

Child's Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: (____) _____

To receive information and personal helps from our office, **clearly** print your e-mail address:

How did you hear about our clinic? Friend/Relative Phone Book Internet(which site) _____
 Our web site Church/Pastor Doctor (Name) _____
 Insurance Co. Other _____

Form completed by: _____ relationship to child _____

Child's Physician: _____ Phone: _____

Clinic: _____

Parent Information:

Are the child's parents: Married Separated Divorced How long? _____

Father: _____

Address if different from above: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____

Occupation: _____

If divorced, is father remarried or in a significant relationship? _____

Mother: _____

Address if different from above: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____

Occupation: _____

If divorced, is mother remarried or in a significant relationship? _____

Insurance information

Person responsible for payment: _____

Insurance Company: _____ Policy # _____

Policy Holder: _____ Group/Account #: _____

Policy Holders relationship to child: _____

Child Information

School Attending: _____ Grade: _____

Teacher: _____ City of School: _____

Child's favorite subject: _____

Extra-curricular activities: _____

Siblings (star any that are stepsiblings)

Name _____ Age _____ Residence: Mom Dad Both Other
Name _____ Age _____ Residence: Mom Dad Both Other
Name _____ Age _____ Residence: Mom Dad Both Other
Name _____ Age _____ Residence: Mom Dad Both Other

How did you hear about our clinic? _____

Health History

Please check any of the following conditions that your child has had in the past.

	Age at last occurrence/comments:
_____ Asthma	_____
_____ Bronchitis	_____
_____ Chronic digestive issues	_____
_____ Croup	_____
_____ Chronic headaches	_____
_____ Multiple upper respiratory infection	_____
_____ Multiple ear infections	_____
_____ Ear tubes	_____
_____ Head injury	_____
_____ Seizures	_____
_____ Surgery	_____
_____ ADD/ADHD diagnosed	_____
_____ Hospitalization	_____
_____ Digestive problems: constipation/diarrhea	_____
_____ Other: _____	_____

Other Health Considerations:

Birth complications: _____
Describe your child's temperament as a baby: ____ Average ____ Challenging
Are there any pets in child's household? ____ Type: _____
Does anyone in the household smoke? _____
Has your child been administered a TOVA test? _____

At what age did your child:

Give up naps: _____
Sleep through the night: _____
Drink with a cup: _____
Eat with a spoon: _____

Does your child have any of the following: (please explain)

Allergies? _____
Drug allergies? _____
Food allergies? _____
Has your child been allergy tested? _____ By whom? _____
Hearing issues? _____
Special education needs/assessment? _____
Prescription medications/nutritional supplements? _____

Has your child experienced any of the following:

_____ Anxiety	_____ Seriously ill parent
_____ Death of close person	_____ Move
_____ Depression	_____ New sibling
_____ Divorce	_____ Nightmares
_____ Sleep issues	_____ Obsessive behavior
_____ Drop in school grades	_____ Separation anxiety
_____ Food issues	_____ Irrational fears
_____ School behavior issues	_____ Change of school
_____ Social issues	_____ Learning issues
_____ Loss of pet	_____ Physical abuse
_____ Sexual abuse	_____ Emotional abuse
_____ Other family trauma: _____	

Information on Immediate and Extended family:

Has anyone in the immediate/extended family been diagnosed or treated for any of the following:
Relationship to child:

_____ Schizophrenia	_____
_____ Major Depression	_____
_____ Manic Depressive disorder	_____
_____ Bipolar	_____
_____ Alcoholism/drug abuse	_____
_____ Suicide	_____
_____ ADD/ADHD	_____
_____ Other _____	_____

Has anyone in the child's immediate family been in therapy before? _____
Whom? _____

Please tell us why you have brought your child to us today? _____

Creating Connections
Merrilie Rackham, LMFT
Registered Play Therapist

Private insurance companies and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits in order for us to bill your insurance company directly. Missouri State Law requires a signed patient consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

ASSIGNMENT OF INSURANCE INFORMATION:

I hereby authorize assignment of benefits and payment of medical/mental health benefits to Creating Connections, Merrilie Rackham, LMFT for services rendered to myself and/or other dependents. I agree to be responsible for payment of any co-pay charges and any balance due for charges not covered by my insurance policy. I understand that co-pays are due at the time of service and any additional charges are due in full upon receipt of my first statement. I authorize refunds to my insurance company for any overpaid benefits.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION:

I hereby authorize Creating Connections, Merrilie Rackham, LMFT to contact my insurance company directly to obtain coverage and payment information regarding my policy.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.

