CROSSROADS Counseling

Child/Minor Intake Form

Form to be completed by parent/guardian

Parent/Guardian Information

Name _____ Date _____

Street Address _____ Phone (h) _____

City, State, Zip _____ Phone (w) _____

Email address _____ Phone (c) _____

Occupation _____

Relationship to the child: □ Parent □ Stepparent □ Grandparent □ Guardian □ Other _____

For confidentiality, when and where do you prefer to be reached? _____

Current Marital Status: Single ____ Engaged ____ Married ____ Separated ____ Divorced ____

Date of Current Marriage/Separation _____ Number of Marriages _____

Who has legal custody of child? _____ □ Joint □ Sole □ Other _____

Name of other custodial parent _____ Phone _____

Do you have consent from the other custodial parent for treatment of said child? □ Yes □ No

If not, this will be required by the counselor before counseling may begin. Please bring custody documents to first session.

How much contact does the child have with his/her biological mother/father? _____

_____

Children:

Name _____ Date of Birth _____ □ M □ F

Name _____ Date of Birth _____ □ M □ F

Name _____ Date of Birth _____ □ M □ F

Name _____ Date of Birth _____ □ M □ F

Name _____ Date of Birth _____ □ M □ F

Please list specific days/time of day for your appointment availability (Day of the week, morning, afternoon, evening) _____

_____

General Information

(Complete all remaining information according to the child coming for treatment)

Name _____ Date of Birth _____

The child is currently living with _____

School _____ Grade _____

Extracurricular activities/interests _____

_____

_____

Medical History

How would you rate your child's current physical health? □ Excellent □ Good □ Fair □ Poor

Is the child complaining of any physical problems? (e.g. headaches, body aches, stomach problems) □ Yes □ No

If yes, please explain _____

Previous hospitalizations for medical reasons:

Date _____ Reason _____

Date _____ Reason _____

Please list any medical conditions or disabilities: _____

_____

_____

Please list any learning disabilities _____

Medication Name **Over the counter or Prescription**	**Dosage**

Counseling & Psychiatric History

Has the child had any previous counseling? □ Yes □ No If yes, for how long? _____

For what reason? _____

Name/location of counselor _____

Has the child ever been diagnosed with or treated for any type of mental illness? □ Yes □ No

If yes, which type? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? □ Yes □ No

If yes, which type? _____

Psychiatric Medication	Dosage

Reasons for seeking help

What concerns about the child have led you to pursue counseling? _____

Where are these concerns causing the most problems? Check all that apply:

□ Home □ Work □ School □ Other _____

When did the present concerns begin to be a problem for the child? _____

What concerns about the child have been identified by others? _____

Please indicate which of the following areas are currently problems for the child. Check all that apply:

□ Lack of motivation	□ Temper tantrums
□ Excessive fears or anxieties	□ Bullying/picking fights
□ Difficulty from being away from specific family members	□ Obsessions/compulsion with specific activities
□ Loss of interest in usual activities	□ Refusal to respond to authority
□ Hearing Voices	□ Getting into trouble at school
□ Decreased/Increased appetite	□ Difficulty making or keeping friends
□ Hyperactivity	□ Other_____

How did you hear about Crossroads Counseling? _____

What do you hope to gain from counseling? _____

_____

CONSENT FOR COUNSELING OF MINORS (AGE 17 & UNDER)

This is to certify that I give permission for the minor named above to participate in counseling offered by Crossroads Counseling Services.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____

Emergency Contact Name _____ Relationship to child _____

Home Phone _____ Cell Phone _____ Work Phone _____

CROSSROADS Counseling

Crossroads Counseling Agreement

Please read carefully before signing the last page of this agreement.

Description of Counseling
Crossroads Counseling Center offers relationship-based, Christ-Centered counseling for individuals of all ages dealing with a wide variety of issues. Our counselors are committed to serving you or your loved one using a wide range of proven professional, biblical, and clinical tools. Wherever you are in your relationship with God, our counselors can help you find purpose in suffering and move toward wholeness and health. Our counselors respect their clients' confidentiality and ensure your privacy by adhering to the American Association of Christian Counselors (AACC) Code of Ethics available to view on www.aacc.net.

