SONYA L. FONTAINE LPC, PLLC
CHILD/ADOLESCENT INFORMATION QUESTIONNAIRE

Date: _____

Child's Name: _____ SS#_____ Sex: ☐ Male ☐ Female
First Initial Last

Age:_____ Date of Birth:_____ School Attended _____ Grade: _____

Biological Parents are: ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed ☐Single

Who is Legal Guardian of Child?: _____ Phone Number: _____

Who does Child primarily live with?: _____ Phone Number: _____

Address: _____
Street Apt # City State Zip

Parent: _____ SS#_____ ☐Mother ☐Father Date of Birth:_____
First Initial Last

Parent: _____ SS#_____ ☐Mother ☐Father ☐Step Parent Date of Birth:_____
First Initial Last

Address: _____
Street Apt # City State Zip

Telephone Number: Home (_____) _____ Work (_____) _____ Cell (_____) _____

E-mail: _____ Permission to contact by email: ☐Yes ☐No Permission to leave a message on your cell phone: ☐Yes ☐No

Do you attend a church: ☐Yes ☐No Church Attended _____ Member: ☐Yes ☐No How regularly _____

Marital Status (Check one): ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed

Mother Employer: _____ Occupation: _____ Employer Phone: (_____) _____
Highest Level of Education: ☐Grade School ☐High School ☐Technical Degree ☐Bachelor's Degree ☐Master's Degree ☐Advanced Degree

Father Employer: _____ Occupation: _____ Employer Phone: (_____) _____
Highest Level of Education: ☐Grade School ☐High School ☐Technical Degree ☐Bachelor's Degree ☐Master's Degree ☐Advanced Degree

Non-custodial Parent – Complete This Section If Applicable

Parent's Name: _____ SS#_____ ☐Mother ☐Father Age:_____ Date of Birth:_____
First Initial Last

Address: _____
Street Apt # City State Zip

Telephone Number: Home (_____) _____ Work (_____) _____ Cell (_____) _____

E-mail: _____ Permission to contact by email: ☐Yes ☐No

Attend a church: ☐Yes ☐No Church Attended _____ Member: ☐Yes ☐No How regularly _____

Marital Status (Check one): ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed

Employer: _____ Occupation: _____ Employer Phone: (_____) _____

Permission to contact: ☐Yes ☐No

Highest Level of Education: ☐Grade School ☐High School ☐Technical Degree ☐Bachelor's Degree ☐Master's Degree ☐Advanced Degree

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List the members of your family and all others currently living in your home:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Source of Referral: ☐Friend _____ ☐Physician _____

☐Minister/Church _____ ☐Other(List) _____

Has child ever consulted a professional counselor or psychiatrist?: ☐Yes ☐No Hospitalized: ☐Yes ☐No

Date _____ Problem Addressed _____ Counselor _____

Date _____ Problem Addressed _____ Counselor _____

Health information:
Primary Care Physician: _____ Phone: _____ Last Visit: _____

1. What medications are you currently taking and the reason:

_____

2. Please list any surgeries or major illnesses you have had:

_____

3. Do you have a history or are currently experiencing of any of the following: (circle all that apply)
Please mark an "X" to the left if any immediate family members have experienced any of these things :

Depression/Sadness	Learning disability	ADHD	Witness to spousal abuse
Decreased ability to sleep	Anger outbursts	Death of a parent	Hyperactivity
Decreased appetite	Mood swings	Death of a sibling	Pornography
Increased appetite	Physical abuse	Forgetfulness	Hearing voices others cannot hear
Increase in sleeping	Sexual abuse	Divorce in family	Same sex attraction
Anxiety/Worry	Emotional abuse	Separation with spouse	Seeing things others cannot
Panic attacks	Addiction to alcohol or drugs	Irritability	Nightmares
Unrealistic fears	Distractibility	Crying Spells	Bed Wetting
Poor grades	ADD	Obsessive-compulsive behaviors	Addiction (other) _____

Suicidal Thoughts: ☐current ☐past frequency: _____ when: _____ Suicide Attempt – date: _____ Hospitalized ☐Yes ☐No

Briefly describe your reason for seeking therapy?

_____

What have you attempted to do to treat this problem? What has worked and has not worked?

_____

_____

How will you know when therapy has been successful?

_____

_____

Please provide any additional information, which you feel pertinent for therapy?

_____

_____

Would you like Sonya to pray with you in session? Circle one: ☐Yes ☐No

Our goal is to best meet your emotional needs in a confidential, respectful and God-centered way.
Please feel free to discuss this or any other issue with us.
Sonya L. Fontaine L.P.C., PLLC

Client Services Contract

Sonya Fontaine

This document is important to you and/or your child as a consumer of services with this therapist. This Agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of Protected Health Information (PHI) for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Policies and Practices to Protect the Privacy of Your Health Information for use and disclosure of PHI for treatment, payment, and health care operations. This Notice, which is included with this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between you as the client and me, your therapist, as your service provider. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me, your individual treatment provider, by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. Please read the following document and sign your initials after each section of the document, acknowledging that you have read and understand the information provided as it relates to you and/or your child as the client.

