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Please take time to read the following information in full. This packet includes 12 pages of information (including this cover page).

Please complete the following packet and scan and e-mail back to hold your appointment. Submitting back via e-mail is considered your consent for e-mail communication. You may also print this form and bring with you to your appointment. ALL SIGNATURES MUST BE MADE IN INK. ELECTRONIC SIGNATURES WILL NOT BE ACCEPTED. A credit card is required to hold your appointment time.

Our office is located in a tan, two-story building on the corner of Commonwealth and Indiana. You may park directly in front of the building or on the side of either street. Ring the bell to be buzzed in, and have a seat in the waiting room until you're called back. The restroom is located past reception if you need it.

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Date: _____

Child's name:_____

Address: _____

City: _____ State: _____ Zip: _____

Child's Date of Birth:_____

1) Parent/Guardian's Name: _____
Parent/Guardian's Phone: _____
Parent/Guardian's Date of Birth: _____
Parent/Guardian's Email Address: _____

2) Parent/Guardian's Name: _____
Parent/Guardian's Phone: _____
Parent/Guardian's Date of Birth: _____
Parent/Guardian's Email Address: _____

Emergency Contact

Name: _____ Phone: _____

Who may we thank for your referral: _____

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PRIVACY NOTICE

REVIVE therapy & healing has implemented the following policy regarding patient privacy and confidentiality. The office holds patient record information confidential and will only use your information for treatment, payment and billing, and with insurance companies if you request a statement for insurance reimbursement. Our staff may also have access to your records for administrative purposes.

DISCLOSING RECORD INFORMATION

Release of information to any other entity will require a signed authorization from you. This request must be dated, show to whom the information is to be released or requested, and the specific information to be released or acquired. These authorizations will have an end date if you ask for it. Additional requests beyond the end date will require a new authorization. I will keep a record of all disclosures in your file. This information will be available for you to review.

LEGAL/CUSTODY

Because my role is that of the child's helper, we will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist. We will not participate in any court proceedings at any time, even with your release.

YOU HAVE A RIGHT TO ACCESS YOUR RECORDS

You can review and obtain copies of your child's records. There are some limitations in accordance with the Texas Health and Safety Code § 611.004. Upon receipt of a written request, I will make the records available within 10 days. Records will be sent via regular mail unless you request in writing to have them sent via electronic mail. Should something unexpected occur to me, such as serious injury or death, your records will be released to my colleague, Emily deAyala, MA, LPC, LMFT 832.301.9160.

ACKNOWLEDGMENT

I acknowledge that I have reviewed this privacy notice.

_____

Signature

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INFORMED CONSENT

QUALIFICATIONS AND CREDENTIALS

Cameron Dumas is a LMSW and child and adolescent specialist at REVIVE therapy & healing. Cameron received her undergraduate degree in Social Work. She then received her Masters in Clinical Social Work with a concentration in children and adolescents from The University of Texas at Austin, Phone: 512.834.6658. Her LMSW license number is 55129. Mail Code 1982, P.O. Box 149347, Austin, TX 78714.

CLIENT RIGHTS

- You and your child have a right to be treated respectfully and with dignity.
- You and your child have a right to decide how long you stay in treatment.
- You and your child have a right to information about your treatment, including records of your treatment. Note: your records will be destroyed in accordance with state board rules.
- You and your child have a right to discontinue or refuse treatment at any time.
- You and your child have the right to express dissatisfaction with treatment directly to me and/or to the boards listed above.
- You and your child have a right to confidentiality, with certain legal and ethical exceptions:

Exceptions include

- If you or your child disclose plan to cause serious harm or death
- If you or your child plans to cause serious harm or death to someone else
- If you or your child discloses abuse (physically, sexually, or emotionally) or discloses abuse from the past
- If a court of law issues a court order, the law requires the information specifically described in the order be provided.5) If you reveal information suggesting child, elder or disabled person abuse and neglect, state law requires the reporting of this to the appropriate authorities.
- If your child is being seen by order of a court of law, the results of treatment or tests ordered may be revealed to the court.
- If you authorize me and/or my agents to file a claim and bill a third party payer, then you are authorizing me and/or my agents to release any medical or necessary information to process these claims.
- You have a right to know I may consult with other clinicians to review my work with you and your child. If your child is under the care of another licensed professional counselor, I am obligated to request to inform that provider.
- If I suspect sexual exploitation by another mental health provider, I am obligated to notify appropriate licensing boards.

