***PLEASE SIGN AND DATE BELOW TO ACKNOWLEDGE RECEIPT OF THIS IMPORTANT INFORMATION***

Prior to your first appointment, please print out and complete all intake forms and bring with you to your appointment. If you are unable to bring the completed forms with you, please show up to your appointment 15 minutes early to complete the paperwork prior to your session.

PLEASE KEEP IN MIND THAT WE ARE A FORM OF MEDICAL OFFICE AND THEREFORE OPERATE IN THE SAME FASHION:

***Remember to bring your co-pay, coinsurance amount, or self pay fee all of which are due prior to your appointment. We currently accept check or cash only for sessions. Parents sending teens/children without a supervising adult must send the teen/child with payment or prepay. Failure to do so will result in cancellation of the session, and a fee of $75 will be charged. Please remember that we have Tracy Wallen to assist you with all of these issues.***

**Please inform us 24 hours prior to your appointment if you need to cancel/reschedule your appointment to avoid the late/no cancel fee of $75.00 as noted in our financial policy. New clients are required to pay a $30.00 fee at the time an appointment is made; this amount is reimbursable; however if you do not show to the appointment or the appointment is not cancelled per our cancellation policy, the $30.00 fee will not be reimbursed.**

_____

Print Name

_____

Signature

_____

Date

**PLEASE COMPLETE WHICHEVER CHECKLIST APPLIES.**
**IF THE CLIENT IS BETWEEN THE AGES OF 14 AND 17, PLEASE COMPLETE BOTH.**

## Adult Checklist of Concerns

Name:_____ Date: _____

Please mark all of the items below that apply and feel free to add any others at the bottom. You may add a note or details in the space next to the concerns checked.

- o Abuse (please specify)
- o Aggression, violence
- o Alcohol use
- o Anger, hostility, arguing, irritability
- o Anxiety, nervousness
- o Attention, concentration, distractibility
- o Career concerns, goals and choices
- o Childhood issues (your own childhood)
- o Children, child management, child care, parenting
- o Codependence
- o Confusion
- o Compulsions
- o Custody of children
- o Decision making, indecision, mixed feelings, putting off decisions
- o Delusions (false ideas)
- o Dependence
- o Depression, low mood, sadness, crying
- o Divorce, separation
- o Drug use
- o Eating problems
- o Emptiness
- o Failure
- o Fatigue, tiredness, low energy
- o Fears, phobias
- o Financial or money troubles, debt, impulsive spending, low income
- o Friendships
- o Gambling
- o Grieving, mourning, deaths, losses, divorce
- o Guilt
- o Headaches, other kinds of pain
- o Health, illness, medical concerns
- o Inferiority feelings
- o Interpersonal conflicts
- o Impulsiveness, loss of control, outbursts
- o Irresponsibility
- o Judgment problems, risk taking
- o Legal matters, charges, suits
- o Loneliness
- o Marital conflict, distance/coldness, infidelity/affairs, remarriage
- o Memory problems

- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions
- Oversensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination
- Relationship problems
- School problems
- Self centeredness
- Self Esteem
- Self neglect, poor self care
- Sexual issues
- Shyness, oversensitivity to criticism
- Sleep problems, too much, too little, nightmares
- Smoking/ tobacco use
- Stress, relaxation, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolation
- Work problems, employment, overworking, can't keep job

Other concerns or issues:_____

_____

_____

**Child Checklist of Characteristics**

Name:_____ Date: _____

Age:_____ Person completing this form: _____

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first, please mark all of the items that apply to your child on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- Affectionate
- Argues, "talks back," smart-alecky, defiant
- Bullies/intimates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates, wastes time
- Difficulties with parent's paramour/new marriage/new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drug or alcohol use
- Eating-poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- Fire setting
- Friendly, outgoing, social
- Hypochondriac, always complains of feeling sick
- Immature, "clowns around," has only younger playmates
- Imaginary playmates, fantasy
- Independent
- Interrupts, talks out, yells
- Lacks organization, unprepared
- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties-truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental retardation

- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor-competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors-biting or hitting self, head banging, scratching self
- Speech difficulties
- Sexual-sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, blasphemes, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics-involuntary rapid movements, noises, or word productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Underactive, slow-moving or slow-responding, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

- _____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it?_____

# Karen Wood, LMHC, CAP
## CONSENT FOR SERVICES

As a client of Karen Wood, LMHC, CAP we are obligated to inform you of your rights to confidentiality.