Psychological Services

The primary mental health service that I provide the public is psychotherapy for individuals (adults, adolescents, and children), couples, families, and groups. Psychotherapy is not easily described in general statements. It varies depending on personalities of the counselor/psychotherapist and client(s), and the particular problems you are experiencing. There are many different methods your individual treatment provider may use to deal with the problems that you hope to address.

Psychotherapy is not like a physician visit. Instead, it calls for very active effort on your part. In order for therapy to be most successful, you will have to work on issues discussed, both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, the practice of psychotherapy is not an exact science and therefore there are no guarantees regarding what you will experience as the outcome of your treatment.

It is important that you, the client, understand that I am not a medical doctor; therefore I do not prescribe medications and am not authorized to practice medicine. If you think that medication should be considered as a part of your treatment, after discussing medication as a treatment option, I am happy to refer you to a physician and to provide coordinated services. Psychological problems can have medical or biological origins and you should have regular physical exams and speak with a physician about all psychological symptoms.

Please initial here to acknowledge that you have read and understand the above Psychological Services. _____

APPOINTMENTS/SESSIONS

Psychotherapy appointments/sessions are typically scheduled once a week for a total of 50 to 55 minutes at an agreed upon time. However, some sessions may be longer or more frequent depending upon the necessity of treatment and in agreement between you and I, your individual treatment provider. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least 24 hours advance notice of cancellation (unless you and I both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment.

If you have missed a scheduled appointment and you do not call me within 7 days, I will accept that as your notice that you have terminated this agreement and that you wish to discontinue services.

Please initial here to acknowledge that you have read and understand the above section on Appointments/Sessions. _____

PROFESSIONAL FEES

The agreed upon fee for a 50-55-minute psychotherapy session is $ _____. (This fee includes time for appropriate note taking and other services associated with regular, weekly sessions). In addition to weekly appointments, I reserve the right to charge a fee per hour for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour, and this fee will be discussed with you prior to providing the service. Other services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I will charge a fee per hour for preparation and will charge a fee per hour for attendance at any legal proceeding; the latter is charged from the time of leaving the office until return. These fees will be discussed with you prior to providing any services and will be considerably higher than traditional therapy fees. All fees must be paid prior to legal proceedings. Additionally, you should understand that I am not considered an expert witness. This means that I can only be called for fact witness and cannot make advisement to the court.

Please initial here to acknowledge that you have read and understand the above section on Professional Fees. _____

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between you, the client, and myself. In most situations, I can only release information about your treatment to

others if you sign a written authorization form that meets certain legal requirements by HIPAA. There are other situations that do not require your authorization, including the following:

If your provider is a candidate for licensure, you should be aware that they will be under the supervision of licensed mental health professionals. As such, they will be meeting regularly with their supervisors to discuss each of their cases, to receive appropriate supervision of their work, and to obtain necessary consultation in order to provide you with the most helpful and effective mental health services. If information regarding your case is to be shared in a group consultation no identifying information would be utilized. Candidates are required by law to tape occasional sessions as a part of their licensure process. Your permission must be sought and obtained in writing prior to any taping. Tapes are used for supervisory purposes only and are destroyed once supervision is complete. They are never maintained as a part of your record. Candidates for licensure will seek your permission and inform you when tapings and/or observations are taking place. Candidates for licensure will provide you with information as to the identity(s) of said supervisor(s) and licensure and contact information for their supervisor(s).

As is common professional practice, I may occasionally find it helpful to consult with other health professionals about your case. No identifying information will be utilized Client Services Contract during said consultation unless you have given specific written consent. Other professionals are also legally bound to keep the information confidential.

I may employ administrative staff to assist in filing and other miscellaneous office
related activities. These personnel may need to have access to protected information in order to perform their duties. All staff members have been given training about protecting your privacy and have signed nondisclosure agreements agreeing to protect your confidentiality.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some other situations where I am permitted or can be required to disclose information without your consent of Authorization:

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client law. I cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in/or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend against the complaint or lawsuit.

If a client files a worker's compensation claim, I may disclose information relevant to that claim to the appropriate parties, including the Administrator of the Worker's Compensation Court.

These are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and, as such, may have to reveal some information about a client's treatment. These situations are unusual, but may occur:

If I have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires I report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.

If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation, the law requires that I report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.

If a client communicates an explicit threat to kill or inflict bodily injury upon a reasonably identifiable victim and he/she has the apparent intent and ability to carry out the threat, or if a client has a history of violence and I have reason

to believe that there is a clear and imminent danger that the client will attempt to kill or inflict serious bodily injury upon a reasonably identified person, I may need to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the client.