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Now that the various aspects surrounding confidentiality have been stated, the specific agreement between you and your child/children follows:

I, (name)_____(relationship to child) _____
I, (name) _____(relationship to child) _____
agree that my/our child (name)_____ should have privacy in his/her therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist. At the same time, except under unusual circumstances, I understand that I have a legal right to obtain this information. I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers not to volunteer information about the sessions, I will respect his/her right not to disclose details. **Basically, unless my child has been abused or is a clear danger to self or others, the therapist will normally tell me only the following**:
• whether sessions are attended • whether my child is generally participating or no • whether progress is generally being made or not

Signature:_____**Date:**_____/_____/___
Signature:_____**Date:**_____/_____/___
Therapist:_____**Date:**_____/_____/___

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COUNSELING PHILOSOPHY

My therapeutic approach can best be described as integrative and client-centered, meaning I pull from many different approaches. This allows me to tailor treatment to meet your child's unique needs.

FINANCIAL ARRANGEMENT

Service	**Rate**
All Sessions (45-50 min)	$125.00
Package of 4 Sessions (45-50 min each)**	$460.00
Missed Sessions (Not cancelled within 24 hours)	**The full price of the session**

Payment is due in full at the time of your session. I accept the following forms of payment: Cash, Check, MasterCard, and Visa. **Cash, check, or debit is strongly preferred.**

It is the policy of the office that you call 24 hours prior to your scheduled appointment time to notify the office that you will not keep your scheduled appointment. In the event that you do not call to cancel your session 24 hours in advance, you will be held responsible for payment for that session and/or your credit card on file will be automatically charged. If continuous cancellations (even those with 24 hour notice) become a pattern, your therapist reserves the right to refer you to another treatment provider.

*All session times include time to collect payment and schedule your next appointment.
** Package sessions are non-refundable. No exceptions.

Should you desire to file for out of network benefits with your insurance company, I will provide you with a superbill every four visits that you can submit to your insurance company. I will provide you with my National Provider Identification (NPI) number only. If there is an issue with reimbursement, I will do my best to assist you, but you will be billed for any correspondence with your insurance company that takes more than 10 minutes at my normal hourly rate. Also, please note that reimbursement is between you and your insurance company, and full payment for your session is still required at the time of the service rendered.

Signature_____

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EMERGENCY POLICY

I check my voice mail and messages several times a day and can be reached by calling the main office number at 832.301.9160. I will make every attempt to return your call within 24 hours or by the next business day. If you do not hear from me within this time frame, please try again.

If I am out of the office for an extended period, I will leave a message on my voice mail to that effect. Messages left may not be returned until I return to the office.

In case of an emergency, you may call any one of the following emergency numbers: 911, United Way Crisis Hotline (713) HOTLINE, MHMRA Crisis Unit (713) 970-7070 or go to the nearest hospital emergency room or fire department for assistance.

OFFICE POLICIES

Please arrive no earlier than 15 minutes before your appointment. We strive to begin and end all appointments on time. We make it our policy not to become involved in any court proceedings or disputes (such as divorce or legal or HR proceedings) outside the office, except that which is mandated by the licensing board. Please note you will be charged your hourly rate for any non-therapeutic work on your behalf. Finally, please reserve e-mail communication for scheduling only.

_____ _____

Signature **Date**

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RELEASE OF INFORMATION – Fill out only AS NEEDED or DESIRED

Please read each item carefully. Mark "yes" or "no," sign and date. Feel free to leave blank anything you are unsure of. Authorization allows for **two-way unfettered communication**. If you have any questions, please ask for clarification.

I authorize Cameron Dumas, MS, LMSW to contact my child's primary care physician (PCP) to coordinate care.

Yes___ No___ Doctor's Name:_____ Phone: _____

I authorize Cameron Dumas, MS, LMSW to contact my child's psychiatrist to coordinate care.

Yes___ No___ Doctor's Name:_____ Phone: _____

I authorize Cameron Dumas, MS, LMSW to contact my child's other psychotherapist to coordinate care.

Yes___ No___ Doctor's Name:_____ Phone: _____

I authorize Cameron Dumas, MS, LMSW to contact my child's school counselor to coordinate care.

Yes___ No___ Counselor Name:_____Phone: _____

I authorize Cameron Dumas, MS, LMSW to contact _____ to coordinate care.

