HERSHEY COUNSELING CENTER

Thank you for choosing the Hershey Counseling Center. We are dedicated to providing the highest quality counseling services and to ensure that our clients have a positive counseling experience.

In preparation to your child's first session please complete the two attached forms:

1. Informed Consent:

    - Both parents (or legal guardians) need to sign the Informed Consent. By signing the Informed Consent you are agreeing to allow your child to be seen for counseling services.
    - Your child can not be seen without the signatures of *both* parents, unless one parent has sole legal custody.
    - You will need to bring a copy of the custody agreement to the first session for us to keep on file.

2. Intake Form:

    Please complete and bring with you to your first session. Completing this in advance allows more time for you and the therapist to talk.

    Thank you. We look forward to working you.

    If you have any questions please call Katie at 717-220-4808.

INFORMED CONSENT

Kevin N. Heller MS NCC LPC RPTS
Licensed Professional Counselor
Hershey Counseling Center
1371 Sand Hill Road
Hummelstown, PA 17036
717-265-4466

Professional Disclosure Statement

Professional Qualifications: BS Behavioral Science, Penn State University; MS Master of Science, Community Counseling, Shippensburg University; NCC National Certified Counselor, National Board for Certified Counselors; Certified as Registered Play Therapist Supervisor, Association for Play Therapy. Extensive training in play therapy theory, modalities and techniques; Significant training in family play therapy strategies with a focus on Filial Family Play Therapy.

Informed Consent

Counseling Relationship

The counseling relationship should be a comfortable and trusting relationship between an individual and his/her therapist where the client can feel free to express their thoughts and feelings in an atmosphere of unconditional positive regard. This is most especially true in my approach to treating your child. Play therapy provides the opportunity for your child to experience and develop that comfortable and trusting relationship in the context of a child centered play session.

It is likely your child will develop a close and trusting relationship in the play session; this is typical and it must be clear that this is a professional relationship rather than a social one. In accordance with the American Counseling Association's Code of Ethics, our contact will be limited to the counseling sessions that you arrange with me except in the case of an emergency.

Services Provided

Services provided include assessment through an initial interview with the caregiver and child together. A play session or two will also be provided to assess further the needs and concerns of your child. No service will be provided without your consent. You are free to limit or end treatment at any time. I honor the uniqueness and complexity of each child, caregiver and family member and tailor my therapeutic approach to the particular needs of each child and their situation.

Contact Information

I can be reached Monday thru Friday between 9 AM and 7 PM. When I am unavailable, please leave a message with voicemail and I will return your call as soon as possible. In emergencies, you can call 911 or Dauphin County Crisis Intervention at 717-232-7511. If, for some reason, you are unable to reach them, go to the nearest emergency room and tell them you are having a mental health emergency.

Clients' Rights

As a parent and caregiver of your child, you may end our counseling relationship at any time, I ask only that we have a session to discuss your thoughts and concerns before sessions are terminated. During the treatment process, please address with me any and all concerns you have about the treatment process. You are the expert on what works for you and your child, and I encourage you to keep me informed as to your experience outside of our play sessions.

I assure you that I conduct my services in a professional manner consistent with accepted legal and

ethical standards. If at any time, for any reason, you are dissatisfied with my services, please let me know. You also have the right to ask for a referral, request copies of reports, and receive a copy of the Code of Ethics under which I practice.

Cancellation
Your session is reserved for you. In the event that you will be unable to keep an appointment, please notify my office 24 hours in advance, so that someone else may utilize this time. If you fail to give a 24 hour notice of cancellation, you will be billed $45.00 (half of a session fee). Also if you are absent for two consecutive sessions, I may ask to terminate our counseling relationship and provide you with appropriate referrals. I recognize the difficulty of scheduling appointments with a child's school schedule and a caregiver's work schedule. I will try and accommodate your needs as best as I can.

Referrals
I realize that I am not able to provide appropriate treatment for all cases that I may have. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide you with some alternatives, including programs and/or people who may be able to assist you. You will be responsible for contacting and evaluating those referrals and alternatives.

Fees and Payment Policy
Our fee is $110 for a 55 minute session and $120 for the initial assessment. For those who do not have insurance or do not wish to use their insurance, payment for services is by cash, personal check, or credit card. The fee for each session will be due and must be paid at each session. As a service to you, I will provide you with a billing statement that you can give to your insurance company if you desire to do so.

For those utilizing insurance, for the insurances we accept, we will bill your insurance company for you. For those insurances we do not accept, we will provide you with a detailed billing slip that will include everything you need to submit your claim.

We ask that at each session you pay your co-pay. Cash, check or credit cards are accepted.

In the event you have not met your deductible, full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay for services when rendered.

I will not do court testimony. If requested, I will write a letter. My fee for writing a letter is $110, and is paid directly to me.

Records and Confidentiality
All of our communication becomes part of the clinical record. Records are the property of Hershey Counseling Center, but you have a right to the information within your record. In keeping with general accepted standards of practice, I may consult with other mental health professionals. The purpose of consultation is to ensure quality of care. Every effort is made to protect the identity of the clients.

Most communications are confidential, but the following limitations and exceptions do exist:

a) You provide me with your consent to release information.
b) I have reason to suspect that you are a threat to yourself or someone else.
c) You or your child disclose abuse or neglect of a child, elderly, or disabled person.
d) I am ordered by the court to disclose information.
e) I am otherwise required by law to release information.

