Suzanne M. Cohen LCSW
LifeDesign Behavioral Health
57 Cooper St. Suite B   Woodbury, NJ 08096

Child Intake Form

Dear Client ________________________,

Welcome to **LifeDesign Behavioral Health**. We appreciate you taking the time to fill out this Intake form to insure that we have accurate information in your file.

Filling out this information can save you future copays and session times. It is also required by insurance companies.

Any uncompleted paperwork will be completed as part of the first evaluation session.

If you ever have a change in your insurance carrier, or in the co-payment required, please let your therapist know. Payment is due at the time the services are provided.

Checks should be made payable to ***Suzanne Cohen LCSW.***

We appreciate your feedback.

Thank you for taking the time to write down this important information.

Sincerely,

Suzanne Cohen, LCSW
Licensed Clinical Social Worker

LifeDesign Behavioral Health

Information and Consent for Treatment

We are pleased that you have selected **LifeDesign Behavioral Health**. This document is designed to ensure that you understand our professional relationship.

I. Client Agreement

All the clinicians at **LifeDesign Behavioral Health** are experienced and professionally trained.

The model of treatment within LDBH involves weekly mental health therapy with clients who are willing and able to work on their mental health issues. Some clients need only a few sessions to achieve their goals, while others may require months or years of counseling. We desire to work with clients who have the capacity to resolve their own challenges with our assistance.

The number of sessions will be decided between you, your therapist (and your insurance company if you are using insurance to cover treatment cost).

Although your sessions may be very intimate psychologically, it is important for you to realize that it is a professional relationship rather than a social one. Please do not invite your counselor to relate to you in any way other than in the professional context of your counseling sessions. We will keep confidential anything that you say to your counselor with the following exceptions: (1) you direct us to tell someone else, (2) we determine that you are a danger to yourself or others, or (3) we are ordered by a court to disclose information. Also, (4) it is mandatory that we report child abuse.

If at any time for any reason you are dissatisfied with services you receive, please let your counselor know.

Sessions are approximately 45 minutes in duration. Please note that it is impossible to guarantee any specific results regarding your counseling goals. We will help you identify your issues, but it is up to you to do the work. Together we will work to achieve the best possible results for you. Our policy is that no weapons of any kind are permitted in any of our offices.

Therapy/treatment can be terminated by either the client or the clinician under the following circumstances: 1) If either the client or the clinician believes therapy/treatment is not being helpful to the client; 2) If the client is not complying with those elements of therapy/treatment essential for progress; 3) If the client's behavior or the behavior of someone in a relationship with the client is harmful or potentially harmful to other clients or the clinician.

II. **Legal Issues**

If you are in the midst of any type of legal issue such as litigation, a dispute with your employer, separation or divorce, please inform your counselor immediately. Please be aware that in child custody cases, we typically need signed permission from both parents, and that medical records are frequently subpoenaed when litigation is involved. Authorizations to release information regarding legal matters must be on LDBH letterhead. Please remember that **LifeDesign Behavioral Health** has no control of, or responsibility for how information is handled once it is released to third parties. **If you are using your insurance, and that insurance provider changes or your card numbers or co-pay changes, please let us know as soon as possible. It is your responsibility to bring this to our attention.**

III. **Cancellation/Office Hours**
In the event that you will not be able to keep an appointment, you must notify us 24 hours in advance. If we do not receive such advance notice, you will be responsible for paying a $25.00 cancellation fee (not covered by insurance) at the discretion of your therapist. Our offices are open during regular business hours and our voice mail system for leaving your therapist a message is available 24 hours a day.

IV. **Emergencies**
LifeDesign Behavioral Health is an outpatient facility. Our clinicians cannot assume responsibility for client's day to day functioning, as some more intensive treatments are designed to do. It is the responsibility of the client to discuss expectations of after-hours care with the therapist upon intake so that, if necessary, an appropriate referral can be made. In the case of an emergency, when a client fears harm to him/herself or another, please dial 911or go to your nearest emergency room, as we are not an emergency facility.

