Douglas Gotel, LICSW, RPT

Intake Form - Child

Identifying Information

Child's Last Name:	Child's First Name:	MI

DOB:	Age:	Grade:	Sex
			_____(M) _____ (F)

Mother's Name:	DOB:

(Check One)	Natural Parent	Step Parent	Adoptive Parent	Relative (Specify):

Father's Name:	DOB:

(Check One)	Natural Parent	Step Parent	Adoptive Parent	Relative (Specify):

Address (Number and Street)	City	State	Zip

Home Telephone	Mother's Cell Phone	Mother Work Phone	Father Cell Phone	Father Work Phone

Emergency Contact/Relation	Mother's Email	Father's Email

PHONE FAX EMAIL
50 E Street SE, Ste. 300 Washington, DC 20001 (202) 430-5461 (202) 543-2332 info@douglasgotel.com

Presenting Problem

For what are you seeking help with today?

Behavioral Concerns (Check all that apply)

	Tantrums		Increased Anger		Shame/Guilt
	Withdrawal		Peer Conflict		Lying
	Loss of Interest/Motivation		Bullying Behaviors		Unlawful Behavior
	Increased Irritability		Phobias		Decreased School Performance
	Overactive		Anxious/Fearful		Bowel/Bladder Control
	Poor Concentration		Regressive/Infantile Behavior		Changes in Eating Patterns
	Impulsive		Self-Injuring		Changes in Weight
	Hypervigilance		Poor hygiene		Nightmares
	Stubborn/Oppositional		Sexualized Behavior		Alcohol/Substance Use
	Physical Violence/Fighting		__Suicidal__Homicidal Thoughts		Other:

Medical History

Has the child ever been hospitalized for illness, physical ailments, emotional problems, etc.?	**_____Yes**	**_____No**
Has the child ever taken, or is he/she currently taking any medications?	**_____Yes**	**_____No**
If yes, please list medication name and frequency of dose.		
Does the child have any allergies that you are aware of (i.e., latex, peanut, soy, etc.? If yes, please indicate:	**_____Yes**	**_____No**
Name and address of primary care physician:		

Developmental History (complete for each child)

Did the mother have any illness or complications before delivery?		**_____Yes _____No**
Did the mother drink alcohol or use drugs during pregnancy?		**_____Yes _____No**
Length of pregnancy?	**Full term? _____Yes _____No**	**Birth weight _____lbs. _____oz.**
As far as you know, did your child meet developmental milestones at an appropriate age (ie., rolling, sitting up, crawling, etc.)? If No, please provide details:		**_____Yes _____No**
Complications at birth? If Yes, please provide details:		**_____Yes _____No**

Living Arrangements

Number of moves in the child's life:		
Has the child ever been placed, boarded or lived away from family?	**_____Y _____N**	**If yes, explain:**

List below all members of your household presently and indicate their relationship to the client:

Name	Relationship	Age	DOB

Educational History (complete for each child)

Name of School		City, State
Does your child have an IEP or 504 Plan?	**_____Yes _____No**	**If yes, what is the disability classification?**

If your child receives specialized instruction of accommodations at school, please check all that apply:

	Service Type
	Behavioral Support Services/Counseling
	Occupational Therapy
	Speech and Language Therapy
	Physical Therapy
	Reading Intervention
	Math Intervention
	Other (describe):

Loss/Trauma History (complete for each child)

List any events in the child's life that could be considered distressing/traumatic (ex: divorce, death of significant persons, witnessing violence, etc.)

Description of Event/Loss	Relationship to Child (if applicable)	Date of Event	Child's Age at Event

Social History/Supports

List your child's involvement in extracurricular activities:
List your child's talents, hobbies and interests:
Describe your child's strengths and character:
How many peers has your child identified as friends?
What resources/supports do you have to access in times of stress/need as a parent/guardian?
Does your family have a spiritual/religious affiliation and involvement with any faith-based institution?
Is there any thing else you would like me to know that you feel would assist me in helping your or your child(ren)?

