ALPHARETTA family therapy

Stephanie Robins, LCSW
3180 Northpoint Parkway, Suite 101,
Alpharetta, GA 30005
404-849-5505
www.alpharettafamilytherapy.com

CHILD CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last **First** **Middle Initial**

Parent or Legal Guardian's Name: _____
Last **First** **Middle Initial**

Child's date of birth: _____ **Gender:** _____

Parent or Legal Guardian's Social Security #: _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Parent or Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions:_____

_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ◆ Yes ◆ No
- If referred by another clinician, would you like for us to communicate with one another?
  ◆ Yes ◆ No

Person(s) to notify in case of any emergency: _____
Name **Phone**

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

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Parents are: ( ) Married ( ) Divorced ( ) Separated ( ) Remarried ( ) Living together ( ) Other * If divorced, **please bring a copy of the custody portion of your divorce decree.
Child's legal custodian/guardian is: _____

Is the child adopted? Yes No If yes, is this the knowledge of the child? Yes No

Please briefly describe your child's presenting concern(s):_____
_____
_____

What are your/your child's goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____
_____
_____
_____

Current Medications (if you need more room, please write on the back of this page):
Name of Medication Dosage Purpose Name of Prescribing Doctor

_____
_____

Please list any past medications.
_____
_____

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

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List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions. Condition Age Treated by whom? Consequences? _____ _____ _____
_____ _____ _____ _____
_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual
__Transgender __ Asexual __In Question __Other

Racial/Ethnic Identity:
__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed

FAMILY:

Who else lives in the home with the child?
_____
_____
_____

How would you describe your child's relationship with his or her mother?_____
_____
_____

How would you describe your child's relationship with his or her father?_____
_____
_____

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____
_____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

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Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____

_____

_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?_____

_____

_____

_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Please briefly describe your child's self-care and coping skills: _____

_____

_____

What are your child's diet, weight, and exercise/activity patterns?_____

_____

_____

Please briefly describe your child's school performance and experience:_____

_____

_____

What are your child's hobbies, talents, and strengths?_____

_____

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PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety			Tantrums			Nausea		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilitie			"Nervous Breakdown"		

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Was the child premature? YES NO Any birth complications or problems?

Please list any problems during infancy or early childhood.

Any speech, hearing, or language difficulties?

Any additional information you would like to include:

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INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your social worker/marriage and family therapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment.

Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask.

Stephanie Robins, LCSW has a Master's of Social Work with a specialty of Children, Adolescents, and Families from the University of Alabama. I am a Licensed Clinical Social Worker in the state of Georgia. Additionally, I have had extensive work experience and training in children and adolescents with chronic/terminal illnesses, ADHD interventions, behavior modification, play therapy, family counseling, parent and patient education, anxiety and depression, and grief and loss counseling.

I have provided counseling services since 1997 at such facilities as Children's Healthcare of Atlanta Egleston—Atlanta, GA, Georgetown University Medical Center—Washington, D.C, and DCH Medical Center—Tuscaloosa, AL.

Theoretical Views & Client Participation

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role, both during and between sessions. This also means avoiding any mind-altering substances including but not limited to alcohol and non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit.

Confidentiality & Records

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Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my office. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. The state of Georgia has a very good track record in respecting this legal right. If for some reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say to me confidential.

Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Structure and Cost of Sessions

STRUCTURE AND COST OF SESSIONS: FEES:
$175: Intake/Initial Session: 45-50 minute Session
$150: Individual Therapy 45-50-minute Session
$150 Couples Therapy 45-50-minute Session
$150: Family Therapy 45-50-minute Session
$150: Parent Meeting and/or Feedback Session
$75: Group 45-50-minute session
$150-$250: For Collaborative Divorce Coach/Child Specialist, Parent Coordination, Mediation

PHONE SESSIONS: Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at $10 per minute.

OUT OF SESSION SERVICES: I am happy to make phone calls, emails, and communication with professionals to make sure you and/or your child have the best multidisciplinary treatment and has a caring team of professionals who are all on the same page. The following are my fees for this communication: $150 per hour for any communication exceeding 10 minutes in a week between therapist and collateral contacts (including lawyers, guardian ad litem, psychiatrists, school counselors, teachers, or any other professionals) $150 per hour for phone calls, emails and letter-writing exceeding 10 minutes per week.

COURT APPEARANCES: I discourage sharing confidential client information regarding specific statements by the client for use of court procedures. In my experience this diminishes the therapeutic relationship and the trust that the client has in the therapist. If court appearances are required however, please note the fee below. $250 per hour, 4 hour minimum required with a $1000 retainer paid at least 2 weeks prior to appearing in court.

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LATE ARRIVALS: Therapy sessions are scheduled to be 45-50 minutes. I understand if traffic and other reasons cause you to be late; however, I still must conclude the session at the scheduled stop time (meaning if you are 10 minutes late, your session will be 35-40 minutes).

