Batta Counseling Center

CLIENT INFORMATION FOR CHILD/ADOLESCENT

Child/Adolescent Name:_____

Date:_____ Date of Birth: _____/_____/_____ Age: _____ Gender:_____

Street Address: _____

City, State, Zip Code:_____

School Name/Grade: _____

Parent/Guardian Name: _____

Phone Number: _____cell or home?

Email Address:_____

Referred By: _____

****

Alternate Parent/Guardian
Name:_____
Relationship to Child/Adolescent:_____
Phone Number:_____ _____cell or home?
Email Address: _____

PAYMENT SOURCE

1. Batta Counseling Standard Fee is $200 for the intake and $160 for subsequent sessions. Payment at the time of service is discounted to $100 without filing for insurance. We unfortunately must charge a $40 fee for missed or late cancellations (36 hours). Please initial here _____

2. What insurance do you carry? _____

I hereby give my permission to the staff of Batta Counseling Center to render treatment and/or service to me and release information in accordance with the Notice of Privacy Practices offered to me at the initial appointment. I understand Batta Counseling Center is contracted with some, but not all, insurance companies, EAPs and Medicaid plans to provide services and that it is my responsibility to make payment in full at the time of service if my plan does not provide coverage. It is also my responsibility to make co-payments at the time of each service. In the event my account is referred to Collections/Small Claims Court for non-payment, I am responsible for all reasonable costs of collection, i.e.; attorney fees, office and court costs, etc.

Signed: _____Date_____

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Batta Counseling Center

CLIENT HISTORY FOR CHILD/ADOL

This form has been developed to help plan the services that are best for your child. Please complete the form as thoroughly as possible.

Child's Name _____ **Date** _____

Birthdate_____

GENERAL

Why are you seeking counseling for this child?

_____

_____

_____

Custody Status of Child: _____ Birth parents (if so, are parent's married?) _____Yes _____No
_____ Mother only _____ Ward of court
_____ Father only _____ Ward of DFC
_____ Adopted _____ Other relative(s)

If parents are divorced/separated, what is visitation schedule? _____

Please list that child lives with, listing custodian parent(s) first followed by brothers, sisters and others:

Full Name	Relationship	Age	Occupation or Grade level

Is there any sibling children not living in the home with the child?

_____
_____

Is there any family history of hearing problems, learning problems or ADHD (hyperactivity)?

_____
_____

Has the child ever lived out of the home or with someone else? _____

Does the child get along with others in the home? _____

How easily does the child make friends? _____

Has it been difficult to keep babysitters or get someone to watch the child? _____

Has the child ever had difficulty with behaviors in the following places? If yes, please describe.

School _____Yes _____No (___) Age _____
Home _____Yes _____No (___) Age _____
Church _____Yes _____No (___) Age _____
Bus _____Yes _____No (___) Age _____

What methods of discipline have you tried:

_____ Spanking/slapping _____ Time outs _____Behavior charts

_____ Removing privileges _____ Taking away nice things _____Others

What worked? _____

Who disciplines the child? _____

Please check all of the following that happened in the child's life in the past 12 months:

_____ Parents divorced/separated _____ Family illness _____Moved
_____ Parent changed/lost job _____ Family accident/death (s)
_____ Family financial issues _____ Child changed schools _____Other

Please check all of the following that apply the child:

_____ Has been physically abused _____ Has physically assaulted someone
_____ Has been sexually abused _____ Has sexually assaulted someone
_____ Has witnessed sexual abuse _____ Has witnessed physical abuse

Do you believe your child has had any involvement in drugs/alcohol/inhalants?
_____Yes _____No If yes, please explain_____

Please list the child's interests (computers, video games, reading, etc.)
_____
_____

SCHOOL

Current School_____ Teacher_____
Does the child like school _____Yes _____No Grade_____

	Grades Made	Teacher Comments
Head Start or Preschool		
Kindergarten		
Grades 1-3		
Grades 4-6		
Grades 7-15		

Has the child received any special services at school (i.e., guidance counseling, speech or language therapy, classes for slow learners, emotional disorders classes)? _____Yes _____No
If yes, please explain_____

Has the child ever been retained, suspended or expelled from school? _____Yes _____No
If yes, please explain_____

DEVELOPMENTAL HISTORY

Were there any problems with the child's birth? _____Yes _____No
If yes, please explain_____

Did either the father or mother use drugs/alcohol prior to or during pregnancy? _____Yes _____No
If yes, please explain_____

At what age did the child do the following: Sit up _____ Crawl _____ Walk _____
Speak more than a single word _____
Say two or more words together _____
Becomes toilet trained _____

Please describe any speech problems _____

ADOLSCENCE (please skip if not applicable)

Indicate by checkmark and age any items that apply to the adolescent.