Electronic Communications

☐ By checking this box, you agree to send and receive electronic communications with counselor including, but not limited to cellular phones calls, emails and text messages regarding you or your child's treatment and appointments. In addition, you are releasing counselor and Hershey Counseling Center from any breach of confidentiality that may occur relating to these transmissions due to the nature of electronic communications.

By your signature below, you are indicating that you read and understood this statement, and that any questions you had about this statement were answered to your satisfaction. By my signature, I verify accuracy of this statement and acknowledge my commitment to conform to its specifications.

____
Printed Name of Client or Child

____________________________________ __________
*Signature of Parent # 1/ Legal Guardian #1 (or Client) Date

____________________________________ __________
*Signature of Parent #2/ Legal Guardian #2 Date

*Both parents (or legal guardians) must sign.

____________________________________ __________
Signature of Counselor Date

This information is required by the Board of Social Workers, Marriage & Family therapists and Professional Counselors, which regulates marriage and family therapists and professional counselors.

Commonwealth of Pennsylvania
State Board of Social Workers, Marriage and Family Therapists & Professional Counselors
P.O. Box 2649
Harrisburg, PA 17105-2649

My signature below acknowledges that I was offered the HIPPA Notice of Privacy Practices.

Client ________________________________ **Date** ____________________

Client name: ____

Please complete this questionnaire to the best of your ability. All the information will assist with the assessment and will remain confidential. Please talk with your therapist regarding questions you may have.

____ ________________________

Signature of person completing forms Date

Child's Information

Name: Last________________________ First________________________ Middle________________________
DOB: _______________ Age: _________ Gender ☐ Male ☐ Female
Address ____
City _________________________ State _________________Zip______________________
Phone numbers: Home____________________ Work ____________________ Cell _______________________
Social Security Number: ____
Who referred you to services ____

Parent/guardian Information

Mother's name____ Occupation ____________________________
Address ____
City ___________________________ State ______________ Zip ________________________________
Phone numbers: Home ___________________ Work _________________ Cell ___________________________

Father's name____
Address ____
City ___________________________State _______________Zip _______________________________
Phone numbers: Home ___________________ Work___________________ Cell __________________________

Emergency Contact

Name: ____ Relationship to child: ___________________________
Address: ____
City __________________________ State _______________Zip __________________________________
Phone numbers: Home ___________________ Work ___________________ Cell ___________________________

What are your reasons for seeking counseling services for your child?

____

____

Describe the behaviors that concern you?

____

____

What goals would you like your child to achieve while in counseling?

____

____

Client name: ______________________________

Family / Developmental History

Please list immediate family members

Name	Relationship to client	Age	Describe how they get along

Family Status: ☐ single parent ☐ separation ☐ divorce ☐ intact family ☐blended family

Please describe custody arrangements and visitation if applicable:

____

____

Briefly describe the structure, rules, limits, and discipline in your home:

____

____

Check any of the following that occurred during your pregnancy with this child:
☐Mother's health problems ☐ Use of drugs, alcohol, tobacco ☐ Medical problems ☐ Injuries
☐ Complications in delivery ☐Premature birth ☐Medical issues with child after birth
☐ Other: ____

Please list approximate ages when child reached the following milestones:

Slept through the night		Walking	
Crawling		First words	
Completed toilet training		Attended Kindergarten	
Attended child care or day care		Able to dress self	

Has your child experienced physical, sexual or emotional abuse? If yes, please explain:

____

____

Client Name: ____

Medical History

Please name your child's primary care physician:

____

Is your child under a physician's care at this time? If yes, for what?

____

Please list any medications your child is taking at this time:

Name of medication	Dosage	Reason for taking	Prescribing Physician

Are there any medical conditions in your family you believe we need to be aware of, i.e. (Allergies, high blood pressure, diabetes, heart condition, cancer), identify family member's relationship to your child and the medical condition: ____

____

Has your child or a member of your family been diagnosed with a mental health disorder? Identify family member's relationship to your child and the medical condition: ______________________________

____

Has your child received mental health treatment prior to this appointment? Please describe: ____________

____

____

Has your child received treatment for any drug and alcohol related issues? ________________________

Please place a check on all that apply to your child, self or other family member. If checked, your therapist will follow up and ask for more information.

SUBSTANCE USED	CHILD	MOTHER	FATHER	OTHER FAMILY MEMBER
Alcohol				
Tobacco				
Amphetamines				
Barbiturates				
Caffeine				
Crack/Cocaine				
Heroin				
Inhalants (Huffing)				
Hallucinogens				
Marijuana/Hashish				
Opiates/Pain Killers				
Over-the-counter Meds				
Tranquilizers				
Crystal Meth				
Ecstasy				

Child Checklist of Characteristics

Name: ______________________________ Date: _____________________

Age _______________ Person completing this form: _______________________________________

Relationship: ______________________

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. Feel free to add any others at the end under "any other characteristics."

☐ Affectionate

☐ Argues, "talks back," smart-alecky, defiant

☐ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes.

☐ Cheats.

☐ Cruel to animals

☐ Concern for others

☐ Conflicts with parents over 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 increases or decreases, odd combinations, over eats

☐ 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
☐ Lack respect for authority, insults, dares, provokes, manipulates
☐ Learning disability
☐ Legal difficulties - truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
☐ Likes to be alone
☐ 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, 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 and circle it

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.