CANCELLATIONS/NO SHOWS: Your appointment time is reserved exclusively for you. If you are unable to attend your appointment please notify me by phone, text message is sufficient when applicable. I require a full business day's notice (24 hrs to 48 hrs prefered notice) for any cancelled appointment. Failure to follow cancellation policy will result in being billed $95 to $150 for the time that was reserved for you. This will not be covered by your Insurance carrier or EAP provider. Payment for late cancellations/no shows ***will be required prior to continued services.***

GOING OVER THE SESSION TIME: The 45-50 minute therapy session includes the parent-check in at the end (if applicable). Any additional time spent in the therapist's office will be billed at a rate of $150 an hour. Once the 50 minutes has been reached, a therapist will inform you and give you the option to continue the conversation (if the therapist has time available) but please note that if you choose to extend the session time, you will be billed at a prorated rate. Please pick up your child on time. I am not responsible for unaccompanied children after the scheduled session time.

The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment. Please note that there is a $55 fee for any returned checks. I will provide you with a receipt upon request.

The receipt of payment may also be used as a statement for insurance or for use of Flexible Spending Account, if you so choose. Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement if I am considered OUT OF NETWORK provider. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Will gladly file claims for when I am IN NETWORK. If I am in network with your insurance company, please be aware that I must provide your insurance company with a diagnosis as well as information about your progress in treatment. They also may have right to audit your entire chart, depending upon your insurance company.

In Case of an Emergency

My practice is considered to be an outpatient facility, and I am setup to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- Call Ridgeview Institute at 770.434.4567 or Peachford Hospital at 770.454.5589.
- Call 911.

· Go to your nearest emergency room.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways (e.g., social, business, etc.), we would then have a "dual relationship." Dual relationships may compromise our treatment and, therefore, are discouraged in the mental health profession. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients secret. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way; they are strictly for your long-term protection.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me to maintain your confidentiality, respect your boundaries, and ascertain that our relationship remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. If you would like for me not to use a cell phone when contacting you, please let me know.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with me. However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy of all emails and texts as part of your clinical record.

Facebook, LinkedIn, Etc: It is my policy not to accept requests from any current or former client on social networking sites such as Facebook or LinkedIn because it may compromise your confidentiality. Additionally, my ethics code prevents me from soliciting endorsements from clients, and the concept of "Fanning" is considered to be bordering on such solicitation. However, it is still your prerogative to view or share any content on my professional pages. Please note that you should be able to subscribe to my professional Facebook page via Really Simple Syndication (RSS) without becoming a Fan and without creating a visible, public link to my Page, which I strongly encourage for your privacy.

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Google: I do not search for clients on Google. I respect your privacy and make it a policy to allow you to share information about yourself to me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material out and bring it to your session.

Twitter & Blogs: I post psychology news on Twitter, and I write a blog on my website. If you have an interest in following either of these, please let me know so that we may discuss any potential implications to our therapeutic relationship. Once again, maintaining your confidentiality is a priority. I would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to my content.

In summary, technology is constantly changing, and there are implications to all of the above that I may not realize at this time. Please feel free to ask questions, and know that I'm open to any feelings or thoughts you have about these and other modalities of communication.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association / American Counseling Association / National Association of Social Workers/American Association for Marriage and Family Therapists. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

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I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form as well as the "Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices" provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me as your therapist, and you are authorizing me to begin treatment with you.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

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Credit/Debit Card Payment Consent Form

*** All clients of Stephanie Robins, LCSW/Alpharetta Family Therapy, LLC are required to have a credit card on file.**

Your Name _____
Print Last First Middle Initial

Client Name (if different) _____

Type of Card: (please circle): VISA MasterCard Discover American Express

Card Number: _____ _____ _____ _____

CVV Number: _____

Exp. Date: _____ (MM/YY)

Billing Zip Code:_____

Is This Card a Health Savings or Flex Spending Account? YES NO

Card Holder's Billing Address:

_____
Street City State Zip

Card Holder's Phone Number:_____

Must initial below:

_____ I understand that if I fail to give a 24 hours' notice for cancelled appointments, I
(Initial) will be charged for the time which has been reserved for me.
Fee is $95 for Late Cancellations or No Shows.

Please choose one of the following:

_____ Please charge this card for sessions.
(Initial)

_____ I plan to pay by cash or check and understand that this card will only be charged
(Initial) if I do not make a payment at the time of service, for missed appointments, or if I cancel without giving appropriate notice.

Signature _____ Date ____ /____ /____

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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your or your child's therapy, and you believe it would be helpful for your therapist to contact them regarding treatment, please read carefully and complete this document. The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you (or your child) as the client. Please provide the necessary information and your signature with today's date as indicated below.

CLIENT'S NAME: _____

I, _____ (client's guardian), hereby authorize Stephanie Robins, LCSW and the following party or parties to discuss my/my child's mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, yours or child's diagnosis.

Teacher(s): _____ Phone: _____
School Counselor: _____ Phone: _____
Physician/Pediatrician: _____Phone: _____
Psychiatrist: _____Phone: _____
Lawyer: _____ Phone: _____
Guardian ad Litem:_____Phone:_____
Other: _____Phone: _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form. Please indicate your preference regarding the information to be shared (check one): ____ The parties stated above may discuss mine and/or my child's medical and/or mental health information without limitations. ____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

_____

_____

Additionally, the above named parties, therapist & person(s) or entity (entities) agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality. Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist at 3180 Northpoint Parkway, Suite 101, Alpharetta, GA 30005 to be effective.

Client /Legal Guardian's Signature:_____ Date: _____