V. **Social Networking**
It is the policy of **LifeDesign Behavioral Health** that employees do not accept requests for friendship, follows or connections from clients or solicit themselves to clients as friends on social networking sites such as Facebook, Twitter, and MySpace. This list is not exhaustive and applies to non-active and active clients for a minimum of two years after discharge.

My signature below indicates that I grant consent for LifeDesign Behavioral Health to provide psychological services and counseling to myself and/or minor members of my family. I also acknowledge that I have received a copy of *Client Rights and Responsibilities (pg.5-6)*, and *Crisis/Emergency Procedures (pg.22)*.

Client/Guardian Signature ________________________________ Date ___________

Client/Guardian Signature ________________________________ Date ___________

Therapist Signature ______________________________________Date ___________

VI. **Insurance Assignment**
I, the undersigned, have insurance coverage with ____________________________ and assign directly to LDBH all medical benefits. If my insurance company does not cover for any reason, I agree that I am financially responsible for all charges. I also hereby authorize LDBH to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that all services provided outside of my therapy session, which are not covered by insurance, will be billed separately.

Client/Guardian Signature
_________________________________Date_________________

VII. To Parents of Adolescents
I understand the need for confidentiality between my son/daughter and his/her therapist and that confidentiality will be maintained unless the therapist determines that my son/daughter is a danger to self or others.

Parent/Guardian Signature __________________________________Date_________

Clients' Rights and Responsibilities Statement

Statement of Clients' Rights

*Clients have the right to be treated with dignity and respect.
*Clients have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
*Clients have the right to have their treatment and other client information kept private.
*Client treatment records may be released without client permission only if an emergency happens or if required by law.
*Clients have the right to easily access timely care in a timely fashion.
*Clients have the right to know about their treatment options. This is regardless of cost or coverage by the client's benefit plan.
*Clients have the right to share in developing their plan of care.
*Clients have the right to information in a language they can understand.
*Clients have the right to have a clear explanation of their condition and treatment options.
*Clients have the right to information about **LifeDesign Behavioral Health**, its practitioners, services and role in the treatment process.
*Clients have the right to information about clinical guidelines used in providing and managing their care.
*Clients have the right to ask their provider about their work history and training.
*Clients have the right to give input on this Clients' Rights and Responsibilities policy.
*Clients have a right to know about advocacy and community groups and prevention services.
*Clients have a right to freely file a complaint or appeal and learn how to do so.
*Clients have the right to know of their rights and responsibilities in the treatment process.
*Clients have the right to receive services that will not jeopardize their employment.
*Clients have the right to list certain preferences in a provider.

Statement of Clients' Responsibilities

*Clients have the responsibility to treat those giving them care with dignity and respect.
*Clients have the responsibility to give providers the information they need, so providers can deliver the best possible care.
*Clients have the responsibility to let their provider know when the treatment plan no longer works for them.
*Clients have the responsibility to discuss concerns about their care.
*Clients have the responsibility to follow the treatment plan
*Clients have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.
*Clients should call their providers with a minimum of 24 hours notice if they are not able to keep an appointment.
*Clients have the responsibility to pay their co-pay at the time of service and to inform the provider of any change in their insurance or required copay.
*Clients have the responsibility to openly report concerns about the quality of care they receive.
*Clients are ultimately responsible for payment should their insurance decline payment for any reason**.**

For New Jersey Only-- Statement of Client Rights (N.J.A.C. 10:37-4.5(b) & (h) 1-6

1. The right to be free from unnecessary or excessive medication.
2. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice.
3. The right to treatment in the least restrictive setting, free from physical restraints and isolation.
4. The right to be free from corporal punishment. 5. The right to privacy and dignity.
6. The right to the least restrictive conditions necessary to achieve the goals of treatment/services.

My signature below shows I have been informed of my rights/responsibilities and understand them.

