CENTER FOR CHILDREN, INC.
6100 Radio Station Road * PO Box 2924
La Plata MD 20646 * (301) 609-9887

FOR OFFICE USE ONLY:

Intake Date: _____ Case Manager: _____

Intake Staff: _____ Case Number: _____

PATIENT INFORMATION (All information on this page should be completed by client/parent only)

NAME: _____
Last First Middle

ADDRESS: _____ CITY: _____ ZIP: _____

HOME/PREFERRED PHONE: _____ OK to call and/or leave messages at preferred number: Y N

CELL PHONE: _____ **WORK PHONE**: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ **AGE:** _____ **GENDER:** male female

SOCIAL SECURITY #: _____ **Parent/Guardian Driver's License #:** _____

Who has care and custody of client, if a minor? _____

Are there custody papers pertaining to the minor in place? Yes ☐ No ☐

Who referred you to Center for Children? _____

MARITAL STATUS

_____ 1-Never Married
_____ 2-Married
_____ 3-Separated
_____ 4-Divorced
_____ 5-Widowed

RACE

_____ 1-American Indian / Alaskan Native
_____ 2-Asian or Pacific Islander
_____ 3-Black / African-American
_____ 4-Caucasian
_____ 5-Other: _____

HANDICAPPED: _____ No _____ Physical _____ Mental _____ Unknown

Explanation: _____

EDUCATION (Check highest grade/category completed)

_____ 1-Never attended school
_____ 2-Special Ed – intensity level: _____
_____ 3-Pre-school / Kindergarten
_____ 4-Completed grades 1-7
_____ 5-Completed grade 8
_____ 6-Completed grades 9-11
_____ 7-High school graduate / GED
_____ 8-Some college (<4 years)
_____ 9-College graduate (4+ years)

EMPLOYMENT STATUS

_____ 1-Full time
_____ 2-Part time
_____ 3-Student
_____ 4-Retired
_____ 5-Unemployed

CLIENT'S PRIMARY (1) AND SECONDARY (2) SOURCES OF INCOME

_____ 1-Employment / wages
_____ 2-SSI
_____ 3-SSDI
_____ 4-SSI/SSDI
_____ 7-Unemployment
_____ 8-Other
_____ 9-None
_____ 10-Pension / Annuities

_____ 5-AFDC _____ 11-Private Disability

_____ 6-PAA _____ 12-Alimony

Has client ever been in therapy before? _____ Yes _____ No

If yes, where and when: _____

_____

Has client ever been hospitalized for mental health reasons? _____ Yes _____ No

If yes, where and when: _____

Is the client coming to this agency because he/she was a victim of a crime? _____ Yes _____ No

Is the client coming to this agency because he/she committed a crime? _____ Yes _____ No

FAMILY INFORMATION

Parent/Guardian Name: _____

_____ Biological Parent _____ Foster Parent _____ Other relationship

Date of Birth: _____ Age: _____ Gender: _____

Social Security #: _____ Driver's License #: _____

Address: _____ City: _____ ZIP: _____

Phone: Home: _____ Cell _____ Work: _____

Name and DOB of Spouse / Significant Other: _____

ALL FAMILY MEMBERS

	NAME	**DOB / AGE**	**GENDER (M/F)**
MOTHER/WIFE			
FATHER / HUSBAND			
CHILDREN:			
OTHERS LIVING IN THE HOME:			

INCOME INFORMATION

Total Gross Family Income: $_____ Annual ____ Monthly ____ # in home: _____

Name / social security # of person responsible for payment: _____

Address: _____

Home phone: _____ Cell phone: _____

Is this person responsible for all CFC clients in this family? _____ Yes _____ No

If no, please explain: _____

_____

Sources of FAMILY Income (please check all that apply)

_____ Salaries and Wages _____ Social Security _____ Unemployment

_____ Alimony _____ Social Security Disability _____ Retirement Pension

_____ Child Support _____ AFDC _____ Widow's Benefits

_____ Other: _____

Center for Children, Inc.

Client Bill of Rights

I. Each client will be treated with dignity and respect

II. At the initial interview, each client will be oriented to the Center for Children's policies, including the Client's Bill of Rights, confidentiality, fees, program rules, and the Client Grievance Policies. Each client will be given a copy of each of these policies in writing.

III. Clients are entitled to a healthy, comfortable, physically safe environment that is free from hazards.

IV. Clients have a right to privacy in the counseling setting.

V. All client records will be kept strictly confidential and shall be released only with the client's written consent, unless subpoenaed and court ordered.

VI. Clients have the right to be informed of the potential benefits and possible side effects of treatment modalities and medications under consideration, and have the right to refuse medication.

VII. Clients have the right to expect the facility to be operated by competent staff.

VIII. Each client has the right to participate in the development of an individualized treatment plan and their right to decision concerning his/her treatment. This includes the right to be treated according to the plan.

IX. If the client believes that his/her rights have not been protected, he/she shall have the right to make grievance complaints in accordance with the Grievance Policy. A client may request the form to do so from the treating therapy or office staff.