What to Expect for the First Session
Once you have made contact with counseling@crossroads140.com, your individual counselor will reach out to you to schedule your first appointment. (For subsequent appointments, contact your individual counselor directly.) Your individual counselor may or may not request a longer first session in order to review and discuss intake paperwork. Please bring the following to your first session:

- Appropriate Intake Forms (one for each Adult or Child),
- Crossroads Counseling Agreement Informed Consent Signature Page
- Credit Card Authorization Form,
- Signed Individual Privacy Statement
- Signed Privacy Statement for Couples and Families (if applicable)

For Child/ Minors
In addition to the required paperwork listed above, please bring appropriate custody documents. For the initial session, the presence of both parents is essential to optimize the counseling experience, to acknowledge each other's informed consent, and to support the minor in the counseling process.

Sessions
Counseling sessions are generally 45 – 50 minutes in length; Telemental Health sessions may vary (see Consent for Telemental Health Services). Counselors will be assigned by the director based upon a variety of factors including client availability, counselor availability, and counseling goals.

Insurance
We are not able to accept any type of health insurance. Depending your insurance plan, you may be able to submit a receipt to your insurance company for reimbursement. Contact your insurance company to see what reimbursement options you may be eligible for.

Fees
Crossroads Counseling has a set fee of $70 for each session of individual, couples', family or group counseling. **This fee is due before the session begins.** Additional Fees are as follows:

- Declined credit card and returned check fee: $50 for processing
- Written or non-client verbal correspondence from the counselor or administrator at discretion of counselor or administrator: $150 per correspondence

Cancellation Policy and Fees

- If you need to cancel and/or reschedule your appointment you must notify your counselor via text, phone call, or email AT LEAST 24 hours before your scheduled appointment time. You will be charged the full $70 session fee for any missed sessions or sessions cancelled less than 24 hours in advance. We require that a signed credit card authorization form be kept on file and that card will be charged if needed.

Payment
Crossroads Counseling accepts cash, checks or credit card. Checks should be made payable to Crossroads Counseling. Please also list the name of your counselor on the "Memo" line of the check. Accounts must be kept current in order to continue counseling. Please note that there is a $2 processing fee if paying by credit card. We are unable to accept health savings account (HSA) cards as a form of payment.

If making a payment outside of your counseling session, please make sure the envelope is clearly marked with Crossroads Counseling. You may remit your payment in the black lock box in the office area at the Westminster Campus or mail your payment to:
Crossroads Counseling
Attn: Brittany Edie
895 Leidy Road
Westminster, MD 21157

Inclement Weather
Crossroads Counseling follows the closures of the Carroll County Public School system when cancelling for inclement weather. If the school or evening activities are cancelled, counseling appointments will be cancelled for that day. In the event that the school system is closed but the offices at Crossroads Church are open, your counselor will contact you individually to see if you are still interested in having your session. Cancellation fees will not be charged if the inclement weather policy is in effect.

Confidentiality
Client confidentiality is of the utmost importance at Crossroads Counseling Center. The only situation in which your personal information would be shared without your consent is:

- when required by law *(those situations are clearly outlined in the Privacy Statement included in our Intake Packet)*

- when necessary as part of the "no secrets" policy for Couple and Family counseling Clients *(outlined in the Privacy Statement for Couples and Family Counseling Clients in our Intake Packet)*

Referral Policy/ Disclaimer
Clients will be referred outside of Crossroads Counseling when treatment required is beyond the scope of care offered. Though Crossroads Counseling strives to be responsible and professional in the referral procedure, it is your full right and responsibility to select the professional of your choice. Crossroads Counseling is not liable for any services provided or not provided by the referred professional.

Termination of Counseling
Counseling services may be terminated when the counselor and the client mutually agree to the termination. If for any reason you feel your best interests are not being served, you have the right to terminate counseling at any time without any moral, legal, or financial obligations other than those already accrued.

My signature indicates I have read the Counseling Center Agreement and agree and commit to its terms.

Client Name (printed) _____
Client Signature _____
Date: _____

Parent/ Guardian Name (printed) _____
Parent/ Guardian Signature _____
Date: _____

Parent/ Guardian Name (printed) _____
Parent/ Guardian Signature _____

Date: _____

CROSSROADS Counseling

Crossroads Counseling Agreement & Informed Consent

Crossroads Counseling Agreement: My signature below indicates that I have read, understand and agree to the Biblically- based counseling services offered by Crossroads Counseling.

