Steve Barns & Associates
The Counseling Center
of Denton Bible Church
Christian Counseling Services
Individual, Marriage, & Family

Phone: (940) 297-6893
Fax: (940) 387-3009
counseling@dentonbible.org
2121 Nottingham Drive
Denton, Texas 76209

Adolescent Intake Form

All information on this form pertains to the child or adolescent being counseled.
Please provide the most appropriate contact information for the parent or legal guardian of the child or adolescent.

Child's Name: _____ _____ _____
Last First MI

□ Male □ Female _____/_____/_____ _____
Date of Birth Age

Email:_____@_____ Home: (____) _____-_____ Cell: (____) _____-_____

Address: _____ _____
Street (or P.O. Box) Apt. #

_____ _____ _____
City State Zip Code

Form Completed By: _____ _____ _____
Last First MI

Relationship to counselee: _____

Child/Adolescent and Siblings

Relationship to counselee: Biological: □ B Through Marriage: □ TM Adopted: □ A Foster: □ Fs

□ B □ TM □ A □ Fs _____ Age _____ □ M □ F

□ B □ TM □ A □ Fs _____ Age _____ □ M □ F

□ B □ TM □ A □ Fs _____ Age _____ □ M □ F

□ B □ TM □ A □ Fs _____ Age _____ □ M □ F

□ B □ TM □ A □ Fs _____ Age _____ □ M □ F

□ B □ TM □ A □ Fs _____ Age _____ □ M □ F

□ B □ TM □ A □ Fs _____ Age _____ □ M □ F

Religious Affiliation

My child attends church at _____.

Attended since: _____ /_____. He/she attends: □ Every Sunday □ Most Sundays □ Occasionally

I attend □ Yes □ No My spouse attends □ Yes □ No

Would you like for your child to receive counseling from a biblical perspective? □ Yes □ No

You and your child do not have to be Christians to receive counseling here. We take your personal beliefs very seriously and will always respect them. We want you and your child to feel free to express your values and beliefs and how they affect the way you live. While we will always respect you and your child's beliefs we may encourage you both to consider what we believe to be biblical truths that, if applied to your lives, will help you live more fulfilling, meaningful lives. Our goal is to introduce ideas during our conversations that will encourage your child to change how he/she is living in ways that will be beneficial and enriching.

_____ _____ /_____ /_____
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Required Documentation

If there is an existing legal document detailing custody arrangements and/or legal guardianship a copy of the document is required before counseling begins.

If the child's parents are separated or divorced ***signatures of both parents*** *are required before counseling begins.*

Father: _____ _____ _____
Last First MI

_____
Signature

Mother: _____ _____ _____
Last First MI

_____
Signature

Legal Guardian: _____ _____ _____
(if different) Last First MI

_____
Signature

Personal Information

For what specifically are you seeking counseling today? _____

_____

_____.

What recent event(s) prompted you to seek counseling for your child? _____

_____

_____.

How have you attempted to change the situation? _____

_____

_____.

What are your expectations in coming here? _____

_____

_____.

Describe your child/adolescent. _____

_____

_____.

_____ ____/____/____
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Describe briefly any significant event(s) in your child's development (physical, psychological, emotional, intellectual, social, spiritual, academic) which may have impacted the current situation. _____

_____

_____

_____.

To what extent is the current problem negatively affecting your child? □ Mildly □ Moderately □ Severely

My child's greatest source(s) of satisfaction is/are: _____

_____

_____.

My child's greatest source(s) of frustration is/are: _____

_____

_____.

My child's favorite leisure activities are: _____

_____

_____.

Describe your child's typical day. _____

_____

_____.

What areas of your child's life are being impacted by the current problem? How has it been impacted?
(check all that apply and briefly explain)

□ Lifestyle (how your child typically lives his/her life) _____

_____.

□ Activities (things your child typically engages in) _____

_____.

□ School related performance and behavior _____

_____.

□ Relationships with family members (immediate, extended) _____

_____.

□ Relationships with others (friends, classmates, etc.) _____

_____.

□ Other _____

_____.

_____ _____/_____/_____
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Indicate the significance (1-very little ——5-a great deal) any of the following play in your child's current situation.