Client____ Date______________

Legal Guardian___________________________________ Date______________

PSYCHIATRIC ADVANCE DIRECTIVE

On November 3, 2004, Governor Rendell (PA) signed into law Act 194, which allows you to create a Psychiatric Advance Directive for mental health care, usually used for inpatient treatment. This is a tool that helps you plan ahead for the mental health services and supports that you might want to receive during a crisis if you are unable to make decisions for yourself at that time. It allows you to document your decisions about your treatment before it is needed, for example, your choice of hospital, types of treatment and who should be notified. A blank copy of a Psychiatric Advance Directive may be available in the office you visit upon your request.

Psychiatric Advanced Directive Questions

Do you have a Psychiatric Advanced Directive? Yes ___ No____

If you do have one, will you provide a copy to TLP/LCS? Yes ___ No ___

If you want one, please ask for it from your psychiatrist or clinician.

Client signature____ Date_________

Legal Guardian signature____________________________________ Date________

HIPAA PRIVACY POLICY

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.

LifeDesign Behavioral Health is committed to protecting your information.

You have the right to inspect and receive a copy of your records.

All responses to requests for PHI will be limited to the minimum amount of information needed to accomplish the purpose of the request or disclosure.

LifeDesign Behavioral Health may use or disclose individual's Protected Health Information (PHI), as defined in the Health Insurance Portability and Accountability Act of 1996, for the purpose of conducting, planning and directing your treatment, making or obtaining payment for care, or otherwise allowed by HIPAA. We may use or disclose your PHI for purposes permitted or required by federal, state, or local law, for example, if we are court ordered, or we determine that you are a danger to yourself or others.

Also, it is mandatory that we report child abuse. Finally, you may give us permission to release your information.

We do not share your information with anyone for their own marketing purposes. For this reason we are not required to obtain and "opt-in election," or an "opt-out election."

PATIENT DISCLOSURE AUTHORIZATION (HIPPA)

It is acceptable for you to leave information on the following phone numbers including appointment reminders: Ph#:_______________ Ph#:_______________

It is acceptable for you to speak with only the following family member(s)/friend(s) regarding my treatment:

Name: ___________________ Ph#:_______________ Relationship:_____________

Name: ___________________ Ph#:_______________ Relationship:_____________

I have read the HIPAA Privacy Policy and Patient Disclosure Authorization.

_____________________________________ ____________

Signature Date

Declaration of Custody and Consent to Therapy (COMPLETE only if Parents initiate therapy)

Client's Name: ___________________________________ Date of Birth ___________

Please choose from one of the following three options regarding your custody arrangement for the above named patient:

❑ I have full legal custody of this client. I have complete authority to make decisions regarding my child's mental health needs.

❑ There is no legal declaration of custody for this client. I have complete authority to make decisions regarding my child's mental health needs.

❑ I share legal custody for this child. I understand that LCS *must* contact the client's other legal guardian before providing treatment for this client, and I agree to this contact.

Name of other legal guardian: ____

Address/Phone number of other legal guardian:

____

Signature and permission of other legal guardian for child to receive therapy:

Signature: ________________________________ Date: ________________

My signature below indicates that I have read and understand this form and give permission for my child to receive therapy:

____

Signature Date

Our signatures below indicate agreement to allow either to sign for release of records:

____

Signature Date

____

Signature Date

FOR OFFICE USE ONLY

Dates of attempts to reach other legal guardian/messages left:

Verbal permission for treatment including evaluation, psychotherapy, psychiatric services, and/or family therapy was granted by ________________________________ during a telephone contact on ________________ at ____________________.

❑ Guardian would like to be involved in treatment.

❑ Guardian does not wish to be involved in treatment

Parent/Child/Psychotherapist
Agreement of Confidentiality

Therapy is most effective when a trusting relationship exists between the therapist and his/her client. Privacy is an especially important ingredient in securing and maintaining that trust.
Although the general goal is for children to have stronger and better relationships with their parents, at times it may be necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with great freedom. This is especially true for adolescents who are naturally developing a greater sense of independence and autonomy.
The purpose of this document is to ensure a more effective treatment relationship between (therapist) __________________________ and (client) __________________________. The sessions between __________________________ and __________________________ will remain confidential. ______________________ will not reveal information learned about ____________________ to the parents except:

- If there is a threat to the life or safety of the child or others
- If progress in therapy has stalled and should be discontinued
- If needed to make a referral if the therapist believes s/he is not competent to treat whatever problem(s) may be discovered in the course of the treatment, and/or
- As necessary for billing for services
- Other conditions as specified in the Informed Consent Form

I understand the need for confidentiality between the therapist and my son/daughter as part of the therapy process. I understand that it will be maintained unless the therapist determines that my child/teenager is a threat to self or others.
I understand that this agreement is binding and may not be rescinded during the course of therapy.

