Merrimack Valley Counseling Association

39 Simon St., Unit 2A
Nashua, NH 03060
Tel. (603) 888-4347 Fax (603)577-9157

20 Merrit Parkway, 2nd Floor
Nashua, NH 03063
Tel. (603)402-9365 Fax (603) 402-9389

Minor Child Information Sheet

Patient Name: ____ DOB: ___________________ Age: _________________
Address: _____________________________________City, ST, Zip ____
Tel. No: _______________________________(H) ___________________________(W) ____________________________(C)
Parent(s) Name: ____
Who does the child reside with? ____
School Name and Telephone Number: ____

Non-custodial parent information, if applicable:
Does the non-custodial parent have a legal right to approve or disapprove treatment for their child? Yes No
If yes, does he/she approve the treatment that will be rendered by
Merrimack Valley Counseling Association? Yes No
If no, we will be unable to provide services until both parents agree to treatment.
If yes, please have the non-custodial parent complete the following:
Name ____ Phone: ____________________________
Address: ____
My signature below indicates my agreement with treatment provided by Merrimack Valley Counseling Association for my child ________________________________. I understand that I may revoke this authorization, in writing, at any time.

____ ____________________________________
Non-Custodial Parent Signature Date

Primary Insurance Subscriber Information:
Name: ____ DOB: _____________________ Relation: ___________________
Insurance Company: ____________________________ ID#______________________ Employer: _____________________
Secondary Insurance Subscriber Information:
Name: ____ DOB: _____________________ Relation: ___________________
Insurance Company: ____________________________ ID#______________________ Employer: _____________________

Emergency Contact Information:
Name: ____Tel No _____________________ Relation _____________________

Current Primary Care Physician:
Name: ____ Tel. No. _________________________________
Address: ____

Medical Conditions: ____
Medications: ____

Pregnancy, Birth and Development:

Were there any problems during pregnancy?

____

Were there any problems at the time of birth or during the post-natal period?

____

Did development occur within normal limits?

____

Please summarize your reason(s) for seeking counseling:

____

____

Statement of Confidentiality:

Within certain limitations, information by you and (if applicable) your child(ren) during the course of treatment will be kept strictly confidential and will not be revealed to any other person and/or agency without your written consent. At your request, any or all parts of your records can be released to any person and/or agency you designate in writing. There are certain situations in which Psychologists, mental health professionals and/or medical professionals are required by law to reveal information without your permission. These include:

1. Clear suspicion that physical abuse, sexual abuse or physical neglect has occurred to a minor.
2. Grave bodily harm or death is threatened to another person
3. Serious suicidal intentions are conveyed and a client or their guardian refuses voluntary treatment to ensure the patient's safety
4. When a court of law issues a subpoena for information obtained during treatment in response to the order of a court of law
5. Reporting as mandated by HIPPA, The Health Insurance Portability and Accountability Act.

If you have questions and/or concerns regarding your rights to confidentiality, please discuss them with your mental health professional at the time of your appointment.

Medical and Payment Authorization/Assignment of Payment/Promise to Pay

I have read the cancellation policy and understand that except in extraordinary circumstances, missed appointments and those canceled without 24 hours notice will be billed directly to me at the full session rate. I also understand that insurance does not cover fees for missed appointments.

I also authorize my mental health provider or the health care vendor providing services or benefits to release any mental health, substance abuse assessments or medical treatment information necessary to effect treatment or claim payments to Merrimack Valley Counseling Association .

I authorize payment of benefits to Merrimack Valley Counseling Association for services rendered, providing other arrangements have not been previously negotiated. I also understand that I am responsible for any services and/or fees that are not covered by my insurance company.

___________________________________	________________	____________________________
Signature of Parent or Guardian	Date	Witness

I certify that the information I provided is accurate and I understand the above Statement of Confidentiality.

_________________________________	__________________	____________________________
Parent or Legal Guardian Signature	Date	Relation to patient

Technology

It is the policy of this agency to limit electronic communication with our clients, including e-mails, LinkedIn©, or the use of cell phones. Please sign below if you are agreeable to having us leave e-mail and/or cell phone messages.

_____________________________   __________________   _____________________________

Parent or Guardian Signature   Date   Relation to patient

Psychological and Neuropsychological Testing

For psychological and neuropsychological assessments, you are responsible for paying the fees for report writing and scoring. The fee is $150 an hour for report writing and scoring. We require an up-front minimum down payment of $300 before testing will be scheduled. Based on the complexity and depth of the assessment, additional hours may be required for scoring and report writing, which is the responsibility of the client/patient. If your health insurance policy does pay for psychological assessments, report writing, etc., Merrimack Valley Counseling Association will reimburse you for any monies we receive from your insurance for testing, scoring and report writing. You will be responsible to pay any remaining balance before test results and written assessments will be released to you or any school or agency requesting them.

If in agreement, please sign and date.

Signature: ______________________   Date: ____________ Relation to Patient: _______________

Parent or Legal Guardian

Client's/Patient's Rights

I acknowledge that I have received or been offered a copy of the patient's Mental Health Bill of Rights and a copy of the HIPAA privacy laws.

______________________________   ________________

Signature   Date

<u>Safety Contract</u>

As the parent or legal guardian of ______________________________ (child's name), I contract to call his/her therapist if I feel he or she is engaging in any self-destructive behaviors that would place my child or others in imminent danger. If my child's therapist is not available, I agree to speak to the on-call therapist. If no direct contact is available, I agree to call 911 or take my child to the nearest hospital emergency room.

Southern NH Medical Center Tel. (603) 577-2000 or (603) 577-2728   St. Joseph's Hospital Tel. (603) 882-3000

This contract shall remain in effect for as long as my child remains in treatment.

Signature:_______________________________Date ______________   ________________________

Parent or Guardian Signature   Relation to Patient