____Breast Development (___) Age
____Development of Body Hair (___) Age
____Growth Spurt Start (___) Age
____Embarrassed by Appearance (___) Age
____Voice Changes (___) Age
____Interest in Others (___) Age
____Dating (___) Age

MEDICAL

Vision problems? _____Yes _____No Glasses _____Yes _____No

Hearing problems/earaches? _____Yes _____No

If yes to any, please explain _____

Gross motor coordination (bike riding, climbing, and running) is ___Good ___Fair ___Poor.

Fine motor coordination (writing, drawing, and crafts) is ___Good ___Fair ___ Poor

Check all of the following conditions that your child/adolescent has ever experienced:

___ Asthma ___Kidney problems ___Heart problems
___ Diabetes ___Mumps ___Chicken pox
___ Measles ___Whooping cough ___Scarlet fever
___Pneumonia ___Encephalitis ___ Otitis media
___ Seizures ___Lead poisoning ___Use IV drugs
___ HIV/AIDS ___Multiple sexual partners
___ Allergies _____

Has the child ever had any serious accidents resulting in injury? _____Yes _____No
If yes, please explain_____

Has the child had any surgery _____Yes _____No
If yes, please explain_____

Does the child have sleep problems? _____Yes _____No
If yes, please explain_____

Does the child have eating problems? _____Yes _____No
If yes, please explain _____

The child's height is _____ and weight is _____.

Is your child taking any medications? _____Yes _____No

If yes, please explain _____

Please list any other medications the child has taken in the past and any reaction to them.
_____
_____

Please list your child's physician(s):
Name: _____ Address: _____ Phone: _____
Name: _____ Address: _____ Phone: _____

Has your child ever had intelligence testing? _____Yes _____No
If yes, please explain

Has your child ever had learning disability testing? _____Yes _____No
If yes, please explain_____

Has your child ever had neurological testing? _____Yes _____No
If yes, please explain _____

Has your child ever had a physical therapy/evaluation? _____Yes _____No
If yes, please explain _____

Has your child ever had previous counseling, residential treatment, individual, group or family treatment? _____Yes _____No
If yes, please explain _____

DESIRED GOALS FOR YOUR CHILD IN TREATMENT ?

INDIVIDUAL _____

FAMILY _____

SOCIAL _____

Signature of Person Completing Form _____

Relationship_____ **Date** _____

Clinician's Summary

_____

_____

_____

_____

_____

_____

_____

Clinician's Signature _____ **Date**_____

BATTA COUNSELING CENTER

CLIENT SELF/PARENT ASSESSMENT

Client Name: _____

Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you, or your child if parent, are affected by each by circling the appropriate number. Please circle one number for every item.

Not a Problem - 1	A Slight Problem - 2	A Moderate Problem - 3	A Serious Problem - 4	A Severe Problem - 5

I. PHYSICAL FUNCTIONS

01	Sleep Pattern	1	2	3	4	5
02	Eating Pattern	1	2	3	4	5
03	Bladder Control	1	2	3	4	5
04	Bowel Control	1	2	3	4	5
05	Seizures or Convulsions	1	2	3	4	5
06	Speech (stuttering/stammering)	1	2	3	4	5
07	Weight Problem	1	2	3	4	5
08	Sexual Functioning	1	2	3	4	5
09	Other_____	1	2	3	4	5

II. EXPERIENCE AT WORK/SCHOOL

10	General Performance	1	2	3	4	5
11	General Satisfaction	1	2	3	4	5
12	Lateness	1	2	3	4	5
13	Absenteeism	1	2	3	4	5
14	Negative Feelings @ Work	1	2	3	4	5
15	Relating to Supervisors	1	2	3	4	5
16	Relating to Co-Workers	1	2	3	4	5
17	Relating to Supervisees	1	2	3	4	5
18	Other_____	1	2	3	4	5