____ __________________________
Signature of Parent   Date

____ __________________________
Signature of Child   Date

____ __________________________
Signature of Psychotherapist   Date

Client and Family Information

Client Personal Information: Name:_________________________ Date of Birth: __________

Address: ____

Best Number to Reach You: ____

Medical Problem(s) (List): ____

____

Overall Health (Please Rate 0-5, 0 being worst and 5 being best): __________

Client Lives With: ____

Was Client Adopted? ❑ Yes ❑ No

Family Information: Mother's Name: ____

Address: ____

Phone Number: ___________________________ Age: ____________________

Occupation: ____

Rate (0-5) Relationship Between Client & Mother: __________

Father's Name: ____

Address: ____

Phone Number: ___________________________ Age: ____________________

Occupation: ____

Rate (0-5) Relationship Between Client & Father: __________

Siblings: Name: ___________________________ Age: ____________________

Name: ___________________________ Age: ____________________

Name: ___________________________ Age: ____________________

Name: ___________________________ Age: ____________________

Stepfamily Information: Stepmother's Name:

____

Address: ____

Phone Number: ___________________________ Age: ____________________

Occupation: ____

Stepfather's Name: ____

Address: ____

Phone Number: ___________________________ Age: ____________________

Occupation: ____

Stepsiblings: Name: ___________________________ Age: ____________________

Name: ___________________________ Age: ___________________

Previous Treatment:

Previous Therapist: ____

Contact Information: ____

Date(s) Seen: ____

Reason(s) Seen: ____

____

Previous Psychiatrist: ____

Contact Information: ____

Date(s) Seen: ____

Reason(s) Seen: ____

____

Other Treatment: ____

____

____

Developmental History- To be filled out by Parent or to the best of your knowledge

Pregnancy & Delivery

a. How was health during pregnancy? ❑ Good ❑ Fair ❑ Poor ❑ Don't Know

b. How old when child was born? ____________________

c. Any of the following substances used during pregnancy?

❑ Beer or Wine ❑ Hard liquor ❑Coffee or other caffeine

❑ Cigarettes ❑ Prescription medications

d. Were there indications of fetal distress during labor? ❑ Yes ❑ No

e. Delivery was: ❑ Normal ❑ Breech ❑Cesarean ❑ Forceps ❑ Induced

f. Was child premature? ❑ Yes ❑ No

g. Weight and height at birth: ____

h. Any birth complications or problems? _________________________________

i. Was the child breast-fed? ❑ Yes ❑ No For how long? ________________

Any allergies? ____

j. How easy was the child (ie. Did he/she follow a schedule well)?

❑ Very Easy ❑ Easy ❑ Average ❑ Difficult ❑ Very Difficult

k. How did the child behave around people?

❑ More sociable ❑Average sociability ❑ Less sociable than average

Developmental Milestones

At what age did the child do each of these?

a. Sat without support: ❑ 3-6 months ❑ 7-12 months ❑ Over 12 months ❑ Don't know

b. Crawled: ❑ 6-12 months ❑ 13-18 months ❑ Over 18 months ❑ Don't know

c. Walked without holding on: ❑ Under 12 months ❑ 1-2 years ❑ 2-3 years ❑ Don't know

d. Speak single words other than "mama" or "dada"