I understand that I am ensured the following rights:

- The right to refuse and /or terminate treatment at any time.
- The right to a complete description and explanation of my counseling.
- The right to confidentiality, whereby, information revealed by me during individual or group therapy , evaluation or testing will be kept STRICTLY CONFIDENTIAL and will not be revealed to anyone without my written authorization. The law provides exceptions to this provision:

1. If the therapist has knowledge of the clients' intent to harm himself or others (homicide/suicide with a plan).
2. If the therapist receives a court order to the contrary.
3. If the therapist has knowledge of neglect/abuse to children or elderly.

Due to grey areas of duty to warn regarding HIV issues, our counselors have chosen to adopt the policy of working with the client regarding these grey area issues. This policy will reduce the risk of jeopardizing the therapeutic relationship and also protect the liability of the therapist to the greatest extent possible regarding invasion of privacy, defamation, or breach of confidentiality. These issues include but are not limited to:

1. If, in my opinion, therapy cannot profitably proceed unless something you tell me is shared with another party. I may need to give you the choice of telling the other party yourself, having me tell them, or terminating therapy.

2. I have an ethical obligation to balance the interests of all human beings. If you tell me, in my opinion, of a situation that may be unethical, harmful, or unfair, I may, at my discretion, give you the choice of correcting the situation if possible, informing relevant party(ies) of the situation, having me tell them, or terminating therapy.

3. In general, I will follow, to the best of my ability, all state laws and regulations, as well as the policy and code of ethics of the Florida Department of Professional Regulation.

4. Please feel free to ask for clarification about any of these matters at any time, either now, during therapy, or before you tell me something I might have to share with others.

**Please note that payments are due upon receiving services. We require a 24-hour notice of cancellation of appointments to avoid being charged a missed appointment fee of seventy-five ($75.00) dollars for insurance clients and $150 for court clients. Repeated cancellation of appointments and/or failure to comply with treatment recommendations is counterproductive and may result in termination of your treatment with the option of referral to another treatment source.**

5. Checks returned for insufficient funds will be subject to a fee of thirty five dollar ($35.00) administration fee above and beyond the bank's penalty fee. If such an event occurs more than once, you will be asked to make payment in cash or money order.

6. Sessions are an average of 45 to 50 minutes in length.

7. If you are finding it difficult to wait until your next session to speak to your therapist you will need to schedule appointments more than once per week. Please remember, telephone calls are for appointment arrangements only, not to have sessions over the phone unless this was previously arranged with your therapist.

8. Emails and texts are also billable and not covered by insurance.

9. In case of an emergency at a time when your therapist is out of town call 911 or First Call For Help at 954-467-6333.

10. **Clients involved in disability filings, legal proceedings, Reunification, Extended Co-Parenting or Parenting Coordination will be charged for all phone calls, emails, texts, report writing/review at a rate of one hundred and fifty dollars ($150.00) per hour and court appearances/depositions door to door at a rate of two hundred dollars per hour ($200) charged at one-tenth of an hour including preparation time and travel. These services are NOT covered by your insurance plan. IF YOU BECOME INVOLVED IN A FAMILY COURT CASE AT ANY TIME DURING YOUR TREATMENT, YOU MAY BE SUBJECT TO THIS GUIDELINE..**

11. **Please be advised that all court and disability involved cases require a retainer of $1,000.00 (unless other arrangements are approved by the therapist). Retainers may be paid by check, cash or credit card. Please note if you choose to use a credit card a fee of $25.00 will be charged to you in addition to the $1,000.00 retainer. At the end of the treatment any retainer balance will be returned to the client. Retainer amounts must be kept at a minimum of $300.00. If your retainer balance falls below $300.00 and it is 48 hours prior to your next scheduled session, that session will be cancelled until the retainer amount is replenished to $1,000.00; replenishing your retainer is necessary regardless of the clients' intent to pay cash or check for that session. The client will be provided with an itemized statement monthly or at the time your retainer falls below $300.00. At this time the client will be required to replenish their retainer to $1,000.00. All services will be suspended until the retainer is replenished.**

12. **All clients involved in parent/child reunification counseling must respect the process by following all recommendations of the therapist. The non-participating parent may not be present in the waiting room during the time of the reunification session and may not attend these sessions unless it is requested by the therapist. Any information non-participating parent feels it is necessary to share will occur via a separate appointment. This time is not billable by your insurance company.**

I hereby certify that I understand the above and have been informed of service policies and procedures. Furthermore, I authorize Karen Wood, LMHC, CAP to render necessary treatment and to file appropriate insurance claims for this treatment if necessary. If I do not have insurance, I agree to pay for services as they are rendered.