____Anger
____Bed wetting
____Disturbing memories (traumatic events, abuse, neglect, etc.)
____Drug, alcohol use
____Eating problems (purging, bingeing, overeating, hoarding)
____Excessive risky behavior (spending, gambling, etc.)
____Family finances
____Family vacations
____Father's emotional well-being
____Father's physical well-being
____Fears, phobias
____Friends visiting the home
____Going out as a family other than to eat
____Illegal behavior (truancy, running away, theft, etc.)
____Learning, academic difficulty
____Leisure time spent together as a family
____Life change adjustment (parents' divorce, move, loss or death of someone close, etc.)
____Loneliness
____Making and/or keeping friends
____Mealtimes spent together as a family
____Mother's emotional well-being
____Mother's physical well-being
____Physical aggressiveness
____Physical complaints, medical problems
____Physical, emotional, sexual abuse
____Relationship between parents
____Relationship between parents and counselee
____Relationships between parents and siblings
____Relationships between siblings and counselee
____Religious or spiritual issues
____Sadness, depression, talk of suicide not related to grief
____Sadness, depression, talk of suicide related to grief
____Self-esteem issues
____Sexual behavior issues
____Sexual identity issues
____Siblings' emotional well-being
____Siblings' physical well-being
____Sleep problems (too much, not enough, nightmares, etc.)
____Social skills (routine interactions with others)
____Stress
____Talk of hurting others
____Time counselee spends with relatives
____Time family spends with relatives
____Time father spends with the child's siblings
____Time father spends with the counselee
____Time mother and father spend together
____Time mother spends with the child's siblings
____Time mother spends with the counselee
____Unusual behavior (bizarre actions, movements, speech, impulsiveness, etc.)
____Unusual experiences (amnesia, imagining things, etc.)
____Visiting friends' homes

Briefly describe anything you noted above. _____

_____

_____

_____.

_____ _____/_____/_____
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Has your child ever attempted suicide? □ Yes □ No

If so, how many times? ____ When? ____ /____ , ____ /____ , ____ /____

By what means? _____.

Has your child ever physically harmed another person? □ Yes □ No

Is there a history of suicide in your immediate or extended family? □ Yes □ No

Are you aware of your child presently having thoughts of harming himself/herself or someone else?

□ Yes □ No

Please describe any of the following that apply to members of your child's family.

Drug or alcohol abuse: _____

_____

_____.

Physical, verbal, or sexual abuse: _____

_____

_____.

Mental health issues (depression, anxiety, bi-polar disorder, etc.): _____

_____

_____.

Share anything else you believe might be helpful for your child and his/her counselor. _____

_____

_____

_____

_____.

Medical Information

How would you characterize your child's physical health? □ Excellent □ Good □ Fair □ Poor

Who is your child's pediatrician or physician? _____

Does your child see him/her □ Regularly □ As needed

List any medical problems your child currently has. _____

_____.

List any medications your child currently takes for physical problems. _____

_____.

Has your child ever been hospitalized for medical reasons? □ Yes □ No If so, please explain. _____

_____

_____.

_____ ____/____/____
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Mental Health Information

Is your child currently under a mental health professional's care (psychiatrist, psychologist, counselor)?
□ Yes □ No

If so, who? _____

Has your child received counseling or psychiatric care in the past? □ Yes □ No

When? ____/_____ , ____/_____ , ____/_____

How long? ____ yrs. ____ mos.

From whom? _____

For what reason? _____

_____.

Has your child ever been given a mental health diagnosis by a mental health professional? □ Yes □ No

If so, what was the diagnosis? _____.

Do you believe the diagnosis was accurate? □ Yes □ No Why or why not? _____

_____

_____.

List any medications your child currently takes for diagnosed psychiatric issues or for other mental health reasons (depression, anxiety, etc.). _____

_____.

Has your child ever been hospitalized for mental health reasons? □ Yes □ No

If so, please explain. _____

_____

_____.

_____ ____/____/____
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Notice of Privacy Practices

This notice describes how health information about your child may be used and disclosed and how you, as the child's parent or legal guardian, can get access to this information. Please review it carefully.

The privacy of your child's information is important to us.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your child's health information. We are also required to give you this notice about our privacy practices, our legal duties, and you and your child's rights concerning this health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices we will change this notice and make a new notice available upon request.

Uses and Disclosures for Treatment, Payment, and Healthcare Operations

We may use or disclose your child's protected health information (PHI), for treatment, payment, and healthcare operations purposes. To help clarify these terms, here are some definitions:

PHI refers to information in your child's health record that could identify him or her.