❑ 9-13 months ❑ 14-18 months ❑ 19-24 months ❑ 25-36 months

❑ Don't know

e. String two or more words together

❑ 9-13 months ❑ 14-18 months ❑ 19-24 months ❑ 25-36 months

❑ Don't know

f. Toilet trained: ❑ Under 1 year ❑ 1-2 years ❑ 2-3 years ❑3-4 years

❑ Don't know

g. Bowel control: ❑ Under 1 year ❑ 1-2 years ❑ 2-3 years ❑3-4 years

❑ Don't know

Medical History:

How would you describe client's general health? ____________________________

How is his/her vision? ____

How is his/her hearing? ____

Are there any chronic health problems (Asthma, diabetes, heart condition, etc.)? _______

____

____

Which of the following illnesses has client had (check all that apply):

❑ mumps/chicken pox ❑ measles ❑ whooping cough ❑ scarlet fever ❑ pneumonia

❑ encephalitis ❑ otitus media ❑ lead poisoning ❑ seizures

❑ recurrent ear infections

Have any of the following occurred (check all that apply):

❑ hospitalizations ❑ allergies ❑ head trauma ❑ major accidents ❑surgeries

❑ periods of loss of consciousness ❑ broken bones

Has the client had any weight changes recently? If yes, please describe: ______________

____

____

Date of last medical exam: __________ Report: ________________________________

____

Has client ever used non-medical drugs? ❑ Yes ❑ No If yes, please explain:

Chemical: _______________________________ Amount: _________________

How? ______________________________ Frequency: ______________________

Date Last Used: _______________________

Has client ever experienced withdrawal? ❑ Seizures ❑ DT's ❑ Hallucination

Do any addicts live in your house? ❑ Yes ❑ No

Does client smoke cigarettes? ❑ Yes ❑ No

If yes: How many cigarettes daily? _________ For how long? _______________

Have you or other family members had previous counseling or psychological testing? If yes, with whom? ___________________________ For how long? ____________

Are you willing to sign a release of information form so that your counselor may write for previous reports? ❑ Yes ❑ No

Does client have problems sleeping? ❑ Yes ❑ No

How many hours of sleep does the client average a night? __________________________

Education:

In what grade is the client currently? ____

Summarize progress (academic, social, testing) at each grade level:

Grades 1-3: ____
____

Grades 4-6: ____
____

Grades 7-9: ____
____

Has the client ever received special educational services? ❑ Yes ❑ No

School Name: ____

School Phone Number: ____

Counselor's Name: ____

What are the client's grades at this point in the semester? __________________________

Has there been a change in the client's academic performance? ❑ Yes ❑ No

Has the school been in contact with you regarding conduct, attendance, or other concerns? ❑ Yes ❑ No

Religious Background:

Denominational Preference: ____

Religious Background of Mother ____________________ Father ___________________

Stepparent ____________________

Explain any changes in the client or family's religious life, if any. ___________________
____
____

SUICIDAL IDEATION

Have you ever, or currently have any thoughts or ideas about suicide? Use the following scale and describe:

0=No 1=Yes 2=Suspected 3=Unknown

_____Thoughts: ____

_____ Intent: ____

_____ Plan: ____

_____ History of violent behavior: ____

_____ Need for physical restraint: ____

HOMICIDAL IDEATION

Have you ever, or currently have any thoughts or ideas about homicide? Use the following scale and describe:

0=No 1=Yes 2=Suspected 3=Unknown

_____Thoughts: ____

_____ Intent: ____

_____ Plan: ____

_____ History of violent behavior: ____

_____ Need for physical restraint: ____

Have you ever had a traumatic experience: ▫ Yes ▫ No

If Yes, what was it?

____

ABUSE / NEGLECT ASSESSMENT *Check if any of the following apply*

As a child or adolescent, have you ever been abused: ☐ Physically ☐ Emotionally ☐ Sexually

Was there a pattern of neglect as a child or adolescent? (i.e. No or little emotional support, no or little food, no or little supervision) ❑Yes ❑No If Yes, what was it:

____

____

______________________________________ ________________________________

Parent/Guardian Signature Date Clinician Signature Date

Child Checklist of Concerns

Child's name: ____ Age: __________

Person Completing this Form: ______________________________ Date: __________

Please mark all of the items that apply to your child. Feel free to add any others at the end.