Name (printed) _____
Signature _____
Date: _____

Informed Consent: If consenting for a minor (17 years or younger) please complete:

Name of Child _____ Date of Birth _____
Does the consenting adult have legal custody of the child: □ Yes □ No
If yes, is it □ joint custody OR □ individual custody?
If no, who is the legal guardian? _____

My signature below indicates that I have read and consent to the Crossroads Counseling Agreement for the client identified above:

Parent/ Guardian Name (printed) _____
Your Relationship to the Client

□ Self □ Stepparent □ Grandparent
□ Parent □ Guardian □ Other _____

Parent/ Guardian Signature _____
Date: _____

Parent/ Guardian Name (printed) _____
Your Relationship to the Client

□ Self □ Stepparent □ Grandparent
□ Parent □ Guardian □ Other _____

Parent/ Guardian Name (printed) _____
Your Relationship to the Client

□ Self □ Stepparent □ Grandparent
□ Parent □ Guardian □ Other _____

Parent/ Guardian Signature _____
Date: _____

CROSSROADS Counseling

Consent for Telemental Health Services

1. I understand that the counseling staff of Crossroads Counseling Center are available for Telemental Health Services (TMH).

2. I understand that TMH provides counseling and support over the internet through email, video conferencing, online chat, FaceTime, and/or phone calls between a client and a counselor who are not in the same physical location.

3. I understand that TMH services offers benefits including easier access, the convenience of meeting from a location of my choosing, a continuity of services during public health emergencies and/ or other life circumstances.

4. I understand there are potential risks to this technology including interruptions and technical difficulties.

5. I understand that if a session is disrupted, I can reach my counselor via phone and/ or email. My counselor or I can choose to discontinue the TMH session if either believes the videoconferencing or phone connections are not adequate for the situation.

6. I understand that in the event of an emergency/ crisis during or between TMH sessions, I may contact 911.

7. I understand that certain information will be verified at the start of each TMH session in order to confirm privacy and safety: the names of all those in the session, the location of the client and phone contact information in case of disrupted technology.

8. I understand that no session may be audio or video recorded by either the counselor or myself without express written consent from both parties.

9. I understand that I am responsible for creating a safe and confidential space during my TMH sessions. I understand that I can ask my counselor for assistance if I am not sure how to create this safe and confidential space.

10. I understand that together with my counselor we will regularly assess the appropriateness of TMH services. Any practical alternatives and modifications will be made as needed.

11. I understand that if I am the parent/ guardian of a minor child receiving TMH services, I will be on the same premises as the minor child and will be available by phone if needed during the entire session.

12. My signature below indicates I have read and understand all of the above information and am aware I have the opportunity to ask questions regarding the procedures and details of TMH services.

13. If I am the parent/ guardian of a minor child, my signature below also indicates I consent for the minor child to receive TMH services. Additionally, the child is willing to engage in these services.

14. I understand that if a minor child or a client is unwilling to engage in the scheduled counseling session, the Cancellation Policy is still in effect (refer to the Crossroads Counseling Center Agreement).

15. I understand that in the case of joint physical and/or legal custody, consent is required from both parents as indicated by signatures below.

Client Name (printed) _____

Client Signature _____

Date: _____

Parent/ Guardian Name (printed) _____

Parent/ Guardian Signature _____

Date: _____

Parent/ Guardian Name (printed) _____

Parent/ Guardian Signature _____

Date: _____

Counselor Name (printed) _____

Counselor Signature _____

Date: _____

Counseling for Minors (AGE 17 & UNDER) Session Phone Contact Information:

Parent/ Guardian Name _____ Relationship to Child _____
Home Phone _____ Cell Phone _____ Work Phone _____
Parent/ Guardian Name _____ Relationship to Child _____
Home Phone _____ Cell Phone _____ Work Phone _____

CROSSROADS Counseling

Crossroads Counseling Center, LLC
Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us at bediecounseling@crossroads140.com. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV Code: _____
Cardholder Billing Address: _____ _____ Cardholder Email (for receipt): _____

I, _____ authorize Crossroads Counseling to charge my credit card above for agreed upon purchases. I understand that there is a $2 processing fee, and that my information will be saved to file for future transactions on my account.

_____ _____
Signature Date

Note: We are unable to accept health savings account (HSA) cards as a form of payment.

CROSSROADS Counseling

Privacy Statement

Notice of Policies and Practices to Protect the Privacy of Your Health Information
This Notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures for Treatment and Health Care Operations
Crossroads Counseling may use or disclose your Protected Health Information (PHI) for treatment purposes with your consent. To help clarify these terms, here are some definitions:

> "PHI" refers to information in your health record that could identify you.
>
> "Treatment" is when Crossroads Counseling provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when Crossroads Counseling consults with another health care provider.
>
> "Use" applies only to activities within the Crossroads Counseling office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
>
> "Disclosure" applies to activities outside of the Crossroads Counseling office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization
Crossroads Counseling may use or disclose PHI for purposes outside of treatment when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Crossroads Counseling is asked for information for purposes outside of treatment, Crossroads Counseling will obtain an authorization from you before releasing this information. Crossroads Counseling will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes Crossroads Counseling has made about conversations during a private, group, joint or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that Crossroads Counseling has relied on that authorization.