Name of Person Completing Form:	Signature	Date:

CONSENT FOR SERVICES

I give consent for my child to receive assessment/psychotherapy services. I give consent to participate in family therapy services related to my child's care.

Signature of Parent/Guardian_____ Date: _____

Signature of Parent/Guardian_____ Date: _____

Douglas Gotel, LICSW, RPT

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.
I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

Douglas Gotel, LICSW, RPT

Authorization for Use or Disclosure of Protected Health Information

You may consent for personal information contained within your clinical record held by Douglas Gotel, LICSW, RPT to be disclosed to the person and/or agencies identified below for the following reasons:

- Planning and monitoring appropriate treatment.
- Case review and consultation with your physician and/or healthcare providers.
- Support and/or involvement of family member(s) or significant other in treatment.
- Information that is required to file a claim with your insurance company or managed care company.
- Information required by your employer if your supervisor refers you to treatment.

Your signature indicates that you authorize **Douglas Gotel, LICSW, RPT,** to release /receive information to the parties named below. Your may revoke this consent at any time by providing written notice. I understand that this authorization is voluntary that the information to be disclosed is protected by the law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Name of Party/Agency: _____

Address: _____

Phone: _____ Fax: _____

This authorization will expire on ____/____/____ or upon the happening of the following event:

_____

Authorization for Use or Disclosure of Protected Health Information

Information to Be Released (Check all requested)	
	Psychotherapy Notes
	Treatment Plan/Summary
	Diagnostic Summary/Psychological Assessment
	Educational Record
	Medical Records
	Other:

Print Client's Name: _____ DOB _____

Client's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witnessed By: _____ Date: _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Authorization Release for Consent to Record and Use of Recorded Material

Video and audio recording are commonly used for consultation, training and research in individual, group and family therapy. In order to record sessions, your written consent is required. The recording of sessions will likely enhance the effectiveness of your or your child's treatment, but is not required. You may decline to have sessions recorded.

Confidentiality

For any of the uses agreed to below, the strictest confidentiality will be maintained, and there will be no sharing of the recorded material beyond the limits specified below. Except for your first names and your voice and/or image on the recording, there will be no information that could identify you. The recording will never knowingly be shared with anyone who knows you. Mental health professionals who may view or hear recorded material of your session (if permission is given here) are bound by law and by code of ethics to the same obligation to protect your confidentiality. Except as noted below, the existence of this recording will not
be discussed with anyone at any time.

Indicate preference by initialing below	
Video & Audio	Audio Only

How Recorded Material May Be Used

_____ _____ **Consultation**

The recording may be shared with a clinical consultant who has been engaged to provide expert clinical consultation regarding the therapy process. This consultation s a vital source of professional development and accountability; it provides additional clinical expertise as a resource to your treatment and increases its effectiveness.

Training

_____ _____ A brief recording excerpt may be used by D. Gotel in the training of child and family therapists to demonstrate concepts and techniques of treatment. No information that could identify you, beyond the content of the tape, will be shared.

_____ _____ **Session Review Only**

The recording may be reviewed privately by D. Gotel prior to the subsequent session. It will not be kept beyond the subsequent session and no recording will be kept beyond the conclusion of treatment.

Freedom to withdraw consent

I understand that I may withdraw previously granted consent at any time without giving a reason, and that this will not affect my or my child's treatment or relationship with the therapist in any way.

Authorization Release for Consent to Record and Use of Recorded Material

Clients Under Age 18

I,_____, hereby give consent to Douglas Gotel LICSW, RPT to
Parent/Guardian

video record counseling sessions with _____for the purposes indicated above.
Child Name

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Douglas Gotel, LICSW, RPT Date

Adult/Family

I give my consent to Douglas Gotel, LCSW, RPT to record individual/family sessions for the purposes indicated above.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Douglas Gotel, LICSW, RPT Date

Douglas Gotel, LICSW, RPT

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment with less than a 24-hour notice.

The therapist reserves the right to terminate services after two consecutive missed or cancelled appointments.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date