- ❑ Affectionate
- ❑ Anxious, Nervous, Worried, Fretful
- ❑ Appetite changes – eating more than normal or less than normal
- ❑ Argues, talks back, defiant, smart-alecky
- ❑ Bullies or intimidates, teases, bossy, picks on, provokes, inflicts pain on others
- ❑ Cheats
- ❑ Cruel to animals
- ❑ Concerned for others
- ❑ Conflicts with parents over persistent rule-breaking, money, chores, homework, grades, etc.
- ❑ Complains
- ❑ Concentration problems, poor focus, difficulty making decisions
- ❑ Cries easily, feelings are easily hurt
- ❑ Dawdles, procrastinates, wastes time
- ❑ Difficulties with parent's paramour/ new marriage/ new family
- ❑ Dependent, immature
- ❑ Developmental delays
- ❑ Disrupts family activities
- ❑ Disobedient, uncooperative, noncompliant, doesn't follow rules
- ❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ❑ Dropping out of school
- ❑ Drug or alcohol use
- ❑ Eating – poor manners, refuses to eat, overeats, hoards food
- ❑ Energy lacking, fatigue, low motivation
- ❑ Exercise problems
- ❑ Extracurricular activities interfere with academics
- ❑ Failure in school
- ❑ Fearful
- ❑ Fighting, hitting, violent, aggressive, hostile, destructive, threatening

- ❑ Fire-setting
- ❑ Friendly, outgoing, social
- ❑ Friendship changes, few friends, withdrawing from friends
- ❑ Hypochondriac, frequently complains of feeling sick
- ❑ Immature, has only younger playmates, clowns around
- ❑ Imaginary playmates, indulges in lots of fantasy
- ❑ Independent
- ❑ Interrupts, yells, talks out of turn
- ❑ Lacks organization, is unprepared, doesn't follow through
- ❑ Legal difficulties – truancy, loitering, vandalism, stealing, fighting, drug use, drinking
- ❑ Likes to be alone, isolates, withdraws
- ❑ Loss of interest in hobbies, friends, normal activities
- ❑ Low frustration tolerance, irritability, angry outbursts
- ❑ Lying
- ❑ Mental retardation
- ❑ Moody
- ❑ Mute, refuses to speak
- ❑ Nail biting
- ❑ Nightmares
- ❑ Need for high degree of supervision at home for play, chores, schedule
- ❑ Obedient
- ❑ Obesity
- ❑ Overactive, restless, hyperactive, fidgety, noisy
- ❑ Oppositional, resistant, refuses, noncompliant, negative
- ❑ Prejudiced, bigoted, intolerant, insulting, name-calling
- ❑ Pouts
- ❑ Recent move, new school, loss or change in friends
- ❑ Poor peer relations – competitive, fights, teases, provokes, assaults
- ❑ Recklessness, high-risk behaviors, lack of concern for self
- ❑ Repetitive movements, rocking, hand-flapping
- ❑ Runs away
- ❑ Sad, unhappy, depressed
- ❑ Self-esteem problems, self-critical, feels worthless, lacks confidence
- ❑ Self-harming behaviors – head banging, cutting, scratching self, biting or hitting self

❑ Sexually inappropriate – preoccupied with sex, publicly masturbates, seductive
❑ Shy, timid
❑ Sleep problems – sleeps too much or too little, insomnia
❑ Speech difficulties
❑ Stubborn
❑ Suicide talk or attempt
❑ Swearing, foul language, bathroom talk
❑ Temper tantrums, rages
❑ Thumb sucking, finger sucking, hair chewing
❑ Tics – involuntary rapid movements, noises or words
❑ Teased, picked on, bullied, victimized
❑ Truant, school avoidant
❑ Under active, slow-moving, lethargic, slow-responding
❑ Uncoordinated, accident-prone
❑ Weight loss or weight gain
❑ Working problems, lack of employment, over-working, can't keep a job
❑ Other (describe): ____
____
____

Please look back over the concerns you have checked off, and choose the one(s) that you most want your child to be helped with: ______________________________________
____
____

Childhood Depression Inventory

Name:_______________________________________

Date:_______________________

Instructions

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups of three statements. From each group pick one sentence that describes you best for the past two weeks. After you pick a sentence from the first group, then go on to the next group of three statements.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been feeling recently. Put a mark like this **X** next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example how this form works. Try it, put a mark next to the sentence that describes you best.