Uses and disclosures with Neither Consent nor Authorization
Crossroads Counseling may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If Crossroads Counseling has reasonable cause, on the basis of professional judgment, to suspect abuse of children with whom Crossroads Counseling comes into contact in a professional capacity, Crossroads Counseling is required by law to report this to the ACS.

Adult and Domestic Abuse: If Crossroads Counseling has reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), Crossroads Counseling may report such to the local agency which provides protective services.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services Crossroads Counseling provided you or the records thereof, such information is privileged under state law, and Crossroads Counseling will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and Crossroads Counseling determines that you are likely to carry out the threat, Crossroads Counseling must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

Patient's Rights and Counselor's Duties:

Patient's rights:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Crossroads Counseling is not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing Crossroads Counseling. Upon your request, Crossroads Counseling will send communications to another address or phone number.)

Right to Inspect and Copy: You have the right to inspect or obtain a copy of PHI in Crossroads Counseling's mental health record for as long as the PHI is maintained in the record. However, Crossroads Counseling reserves the right to deny your access to PHI under certain circumstances. On your request, Crossroads Counseling will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. However, Crossroads Counseling reserves the right to deny your request. Upon your request, Crossroads Counseling will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, Crossroads Counseling will discuss with you the details of the accounting process.

Counselor's Duties:

Crossroads Counseling is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

Crossroads Counseling reserves the right to change the privacy policies and practices described in this notice. Unless Crossroads Counseling notifies you of such changes, however, Crossroads Counseling is required to abide by the terms currently in effect.

If Crossroads Counseling revises policies and procedures, Crossroads Counseling will provide you with a revised notice by mail or in person.

Complaints

If you are concerned that Crossroads Counseling has violated your privacy rights, or you disagree with a decision Crossroads Counseling made about access to your records, please bring this to the attention of the Director of Crossroads Counseling Services in writing.

Effective Date, Restrictions and Changes to Privacy Policy

This notice will be in effect as of January 1, 2019

CROSSROADS Counseling

Privacy Statement Acknowledgement Form

This certifies that I have received from my counselor at the Crossroads Counseling Center a copy of the notice of policies and practices to protect the privacy of my health information.

_____ _____

Signature of Client Date

_____

Printed Name

_____ _____

Signature of Parent or Legal Guardian
(If Client is under 18)

Relationship to Client

_____ _____

Printed Name Date

CROSSROADS Counseling

Privacy Statement for Couples & Families

SPECIAL CONSIDERATIONS FOR COUPLES AND FAMILY COUNSELING CLIENTS

When Crossroads Counseling agrees to treat a couple or a family, Crossroads Counseling considers that couple or family (the treatment unit) to be the patient. If there is a request for the treatment records of the couple or the family, Crossroads Counseling will seek the authorization of all members of the treatment unity before Crossroads Counseling releases information to their parties.

Crossroads Counseling may see a smaller part of the treatment unit for one or more sessions. These sessions should be seen by you as a part of the work that Crossroads Counseling is doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions, understand that generally these sessions are confidential in the sense that Crossroads Counseling will not release any information to a third party unless required by law to do so or unless Crossroads Counseling has your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, Crossroads Counseling would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, Crossroads Counseling may need to share information learned in an individual session with the entire treatment unit if Crossroads Counseling is to effectively serve the unit being treated. Crossroads Counseling will use the best judgment as to whether, when and to what extent we will make disclosures to the treatment unit, and will also if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you would like kept completely confidential, you might want to consult with an individual counselor who can treat you individually.

This "no secrets" policy is intended to allow Crossroads Counseling to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If Crossroads Counseling is not free to exercise clinical judgment regarding the need to bring this information to the family or the couple during their counseling, Crossroads Counseling might be placed in a situation where we will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____ being seen, acknowledge by our
(couple/family or other unit)
individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with _____, and that we
(counselor)
enter couple/family counseling in agreement with this policy.

Signature _____ Date_____

Printed Name _____

Signature _____ Date_____

Printed Name _____

Signature _____ Date_____

Printed Name _____

Signature _____ Date_____

Printed Name _____

Use additional date and signature lines as is necessary. If someone is signing in a representative capacity, such as a parent or a court-appointed guardian or conservator, such capacity should be stated and the person being represented should be specified.