III. BEHAVIOR

19	Difficulty w/Daily Routine	1	2	3	4	5
20	Letting Others Take Advantage of You	1	2	3	4	5
21	Hyperactivity (can't sit still)	1	2	3	4	5
22	Repeating Certain Acts Again and Again	1	2	3	4	5
23	Physically Abusing Others	1	2	3	4	5
24	Alcohol Use to Cope w/Problems	1	2	3	4	5
25	Drug Use to Cope w/Problems	1	2	3	4	5
26	Lying	1	2	3	4	5
27	Stealing	1	2	3	4	5

Not a Problem - 1	A Slight Problem - 2	A Moderate Problem - 3	A Serious Problem - 4	A Severe Problem - 5

IV. BEHAVIOR (CONTINUED)

28	Withdrawing from Others Socially	1	2	3	4	5
29	Dependency (relying on others to make your decisions and take care of you)	1	2	3	4	5
30	Suspiciousness (questions other people's motives)	1	2	3	4	5
31	Hostility (feeling angry toward others)	1	2	3	4	5
32	Other_____	1	2	3	4	5

V. FEELINGS AND MOODS

33	Depression (sadness)	1	2	3	4	5
34	Euphoria (feeling "high")	1	2	3	4	5
35	Sudden Changes in Mood for No Apparent Reason	1	2	3	4	5
36	Anxiety (nervousness)	1	2	3	4	5
37	Lack of Energy	1	2	3	4	5
38	Feeling Angry	1	2	3	4	5
39	Not Liking Self	1	2	3	4	5
40	Not Liking Others	1	2	3	4	5
41	Other_____	1	2	3	4	5

VI. INNER THOUGHTS AND IDEAS

42	Thoughts about Hurting Yourself	1	2	3	4	5
43	Having Unwanted Thoughts Again and Again	1	2	3	4	5
44	Worrying About Your Health	1	2	3	4	5
45	Believing You Are Inferior to Others	1	2	3	4	5
46	Believing You Are Better Than Others	1	2	3	4	5
47	Seeing Things Without Apparent Cause	1	2	3	4	5
48	Hearing Things Without Apparent Cause	1	2	3	4	5
49	Experiencing Confusion	1	2	3	4	5
50	Memory	1	2	3	4	5
51	Other_____	1	2	3	4	5

BATTA COUNSELING CENTER

CLIENT RIGHTS

Each participant has the following rights:

1. A patient is entitled to services in accordance with standards of professional practice; appropriate to their needs; and designed to afford a reasonable opportunity to improve the patient's condition.
2. Right to be informed of the various steps and activities involved in receiving services which includes:
   (1) The nature of the treatment or habilitation program proposed.
   (2) The known effects of receiving and of not receiving the treatment or habilitation.
   (3) Alternative treatments or habilitation programs, if any
3. Right to confidentiality under federal and state laws relating to the receipt of services. (see "Confidentiality" section below)
4. Right to make an informed decision whether to accept or to refuse treatment. A voluntary participant, who has not been adjudicated incompetent, is entitled to refuse to submit to treatment. An involuntary participant who wishes to refuse to submit to treatment is entitled to refuse to submit to treatment. An involuntary participant who wishes to refuse to submit to treatment is entitled to petition the committing court or hearing officer for consideration of the treatment. In the absence of such a petition, the program may proceed with the proposed treatment. Whenever a participant gives an informed consent to receive services of the program, consent must be made in writing and included in the participant's record.
5. Right to humane care and protection from harm, abuse and neglect.
6. Patients have the right not to be secluded or restrained. Agency will employ de-escalation techniques and, if necessary, will call upon outside authorities for help (e.g. police, EMS etc.)
7. Right to practice the participant's religion.
8. Right to contact and consult with counsel and private practitioners of the participant's choice at the participant's expense.
9. A patient is entitled to exercise the patient's constitutional, statutory, and civil rights except for those rights that have been denied or limited by an adjudication or finding of mental incompetency in a guardianship or other civil proceeding. This section does not validate the otherwise voidable act of an individual who was:
   (1) mentally incompetent at the time of the act; and (2) not judicially declared to be mentally incompetent .
10. Right to inspect and copy the participant's case record. A participant's review of the participant's case record shall be recorded in the case record. Any denial of the participant's right to review the participant's record shall be recorded in the participant's record, together with the reasons for denial of the review. By policy the drug court may permit the withholding from the participant all or part of the participant's record if:
    a. withholding is necessary to protect the confidentiality of other sources of information;
    b. it is determined that the information requested mat result in harm to the physical or mental health of the participant or another person;
    c. the consent was not given freely, voluntarily, and without coercion; or
    d. granting the request will cause substantial harm to the relationship between the participant and the certified drug court or to the certified drug court's capacity to provide services in general.
11. Waiver of rights. A participant may waive any of the rights enumerated in subsection "(2)" of this Section if the waiver is given voluntarily and knowingly. Any waiver shall be in writing and documented in the participant's record. The waiver may be withdrawn at any time, and in no event may admission to a program be conditioned upon the giving of such a waiver.
12. Investigation of violation of participant rights. A procedure for the review, determination, and amelioration of instances of alleged violations of a participant's rights shall be established by policy in accordance with the following:
    (A) Cases of alleged violation of a participant's rights are investigated through the use of the established Grievance Policy (see Privacy Officer for more details).
    (B) The results of the investigation of cases of alleged violation of a participant's rights are entered in the participant's record and the personnel file of the staff members involved.

Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser, unless:

(1) The patient consents in writing; OR

(2) The disclosure is allowed by a court order; OR

(3) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation; OR (4) The patient commits or threatens to commit a crime either at the program or against any person who works for a program.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 for federal laws and 42 CFR part 2 for federal regulations.)

MY SIGNATURE BELOW CONFIRMS THAT I HAVE RECEIVED AN ORAL EXPLANATION OF MY RIGHTS AND THAT I ALSO RECEIVED A HARD-COPY OF THIS FORM:

_____ _____

Parent/Guardian/Authorized Representative Date

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BATTA COUNSELING CENTER

NOTICE OF PRIVACY PRACTICES

Effective 9/1/13

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who will follow this notice?

Batta Counseling Center provides counseling services to our clients in partnership with other professionals and organizations. The privacy of information practices in this notice will be followed by:

- Any health care professional that treats you at either of our locations.
- All staff within our organization.
- Any business associate or partner of Batta Counseling Center with whom we share PHI.

What is done with your Protected Health Information (PHI)?

We understand that PHI about you is personal and we are committed to protecting that information. To provide you with quality care and to comply with legal requirements, we create a record of the care and services you receive here which is **your chart.** Since we are required by law to do so, we will:

- Keep PHI about you private.
- Give you notice of all up-to-date privacy policies.
- Follow the terms of the notice.

What if there are changes in our policy?

We may change our policies at any time, which could apply to the PHI information we already have about you and any new information after the change occurs. Before we make a significant change in our policies, however, we will change our notice and post it in the waiting areas. You can receive a copy of the latest notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register at our office for treatment.

When would we use and disclose Protected Health Information (PHI) about you?

- We may use and disclose PHI information about you for treatment (such as sending PHI information about you to a specialist as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company, Medicaid or Medicare); and to support our health care operations (such as comparing client data to improve treatment methods).
- We may use or disclose PHI about you without your prior authorization for other reasons. Subject to certain requirements, we may give out PHI about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections and emergencies. We also disclose PHI information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.
- We also may contact you for appointment reminders or to fill short-notice vacancies.

Other uses of Protected Health Information (PHI).

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing PHI about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding Protected Health Information (PHI) about you.

- In most cases, you have the right to look at or get a copy of PHI that we use to make decisions about your care when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related expenses. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe information in your record is incorrect or if important information is missing, you have the right to request that we correct the records by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us, if it is not part of the PHI maintained by us, or if we determine that the record is accurate. You may appeal in writing a decision by us not to amend a record.

- You have the right to a list of those instances where we have disclosed PHI about you other than for treatment, payment, health care operations or where you specifically authorized a disclosure when you submit a written request. The request must state the time period desired for the accounting – which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper form. The first disclosure list request in a 12-month period is free. Other requests will be charged according to our cost of producing the list. We will inform you of the cost prior to preparation of the list.
- You have the right to request that PHI about you be communicated to you in a confidential manner. For example, sending mail to an address other than your home, or by notifying us in writing of the specific way or location for us to use to communicate with you.
- You may request in writing that we not use or disclose PHI about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision upon your request.
- You have the right to and will be notified if there has been an unsecured breach of your PHI.