EXAMPLE:

- ❑ I read books all the time.
- ❑ I read books once in a while.
- ❑ I never read books.

Remember, pick out the sentences that describe your feelings and thoughts in the past two weeks.

1. ❑ I am sad once in a while.
   ❑ I am sad many times.
   ❑ I am sad all the time.

2. ❑ Nothing will ever work out for me.
   ❑ I am not sure if things will work out for me.
   ❑ Things will work out for me O.K.

3. ❑ I do most things O.K.
   ❑ I do many things wrong.
   ❑ I do everything wrong.

4. ❑ I have fun in many things.
   ❑ I have fun in some things.
   ❑ Nothing is fun at all.

5. ❑ I am bad all the time.
   ❑ I am bad many times.
   ❑ I am bad once in a while.

6. ❑ I think about bad things happening to me once in a while.
   ❑ I worry that bad things will happen to me.
   ❑ I am sure that terrible things will happen to me.

7. ❑ I hate myself.
❑ I do not like myself.
❑ I like myself

8. ❑ All bad things are my fault.
❑ Many bad things are my fault.
❑ Bad things are not usually my fault.

9. ❑ I do not think about killing myself.
❑ I think about killing myself but would not do it.
❑ I want to kill myself.

10. ❑ I feel like crying everyday.
❑ I feel like crying many days.
❑ I feel like crying once in a while

11. ❑ Things bother me all the time.
❑ Things bother me many times.
❑ Things bother me once in a while.

12. ❑ I like being with people.
❑ I do not like being with people many times.
❑ I do not want to be with people at all.

13. ❑ I can not make up my mind about things.
❑ It is hard to make up my mind about things.
❑ I make up my mind about things easily.

14. ❑ I look O.K.
❑ There are some bad things about my looks.
❑ I look ugly.

15. ❑ I have to push myself all the time to do my schoolwork.
❑ I have to push myself many times to do my schoolwork.
❑ Doing school work is not a big problem.

16. ❑ I have trouble sleeping every night.
❑ I have trouble sleeping many nights.
❑ I sleep pretty well.

17. ❑ I am tired once in a while.
❑ I am tired many days.
❑ I am tired all the time.

18. ❑ Most days I do not feel like eating.
❑ Many days I do not feel like eating.
❑ I eat pretty well.

19. - [ ] I do not worry about aches and pains.
    - [ ] I worry about aches and pains many times.
    - [ ] I worry about aches and pains all the time.

20. - [ ] I do not feel alone.
    - [ ] I feel alone many times.
    - [ ] I feel alone all the time.

21. - [ ] I never have fun at school.
    - [ ] I have fun at school only once in a while.
    - [ ] I have fun at school many times.

22. - [ ] I have plenty of friends.
    - [ ] I have some friends but I wish I had more.
    - [ ] I do not have any friends.

23. - [ ] My school work is alright.
    - [ ] My school work is not as good as before.
    - [ ] I do very poorly in subjects I used to be good in.

24. - [ ] I can never be as good as other kids.
    - [ ] I can be as good as other kids if I want to.
    - [ ] I am just as good as other kids.

25. - [ ] Nobody really loves me.
    - [ ] I am not sure if anybody loves me.
    - [ ] I am sure that somebody loves me.

26. - [ ] I usually do what I am told.
    - [ ] I do not do what I am told most times.
    - [ ] I never do what I am told.

27. - [ ] I get along with people.
    - [ ] I get into fights many times.
    - [ ] I get into fights all the time.

