child for therapy, please make sure you return to pick them up on time (the top of the hour, unless otherwise stated by the therapist).

Client Signature (parent/guardian if under 18 yrs)

Date

Safe Harbor Agreement

1. Parties. The parties to this Agreement are:

_____ and _____ (together "the parents"),

_____ (children),

_____ ("the therapist"), and/or

_____ ("the parenting consultant, PC, or guardian ad litem, GL)

2. Goal. The therapeutic goal is to permit the children to have a place that they deem safe to be able to speak to a mental health provider about any apprehensions, concerns, or issues without fear that what they say will be used to interfere with or create problems in their relationship with either parent.

3. Safe harbor. In order to effectuate the stated goal, the parties acknowledge the importance of the therapist's office being a safe harbor—a place where the children can be truthfully assured that what they say will not be disclosed to third parties without their consent.

4. AGREEMENT: Therefore, to create the safe harbor for the children, the parties agree as follows:

- **No court/no depositions.** Neither parent shall, nor will either parent permit his or her attorney to, subpoena the therapist or her notes to a trial, hearing, deposition, or arbitration.

- **No interrogations.** Neither parent shall, nor will either parent permit his or her attorney to, demand answers from either the therapist or the children to questions about the content of the therapy.

- **No disclosure.** The therapist agrees that he/she shall not divulge to either attorney, to the judge, or to any other third party except the PC or GL, any matter relating to the content of the therapy with the children (except required disclosures under the Child Abuse Reporting Act) without the children's explicit consent.

- **Exceptions:**

    1. The therapist shall be free to advise the PC or GL that certain matters which arose in therapy should impact particular parenting decisions within the purview of the PC or GL.

    2. The therapist, at his or her sole discretion, may divulge what he/she deems to be sufficient pertinent information, so that the PC or GL will have the necessary predicate data to make an informed decision about a parenting matter within the purview of the PC or GL.

    3. If the PC or GL makes a decision based on input from the therapist, the PC or GL shall only reveal in the decision that amount of information which the therapist authorizes about the children's statements.

    4. Accordingly, the parents understand and accept that occasionally there may be a decision which reads: "I have decided this based on input from the children's therapist," without further explanation.

5. Each parent understands certain information that is gathered and/or exchanged may be released to one or both parent and/or child at the therapist's discretion if it is thought beneficial to the child's progress.

- **No Loophole.** To preclude either parent or either parent's attorney from seeking access to the content of the children's therapy through the therapist's communication with the PC or GL, the parents affirmatively agree that they shall not, nor will they permit their attorneys to, interrogate or to subpoena the PC or GL notes or recollections of communications with the therapist to any trial, hearing, deposition, or arbitration. Notes that contain information about the children's therapy shall be stored in a file separation from the parents' PC or GL file.

- **Enforcement.** Any party, or his or her attorney, who seeks to interrogate or subpoena the therapist or PC or GL regarding the content of the children's therapy shall be liable for all attorney fees and costs incurred to resist answering discovery requests or to quash a subpoena.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

_____ _____

Therapist Signature Date

_____ _____

PC or GL Signature Date

CONSENT TO COMMUNICATE, BILL, & TREAT
(sign in front of provider at appointment)

I understand that **Gmail is NOT a secure network and is not protected by HIPAA.** Email communication and any of its attachments may contain confidential and privileged information for the exclusive use of the designated recipients (you and/or The House of Hope, including Therapists and Office Administrator/Billing).

I authorize The House of Hope to communicate with me and/or with each other regarding myself via

Email _____ (please initial) Email Address _____

Text Messages _____ (please initial) Cell Phone # _____

I authorize the release of all information that is obtained by The House of Hope to my referring doctor or funding source and I authorize payment from my funding source for services rendered to The House of Hope. I acknowledge full responsibility for payment for all costs incurred including **deductibles and co-pays and understand co-pays are due the date services are rendered.**

OR

I agree that insurance will **NOT** be billed and have opted for **Self-Pay** in the amount of $_____/per session (therapist will fill in) and acknowledge full responsibility for payment on agreed upon amount. I understand **payment is due the date services are rendered.**

I understand that I have the option to switch **Insurance Billing to Self-Pay**, or **vice versa** anytime, but if insurance has already been billed for a specific date of service(s), I am responsible for the allowable amount(s) for that date of service(s).

I understand collaboration is an important part of the treatment process and may be conducted with an appropriate signed release with, but not limited to: school guidance counselors, lawyers, teachers, doctors, child protective services, probation officers, and other mental health providers as appropriate. Effective July 15, 2017, additional services such as case summary letters, phone calls, emails, report readings, documentation for disability, guardian ad litem correspondence, and other communication or services other than direct therapy, may incur additional charges not covered by insurance and will be charged accordingly. **I agree to pay the additional charges of $50 per service and/or $100 per hour, whichever is greater, to be paid in full before services are rendered.**

I understand it is The House of Hope's policy to not testify in court regarding custody or placement of children. These situations negatively impact the therapeutic relationship and process. I understand and agree to pay **an additional fee of $500 per half day/$1000 per full day** if a House of Hope therapist has been subpoenaed or is requested to testify in court. **This fee is due in full by the requesting party on or before the day of the court appearance.**

I have read and understand the information given regarding my rights and treatment procedures. I can obtain a copy of HIPAA at any time and I understand this consent to treatment will be enforced until such time that I withdraw consent.

_____ _____

Client Signature (parent/guardian if under 18 yrs) Date

_____

Please Print Name