Yes___ No___ Phone: _____

_____
Print Name

_____ _____
Signature Date

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CREDIT CARD AUTHORIZATION FORM
(REQUIRED AT TIME OF APPOINTMENT)

READ CAREFULLY – IT IS YOUR CHOICE WHETHER TO COMPLETE THIS PAGE AND RETURN VIA E-MAIL OR COMPLETE AT THE OFFICE. REVIVE WILL NOT BE HELD LIABLE FOR ANY INFORMATION SUBMITTED ELECTRONICALLY.

Person Financially Responsible

Name:_____

Credit Card Information: This information will be used to charge a nonrefundable $25 fee to hold your first appointment. This $25 is deducted from the cost of your first visit. Otherwise, this information is kept on file and used only when there is a late cancellation and/or no show. If you wish to pay regularly with your credit card, your card must be present to swipe at the session. This information will also be used to communicate with your credit card company if necessary or if you fail to make a payment.

Card Type: __ MasterCard __ Visa (No Amex or Discover)

Name as it appears on the card:_____

Card #:_____ Expiration:_____

Security Code:_____

FULL Billing Address: _____

_____ _____

Signature of Client **Date**

_____ _____

Signature of Person Financially Responsible **Date**

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MEDICAL AND PSYCHIATRIC HISTORY

Please list your current medications.

MEDICATION	PURPOSE	STRENGTH	TAKEN HOW OFTEN

Please list and describe any major medical events or diagnoses.

_____

_____

My child's physical health can best be described as: Good___ Fair___ Poor___

PRENATAL/ DEVELOPMENTAL HISTORY

Is your child adopted ?____ If yes, do you have any involvement with birth parents?_____

Did you have complications during pregnancy/delivery? _____
Parent substance abuse during/post-pregnancy? _____
Did you have complications during pregnancy/delivery? _____

Unusual childhood development/milestones? _____

PARENT RELATIONSHIP STATUS:

Married □ Partnered □ Divorced/separated
Name of Partner/Spouse:_____
Duration of relationship:
Child's siblings: (Name, ages, grades): _____

_____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today:

_____

_____

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Please check all of your child's behaviors and symptoms in the past **3 months**.

	Distractibility		Change in sleep patterns/difficulty sleeping
	Hyperactivity		Change in appetite
	Impulsivity		Memory problems
	Bordedom		Dizziness or fainting
	Poor memory/confusion		Lack of Energy/Fatigue
	Sadness/depression		Urination difficulty or urinating often (circle)
	Hopelessness		Nausea
	Thoughts of death		Poor balance or trouble walking
	Self-harm behaviors (if yes please describe)		Repetitive, rigid, or unusual behaviors (if yes please describe)
	Crying spells		Stomach aches
	Loneliness		Chest pains
	Recurring, disturbing memories		Head aches
	Anxiety/Worry		Bed wetting
	Panic Attacks		Nightmares
	Fear away from home		Visual hallucinations
	Fear of leaving parent		Auditory hallucinations
	Social discomfort		Impulsive
	Phobias		Hyper active
	Obsessive thoughts		Defiance
	Compulsive behavior		Aggression/fights
	Racing thoughts		Homicidal thoughts
	Wide mood swings		Frequent arguments
	Irritability/anger		Fire setting
	Peer sibling conflict		School problems
	Stealing		Sexual behavior
	Destroys property		Computer/video game addiction
	Running away		Alcohol and/or drug use (circle)
	Curfew violations		Lack of motivation
	Lying		Withdrawal

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	

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Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse and/or Drug Abuse (circle)	

Please check if your child has experienced any of the following types of trauma or loss:

	Emotional abuse		Lived in a foster home
	Sexual abuse		Multiple family moves
	Physical abuse		Homelessness
	Parent abuse		Loss of a loved one
	Teen pregnancy		Financial problems
	Neglect		Natural disaster
	Violence in the home		Crime victim
	Crime victim		Parent illness or sibling illness (circle)

Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes, please describe:

_____

_____

Has your child ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:

_____

_____

Has your child recently been physically hurt or threatened by someone else? If yes, please describe:

_____

_____

In the past 12 months, have your child seen another psychotherapist or mental health provider?
Yes___ No___

In your lifetime, have your child ever seen a psychotherapist or mental health provider?
Yes___ No___

In your lifetime, have your child ever been in a state hospital or psychiatric facility?
Yes___ No___

Has anyone in your family ever been in a state hospital or psychiatric facility?
Yes___ No___

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In your lifetime, has your child ever thought about or attempted suicide?
Yes___ No___

If yes, please explain: _____
_____

Is your child currently experiencing any suicidal thoughts or feeling suicidal? Yes___ No___
If yes, please explain: _____

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