All written requests or appeals should be submitted to our Privacy contact listed at the bottom of this notice.

Complaints

- If you are concerned that your privacy rights may have been violated or you disagree with a decision we made about access to your records, you may contact our Privacy Officer.
- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.
- Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Officer:

Janelle Batta, Owner
Batta Counseling Center
920 Kathy's Way, Suite C
Greensburg, IN 47240
(812) 222-2626
(812) 222-2627 (FAX)

BY SIGNING BELOW I UNDERSTAND AND AGREE TO THE ABOVE NOTED PRIVACY POLICY:

_____ date: _____
Parent/Guardian/Authorized Representative

BATTA COUNSELING CENTER

TREATMENT AUTHORIZATION AND SERVICES CONTRACT *BATTA COPY*

PLEASE READ CAREFULLY AND SIGN WHERE INDICATED

Welcome to our practice and thank you for seeking services here. We have established office policies to allow us to provide high quality services to you and your family. This contract contains information about our professional services and business policies. Please read it carefully and discuss any questions you may have with your therapist. Your signature on the last page of this contract indicates your agreement with the information in the contract.

DESCRIPTION OF COUNSELING SERVICES

Psychiatry/psychology/social work is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems presented. There are a number of different approaches that can be utilized to address the problems you and/or your family would like to address. It is not like a visit to your medical doctor in that it will require a very active effort on your part. In order to be most successful, you will have to work both during your sessions and at home.

Therapy has both risks and benefits. Risks sometimes include experiencing uncomfortable feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Therapy often requires recalling unpleasant aspects of your history. Therapy has also been shown to have benefits as it often leads to significant reductions of feelings of distress, better relationships, and resolutions of specific problems. However, there are no guarantees about what will happen.

Your signature at the end of this contract verifies that you give your Batta Counseling Center therapist permission to counsel and provide therapy to or on behalf of the person named on the CLIENT INFORMATION FORM. You may withdraw this permission at any time.

MISSED/BROKEN APPOINTMENTS

We require at a minimum 24 hour notice for appointment cancellations. Without such we find it difficult to maintain our schedule. If this advance notice is not received, there will be a **$40 charge** for the missed/broken appointment.

RESPONSIBILITY FOR FEES

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance, however you are responsible for co-payment amounts and deductibles as set by your benefit plan. These payments are due and payable at each appointment. It is important that you make yourself aware of the benefits provided by your plan and if Batta Counseling Center's services are covered by the plan. Though we have access to some insurance information and may anticipate your benefits, we in no way guarantee such benefits.

INSURANCE

Your signature authorizes this office to release information required by your insurance carrier or other third party payer for the processing and payment of claims for services rendered. Your signature also authorizes your insurance carrier or other third party payer to make payment directly to this office.

UNPAID ACCOUNTS

Accounts on which there is not payment activity for 90 days may be referred to an outside agency for collection. Checks returned for insufficient funds will incur a $15.00 service fee.

EMERGENCIES

If you find yourself in an acute emergency that requires immediate attention, you should consider using the emergency services available through the ER of Dearborn County Hospital or Margaret Mary Hospital. You may also consider using a facility specified by your insurance plan.

CONFIDENTIALITY

In general, the confidentiality of all communication between a client and therapist is protected by law and we can only release information about our work to others with your written permission. However, there are exceptions and they are outlined in the Notice of Privacy Practices that has been provided to you.

Indiana law requires the following statement:

I, the undersigned, agree and consent to participate in the mental health services offered and provided by Batta Counseling Center mental health providers as defined by Indiana law.

I understand that I am consenting and agreeing only to those mental health services that the above referenced provider is qualified to provide within:

a) the scope of the provider's license, certification, and training; or

b) the scope of license, certification, and training of those mental health providers directly supervising the services received by the client.

_____ date: _____

Parent/Guardian/Authorized Representative

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c) the scope of the provider's license, certification, and training; or

d) the scope of license, certification, and training of those mental health providers directly supervising the services received by the client.

No signature required. This is your copy to keep for your reference. date: _____