Patient Care Communication Form

Physician's Name ________________________________ Telephone Number _______________

Address ____

Dear Doctor _______________________________________

Your Patient, _______________________ was recently referred by ____________________.

We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation: _____________ **Date of Next Appointment**:_____________
Diagnoses and/or presenting problems: ____

____

Treatment Recommendations: ____

____

Medications: ____

Please call if further information would be helpful.

Clinician's Printed Name ____

Address ____

Telephone Number ______________________________

Sincerely, ____

Clinician Signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 24 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION

I, _______________________________ hereby authorize____________________________

Print Patient's Name ***Print Treating Clinician's Name***

Please Check One

To release any applicable mental health information to my primary care physician

_______ (PCP) named above.

_______To release any applicable substance abuse information to my PCP named above.

_______To release only medical information to my PCP named above.

_______Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that the action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

_________________________________ __________________________ ______________

Print Name of Patient or Guardian ID Number Date of Birth

_________________________________ ________________________

Signature of Patient or Guardian Date

Financial Responsibility Agreement & Authorization to Release Information to Insurance Company

LifeDesign Behavioral Health agrees to provide me outpatient services for a fee. In return, I agree to pay the amount of $_______________ per session. I understand that payment is due at the time of service, and that my balance must be paid by completion of my treatment. If for any reason I am not able to make a payment, I will inform my therapist before treatment to discuss options.

Cash, personal checks are accepted. There is a $25.00 service charge for all returned checks. We can provide you with a receipt for fees paid if you would like.

Check with your insurance company to determine if your coverage honors outpatient counseling provided by your clinician. Please note that many insurance companies require audits that request information about symptoms, diagnosis, and treatment. By using insurance you are granting permission for us to communicate confidential information to your insurance company.

Any changes in your insurance plan or card numbers, **please call to update your information immediately.** I am aware that I am fully responsible for any services provided to me or my family members in the event that my insurance is no longer valid.

Authorization to release Information to my insurance company:

My signature below indicates my permission for LifeDesign Behavioral Health to bill my insurance for payment. I give my permission to disclose information such as my diagnosis, my medication and dates I will be attending, as well as other pertinent information in order for my insurance company to grant authorization of my attendance.

_________________________________ _________________________________

Patient signature Date Clinician signature Date

____

Parent/Guardian signature Date

PAYMENT OPTIONS

_____ Personal Check _____ Cash

Crisis/ Emergency Procedure

LifeDesign Behavioral Health is dedicated to assisting you through difficult life transitions. However, we have limits in our ability to assist you. In particular cases, we do not offer crisis services, such as 24-hour hotline or emergency sessions after regular hours. This means we are typically unable to provide immediate responses to calls that come in after business hours. Please take the following steps if you find yourself in a crisis situation or struggling in such a way that requires immediate attention.

1) IF IT IS A MEDICAL EMERGENCY PLEASE CALL 911 FIRST.

2) Call the 24-hour crisis hotline in the country /city in which you reside. You can call 1-800-SUICIDE (784-2433) from anywhere in the U.S. toll free.

Pennsylvania
Easton 610-252-9060
Bucks County Upper 215-257-6551
Bucks County Central 215-245-2273
Bucks County Lower 215-785-3785
Centre County 1-800-643-3432
Chester County 610-918-2100
Norristown- Montgomery County 800-452-4189
Montgomery County 610-279-6100
Philadelphia 215-686-4420
Delaware County 610-447-7600 / 610-237-4210
Lancaster County 717-394-2631
York County 717-632-4900

New Jersey
Atlantic County 24 hours 609-344-1118
Burlington County 609-835-6180
Mercer County 800-273-8255
Camden County 856-428-4357
Gloucester County 856-845-9100

Delaware
From anywhere in state – toll free 800-262-9800
From anywhere in state - local 302-761-9100

Maryland
From anywhere in state 800-422-0009

3) Our office staff is available from 9am-5pm Monday through Friday.
Voice mail is available for you to leave messages at any time day or night.

4) For after hours emergencies, dial 911 or go to your nearest emergency room, as we are not an emergency facility.