Name (printed) _____

Signature _____ Date _____

Creating Connections
Merrilie Rackham, LMFT

Welcome to my office. We want to help make your experience with us pleasant and comfortable. Please feel free to ask questions about anything you do not understand.

Client Name _____

Business and Billing Policies

> I agree to pay my co-pays at the time of service.

- Personal accounts must be up to date for appointments to be scheduled.
- A 10 percent discount is provided for payments that are made in full at the time of service. This applies only to clients for whom we are not billing insurance.
- A variety of payment options are available for clients not using insurance. Please ask for information.
- I understand that Creating Connections will submit claims to my insurance company and I am responsible for any unpaid balance. Benefits quoted by Creating Connections were provided by your insurance company and are NOT a guarantee of payment. We strongly encourage you to contact your insurance company to verify information about your benefits.
- Creating Connections is **not** a Medicare provider.
- I agree to notify Creating Connections of any insurance change during the course of my treatment.
- I authorize payment of benefits to be made directly to Creating Connections for services provided by Creating Connections for myself or the above-named patient.

> I agree to pay all bills within 30 days after receiving a statement or as otherwise expressly agreed.

- Phone consultations with the therapist that exceed 10 minutes in length will be billed as a session and charged based on the time spent. You will be responsible for the co-pay or cash payment for that time.
 - When we have received payment from your insurance company, you will be sent a bill for the balance or a refund check will be issued if more was paid than anticipated.
 - If your insurance changes while you are a client here, it is your responsibility to let us know and to give us a copy of your new insurance card.
- > I agree to give a 24 hour notice for cancellation or change of appointments. Insurance companies do not pay for appointments that are cancelled or missed. A \$50 charge will be added to your balance for late cancelled or missed appointments.**
- Clients who do not show for appointments or make late cancels may lose their right to continue therapy at Creating Connections..
 - I understand that a \$25 fee will be assessed for checks returned to us by the bank.
 - If it is necessary for us to use collection services to receive payment from you, you will be assessed the amount owed Creating Connections plus the amount charged by the collection service.
 - As part of our ongoing efforts to insure high quality service, you may be called after your first appointment to check to see if your experience was satisfactory.

Psychological Service Policies

- Counseling sessions are 50 minutes in length unless otherwise specified.
- The information we gather about you will be kept private. Please review the Privacy Policy you receive at the time of your intake.
- Your therapist will take from 1 to 3 sessions to evaluate your needs, set goals with you and determine a treatment plan.
- **If for any reason you are not comfortable with your therapist, we will be happy to place you with someone else or refer you as necessary.**
- Therapists will return calls within 24 hours with the exception of weekends. When leaving messages please indicate times and numbers where you are most easily reached.
- All intake forms must be completed on your initial visit.
- Children under the age of 10 are not allowed to wait in the lobby while you attend a session.

Signature of Client/Guardian_____

Date:

**Creating Connections
Merrilie Rackham, LMFT
Registered Play Therapist**

NOTICE OF PRIVACY PRACTICES

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.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Creating Connections, privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care and respect. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures; we continually assess new technology for protecting information.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number and address listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How and why information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within Creating Connections, Merrilie Rackham, LMFT.* We share information within our company to deliver you the health care services and the related information specified in your plan.
- *We may share information within Creating Connections, Merrilie Rackham, LMFT with our multidisciplinary licensed or certified staff for purposes of consultation or referral and to insure the highest quality and most appropriate care.*
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as for the purpose of claim

processing. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

Creating Connections, Merrilie Rackham, LMFT does not share any customer information with third party marketers who offer their products and services to our patients.

Email Reminders:

We now have an email reminder system available for your convenience. At your request, we can send you a reminder via email to let you know of an upcoming appointment, however, it is important that you understand that the internet is not a secure delivery system.

_____ Yes, please send me email reminders. _____ No, thank you.
Initial Initial

Email address is: _____

* Information shared with text or email is not HIPPA compliant.

We are committed to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it is at our office, over the phone or through the Internet.

Signed _____ Date _____