X. No client shall be discriminated against on the basis of sex, religion, natural origin, ethnicity, race, sexual orientation, or disability.

XI. No client shall be abused sexually, physically, or mentally by any staff of this agency. Any allegations of abuse should be immediately reported to the Executive Director. The program will then notify the local law enforcement agency.

XII. Clients are expected to report to each session on time and the therapist shall be responsible for starting and ending each session on time.

XIII. Clients have the right to refuse to participate in physically intrusive research or any other research that is offered to them.

XIV. Clients have the right to review their records, unless it is the decision of the physician and/or Clinical Director that such release is clinically contraindicated. In these cases, the client may request a summary of the record. In all cases, the review requires five days advance notice and must take place at the office of the Center for Children and in the presence of the treating therapist, a Clinical Supervisor, or the Executive Director.

I have read and I understand my rights as a client of the Center for Children, Inc.

_____ _____

Client/Guardian Signature Date

Center for Children, Inc.
Admission Policy

My records are strictly confidential and will be released to other agencies or professionals only with my written permission with the exceptions below:

1. Portions of my records or information concerning my situation can be released to agencies, professionals, or my family as appropriate in the event of an EMERGENCY situation. In extreme emergencies, where I am in danger of harming myself or others, appropriate authorities may be called without my consent at that time.

2. If I am being evaluated under court order, I have no rights of confidentiality pertaining to my evaluation.

3. If I, or my child, disclose(s) any incidence of child abuse and/or neglect or where child abuse and/or neglect is suspected, all staff at the Center for Children are required, by law, to report it to the Department of Social Services for evaluation.

4. I understand that if my, or my child's, therapist is subpoenaed to appear as a witness in court, disclosure of some of my Records might be court ordered.

5. If I choose to consult a private physician regarding medication needs, permission is required to exchange information.

6. Clinicians will assist in making a referral to another agency if my situation is not appropriate for treatment.

7. The Center for Children does not discriminate on the basis of race, creed, religion, color, age, national origin, politics, sexual orientation, or physical disability.

8. I understand that some services of the Center for Children are funded by state agencies and there are occasional on-site visits that include random case record review. All of those persons are bound by the same code of confidentiality as employees of the Center for Children. Information may be shared by my clinician with my supervisor and other clinicians for case staffing purposes.

9. I understand that my child also has the right of privacy and will not request access to their records.

10. Any questions or complaints regarding procedures, policies, or the handling of my case at the Center for Children should be directed to the Executive Director. The grievance procedure and client rights are a part of my intake packet.

11. It is our responsibility, legally and morally, to take appropriate steps when a client appears to be clearly dangerous to himself/herself or others. The staff of the Center for Children are all mandated to report in the event of a child abuse complaint. We will support and encourage you to report the incident(s) to the local authorities. If that is not possible, we will make the report ourselves.

Initials _____

Center for Children, Inc.

Discharge Policy

I. Discharge, length of time, and successful program completion vary by client and program. Your therapist will discuss with you what your needs are, what your goals are, and recommend duration and type of treatment.

As a client, you have the right to have input on both your length of therapy and how discharge will be determined. If you disagree or feel another form of therapy will be beneficial, please feel free to tell your therapist, and together you can work towards an appropriate discharge or alternative treatment plan, either without our agency or elsewhere.

Discharge can be a very rewarding experience. Positive discharges can be accomplished by working with your treatment provider. Usually positive discharges are mutually agreed upon for some of the following reasons:

1. Treatment goals have been met. More specific criteria are established for patients in court-ordered programs.
2. The client needs a more intensive level of care than this agency can provide.
3. Transfer of residence outside of our geographic area.

When you are planning to terminate therapy, if it was not previously scheduled, please notify your therapist at least three weeks in advance. A discussion of the reasons for termination, including positive and negatives points of therapy will be mutually useful.

II. Good therapy can only be done when there is consistent attendance. In addition, it is difficult to obtain and maintain improvements when not attending therapy regularly. Unplanned discharge, not usually positive, can occur for some of the following reasons:

1. If you miss two scheduled appointments in a row and we have received no contact from you.
2. If you miss more than 50% of your scheduled appointments in a three-month period.
3. If you do not show for a scheduled appointment and we receive no contact from you within the next sixty days.

Initials _____

Center for Children, Inc.

Fee Policy

I. Clients will be expected to pay the full fee for therapy prior to each session (that is, when they first enter the waiting room). Exceptions to the full fee policy are those clients using insurance or whose fees are paid by another agency. Insured persons must pay full fee until they prove that their deductible has been met; at that time, they must pay co-pay prior to each visit.

II. Clients who qualify for sliding scale must fill out appropriate request paperwork and provide proof of income and expenses, which will be requested to be provided annually. We may at any time request new proof of income or reevaluate sliding scale fees. The State determines caps for non-insured individuals.