If the client threatens to harm herself/himself, I am obligated to seek hospitalization for her/him, or to contact family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Information from clients' files may be compiled to study various issues such as treatment outcomes and client satisfaction to improve the services offered. Your name or any identifying information will not be used in such research.

All clients that consent to group psychotherapy will be informed about the importance of maintaining confidentiality. It is important to understand, however, that I cannot guarantee that all group members will keep any and/or all information provided by clients in the group setting confidential.

While this written summary of expectations to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. In situations where specific advice is required, formal legal advice may be needed.

Please initial here to acknowledge that you have read and understand the above section on Limits on Confidentiality. _____

PROFESSIONAL RECORDS

The laws and standards of the mental health profession require that I keep Protected Health Information about you in your Clinical Record. Except in circumstances that involve danger to yourself and/or others, where information has been supplied to me confidentially by others, or if the information has been gathered in reasonable anticipation of or specifically for use in litigation, you may

examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or distressing to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $1.00 per page (and for certain other expenses). If I determine that obtaining your record may cause harm, I have the right to refuse your request for access to your records. You have the right of review in some instances, which I will discuss with you upon request. In some instances, there is no right to have a review of the decision to refuse your request to inspect and/or copy the protected health information in your record.

You should be advised that in the event of my untimely death or catastrophic illness, I have made provision for a licensed colleague to maintain my records for the time required by law and to destroy them in accordance with HIPPA and my licensing body. In my absence my licensed proxy will use his/her best clinical judgment with regard to any request for records.

Please initial here to acknowledge that you have read and understand the above section on Professional Records. _____

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my practice policies and procedures recorded in your records; and the right to a paper copy of this Agreement and/or the Notice of Policies and Practices to Protect the Privacy of Your Health Information. I will be happy to discuss any of these rights with you.

Please initial here to acknowledge that you have read and understand the above section on Client Rights. _____

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. I will provide them with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also, at your request and with your child's knowledge provide parents with a summary of your child's treatment when it is complete. Any other communication will require the child's Authorization, unless I have reason to believe that the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. I reserves the right to refuse to provide services to a child if a parent will not agree to accept these conditions.

Please initial here to acknowledge that you have read and understand the above section on Minors & Parents. _____

COUPLES & FAMILY COUNSELING

Working with couples and families is different than working for an individual client. When I work with a couple or family, all members of the relationship system is the client, and all members of the system have rights to informed consent and confidentiality. This means that all persons with legal status would have to sign any release of information forms, before any information could be released outside of that system. If my records were subpoenaed, I will assert the counselor-client privilege on behalf of the client system.

During my work with a couple or family I may see a smaller part of the relationship system e.g., an individual or the parents without the children. These sessions should be seen by you as part of the work I am doing with the couple or family. If you are involved in one or more of these sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or I have your written authorization. In fact, since those sessions are considered a part of the treatment of the couple or family, I would also seek the authorization of the other

individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the relational system) with the entire unit, that is the couple or family, if I am to effectively serve the system. I will use my best judgment as to whether, when, and to what extent I will make disclosures, and will also, if appropriate, first give the individual or smaller part of the system the opportunity to make the disclosure. Thus if you feel it necessary to talk about matters that you absolutely do not want to be shared with anyone, you may want to consult with an individual therapist who can see you individually.

This "no guaranteed secrets" policy is intended to allow me to continue to serve the couple and 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 relational system. 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 family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during counseling, I may be placed in a situation where I will have to discontinue services to the couple or family. This policy is intended to prevent the need for such discontinuation.

Please initial here to acknowledge that you have read and understand the above section on Client Rights. _____

BILLING & PAYMENTS

You will be expected to pay for each session at the beginning of the scheduled appointment time, I have agreed otherwise or unless another arrangement has been made regarding insurance coverage. Insurance is only accepted by licensed counselors/psychotherapists and coverage will only be accepted when agreed upon by the individual treatment provider and the client. Payment schedules for other professional services will be agreed to when they are requested.

By signing this document, you are stating that you understand that you are responsible for any and all fees for services provided by this therapist to which you have consented, and that failing to pay such fees may result in termination of any

further services available to you. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is her/his name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

Please initial here to acknowledge that you have read and understand the above section on Billing & Payments. _____

INSURANCE REIMBURSEMENT

In order for you and I to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. At my discretion, I can fill out forms and provide you with whatever assistance needed in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of your fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I can provide you with a copy of any report that I am required to submit, if you request it.

Once I have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

Please initial here (if applicable) to acknowledge that you have read and understand the above section on Insurance Reimbursement. _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT IN ITS ENTIRETY AND AGREE TO ITS TERMS AS IT RELATES TO YOU AND/OR YOUR CHILD AS A CLIENT OF NLC AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA REQUIRED Notice of Policies and Practices to Protect the Privacy of Your Health Information AS DESCRIBED ABOVE.

[ ] I agree [ ] I do not agree for my PCP _____ to be contacted about my counseling.

_____ _____

Client Signature Print Name

_____

Date