Name _____ Date _____

***Karen Wood, LMHC, CAP***
***2400 North University Drive. Suite 201***
***Pembroke Pines, FL 33024***
***www.browardcounseling.com***

Name of Client_____

**PLEASE READ AND INITIAL ALL ITEMS TO THE LEFT. THANK YOU**

Charges may include:

____(initials) Self pay non-court related clients **$125.00** per session; court related clients **$150.00** per session; court appearance/deposition related services including preparation, travel and court appearance **$200.00** per hour.

____(initials) Phone sessions, emails, texts and emergency phone calls can also be charged to my insurance (if appropriate) or authorized credit card at the rate of **$125.00** per hour for non-court related clients and **$150.00** per hour for court related clients.

____(initials) Co-pay and/or co-insurance for session: **$_____**

____(initials) Charge for cancellation without 24 hours' notice or for a no-show appointment: non-court related clients **$75.00** as agreed in the Policies and Procedures**;** court related clients **$150.00** as agreed in the Policies and Procedures.

____(initials) I agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, which will be charged for any outstanding balance owed.

____(initials) Outstanding balances beyond 30 days are subject to a **$20.00** administrative fee being added to your account balance EVERY 30 DAYS due to administrative costs. Outstanding balances beyond 60 days are subject to your account being forwarded to an outside collection agency.

____(initials) Returned checks will be subject to an additional fee of **$35.00** in addition to any bank fees which must be paid within 30 days and must be paid by cash or money order to Karen Wood, LMHC.

____(initials) I agree to not dispute any charges and understand that if I do so I will be responsible not only for the charges for services rendered but any charges accrued by the credit card company. All invoices are charged based on records kept on file and are allowed to be released to all parties in the case of a dispute.

____ (initials) I understand that this authorization will remain in effect until I cancel it in writing or one year from the date of signing.

Signature:_____ Date:_____

FINANCIAL POLICY

I consent to psychological therapy, consultation and/or testing. I understand that it is my responsibility to cooperate with treatment. Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. **I understand that if I do not agree with this policy I have the option to pay cash for services to protect my privacy.**

Signature: _____ Date: _____

Signature: _____ Date: _____
(Second parent)

I authorize payment of medical benefits to Karen Wood, LMHC for services rendered. If a problem occurs with the insurance company regarding payment of medical benefits, the patient is responsible for payment of the medical benefits for services rendered in our office. All follow-ups with the insurance company are the responsibility of the patient.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Charges for services are due and payable at the time services are rendered, unless prior arrangements have been made with your therapist. If you have health insurance, it should be understood that this is an arrangement between you and your insurance company to pay you certain amounts for medical care. Your therapist's bill is an agreement between you and your therapist. You are responsible for payment of your bill, regardless of the status of your insurance claim. Insurance companies have a schedule of fees, which they will pay. Your therapist's fees may be more or less than this actual schedule. You are directly responsible to the therapist for your account, regardless of your insurance company schedule. If you fail to meet your financial responsibilities, your account may be turned over to a collection agency or the appropriate court. You will be responsible for a $20 administration fee per month for every month that our office attempts to collect on any amount owed. I hereby give my consent to release necessary information for taking such action. The patient will be responsible for any fees incurred because of collection or court actions.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Because time has been reserved exclusively for me and/or family member(s), I understand that I am required to provide at least twenty-four (24) hours advance notice if unable to keep the scheduled appointment. **In the event that I do not provide the twenty-four (24) hour notice, I am responsible for the reserved appointment at the rate of seventy-five ($75.00) dollars for non-court related clients and one hundred and fifty ($150.00) dollars for court clients.**

I hereby assume responsibility for all charges that may be incurred for treatment rendered to myself and/or family member(s). I understand the above described financial policy. I have also read and understood the Patient's Rights and responsibilities and the HIPAA Notice of Privacy Practices. I received a copy of both to retain for my records.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)