III. If payment is not made at the time of session, it must be made prior to the next scheduled session. If not, the session will be canceled, even if the client is physically present, and the missed appointment charge will be added. If a problem arises relating to making up missed payment, the client should contact the Office Manager at (301) 609-9887 before the next appointment.

IV. You are financially responsible for missed sessions or when 24 hours notice is not given, regardless of the reason for the absence. You will be charged s $40.00 fee for missed appointments. Insurance companies will not pay for missed appointments.

V. It is the client's responsibility to leave us a daytime phone number where they can be reached in an emergency.

VI. It is your responsibility to verify coverage with your insurance carrier.

VII. There is a $25.00 fee for returned checks.

CLIENTS WHO USE PRIVATE INSURANCE

You are responsible for the fee, regardless of the action of your insurance company. Please find out what the requirements are of your particular insurance company. Many insurance companies require the referral of a physician, in writing, on the appropriate form. Other questions you might ask your insurance company are:

1. Does our insurance pay for outpatient psychotherapy?
2. How much will it cover? How many visits are covered?
3. Does your insurance pay for Licensed Clinical Social Workers (LCSWs)?
4. How much is the deductible and has the deductible been fulfilled?

Please do not hesitate to call if you have any questions.

Initials _____

This contract applies to the following family members:

_____	_____
_____	_____
_____	_____

_____ _____

Client / Guardian Signature Date

_____ _____

Center for Children Representative Date

Center for Children, Inc.
Patient Authorization Form

In consideration for services rendered or to be rendered by

Center for Children, Inc.

I hereby assign benefits due me and authorize payment for all third party insurance carriers, including Medicare Part B, Blue Cross/Blue Shield, and Maryland Health Partners, directly to

Center for Children, Inc.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical records, for this and any related claims to the Social Security Administration and Health Care Financing Administration (for Medicare Part B), Medical Assistance, Blue Cross/Blue Shield, Maryland Health Partners and all third party insurance carriers in order to determine benefits to which I may be entitled. I permit a copy of this authorization to be used in place of the original.

I understand I am financially responsible for any charges not covered or not covered in full by this assignment.

This authorization may be revoked by either me or any of the above third-party insurance carriers at any time in writing.

_____ _____
Signature of Subscriber or Beneficiary Date

_____
Please print patient's name

WAIVER

I, _____, understand and am aware that if my insurance company required a referral and I DO NOT provide one, that I am opting to use my out-of-network benefits.

_____ _____
Signature of Subscriber or Beneficiary Date

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EMERGENCY INFORMATION AND CONSENT FORM

CLIENT INFORMATION	IN CASE OF EMERGENCY	MEDICAL INFORMATION
Client Name	Home Phone	Emergency Physician
Address	Work Phone	Attending Physician
City	Cell Phone	Address
State Zip		Telephone
	Contact #1	Hospital Preference
SSN	Relationship	Known Health Problems
	Home #	
Gender Male Female	Work #	Diagnoses
	Cell #	
Medicaid #	Contact #2	Medications
Medicare #	Relationship	
Insurance #	Home #	
	Work #	
	Cell #	
	Contact #3	Allergies
	Relationship	
	Home #	
	Work #	
	Cell #	

EMERGENCY CARE CONSENT

This consent is to be signed upon client's enrollment in services

- In case of an emergency, the staff of the CFC Program will provide immediate and appropriate First Aid. In the event that hospitalization, emergency room, or any other appropriate medical or dental care is indicated, the client will be accompanied by a staff person via appropriate transportation to the closest appropriate medical facility.
- I will also hold CFC harmless against any liability caused by their taking of any emergency procedures and/or making any contacts.
- As _____, I agree to the Emergency Process outlined.

_____ _____
Patient Signature Date

_____ _____
Parent / Guardian Signature Date

_____ _____
Center for Children Witness Date

Briefly, please indicate the reason that you are seeking services with Center for Children.

Signature:_____

Date:_____

INSURANCE INFORMATION

Client name: _____ Date of birth: _____

Parent/Guardian Signature: Date:

**** Please notify the front desk of insurance changes or updates prior to the next visit after obtaining.**

PRIMARY INSURANCE (please mark with "X"):

	Aetna
	APS
	Carefirst BCBS
	Cigna
	Humana
	Magellan

	Medical Assistance
	Med Star
	Tricare
	Value Options
	United Behavioral Health
	United Health Care

Policy #: _____ Group #: _____

Subscriber Name:_____

Subscriber Date of Birth: _____

Subscriber Address: _____

_____

Subscriber Social Security*:_____

* Insurances, for verification purposes, often ask for SS#.

SECONDARY INSURANCE (please mark with "X"):

	Aetna
	APS
	Carefirst BCBS
	Cigna
	Humana
	Magellan

	Medical Assistance
	Med Star
	Tricare
	Value Options
	United Behavioral Health
	United Health Care

Policy #: _____ Group #: _____

Subscriber Name:_____

Subscriber Date of Birth: _____

Subscriber Address: _____

_____

Subscriber Social Security*:_____

* Insurances, for verification purposes, often ask for SS#.