Treatment is when we provide, coordinate, or manage your child's healthcare and other services related to his or her healthcare. An example of treatment would be when we consult with another healthcare provider, such as your child's family physician, pediatrician, or other practitioner.

Payment is when we obtain financial compensation for your child's healthcare. Examples of payment are when we disclose your child's PHI to your child's health insurer to obtain reimbursement for his or her healthcare or to determine eligibility or coverage.

Healthcare Operations are activities that relate to the performance and operation of our practice. Examples of healthcare operations are quality assessment and improvement activities; business-related matters, such as audits and administrative services; and case management and care coordination.

Use applies only to activities within Steve Barns & Associates, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies your child.

Disclosure applies to activities outside of Steve Barns & Associates, such as releasing, transferring, or providing access to information about your child to other parties. We may disclose to a family member, other relative, a close personal friend, or any other person identified by you as your child's parent or legal guardian, the health information that is directly relevant to such person's involvement with your child's care or payment related to your child's healthcare.

Counseling Notes are notes we have made about our conversation with your child during a private, group, joint, or family counseling session, which we have kept separate from the rest of your child's medical record. These notes are given a greater degree of protection than PHI.

As a minor your child's right to confidentiality does not extend as far as an adult's in most cases. However, your child's counselor has discretion in most cases about what will be discussed with you, as the child's parent or legal guardian.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. An "authorization" is written permission that is above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment, and healthcare operations, we will obtain an authorization from you, as your child's parent or legal guardian, before releasing this information. We will also obtain a separate authorization before releasing your child's counseling notes.

You, as your child's parent or legal guardian, may revoke all such authorizations (of PHI or counseling notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

_____ _____/_____/_____
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Uses and Disclosures without Consent or Authorization

We may use or disclose PHI without your consent or authorization, as your child's parent or legal guardian, in the following circumstances:

Child Abuse: If we have cause to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or some other local or state law enforcement agency.

Adult and Domestic Abuse: If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Services.

Health Oversight: If a complaint is filed against us with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from us relevant to that complaint.

Judicial or Administrative Proceedings: If your child is involved in a court proceeding and a request is made for information about his or her diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you, as your child's parent or legal guardian, your personal or legally appointed representative, or a court order. The privilege does not apply when your child is being psychologically evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If we determine that there is a probability of imminent physical injury by your child to himself or herself, or others, or there is a probability of immediate mental or emotional injury to your child, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

Worker's Compensation: If you file a worker's compensation claim on your child's behalf we may disclose records relating to your child's diagnosis and treatment to his or her employer's insurance carrier.

Patient Rights

Right to Request Restrictions: You have the right to request restrictions, as your child's parent or legal guardian, on certain uses and disclosures of protected health information about your child. However, we are not required to agree to a requested restriction.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of PHI in our mental health and billing records used to make decisions about your child for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment, as your child's parent or legal guardian, of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor given authorization (as described previously). On your request, we will discuss with you the details of the accounting process.

_____ _____/_____/_____
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Questions or Complaints

For more information about our privacy policy, or if you have questions or concerns, please contact us. If you are concerned that we have violated your child's privacy rights, or you disagree with a decision we made about access to your child's records, you may complain to us using the contact information given below. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Should you wish to contact the Texas State Board of Examiners of Professional Counselors, the address is: Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369.

Office Manager: Meg Hamilton
Email: counseling@dentonbible.org
Phone: 940-297-6893
Fax: 940-387-3009
Physical address: 2121 Nottingham Dr., Denton, Texas, 76209
Mailing address: 2300 E. University Dr., Denton, Texas, 76209

Acknowledgement of Receipt of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.
Printed name

_____ _____ /_____ /_____
Signature of parent or legal guardian Date

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Child's parent or legal guardian refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other

(Specify)_____.

_____ _____ /_____ /_____
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Fees

We offer several options regarding our fees. The fee will vary, depending on the certification and experience level of your child's counselor. Some counselors can file on your insurance. Some of our counselors offer a sliding scale as a way of making counseling more affordable for all who need it. The office manager will go over the options with you at the time of scheduling your first session.

The following is our current fee structure:

Steve Barns, LPC-S, LMFT————Sliding scale, some insurance
Mary Winter, LPC————————Sliding scale
Alex Kelley, Biblical Counselor———$45.00/session
Randy Nickerson, LPC————————Sliding scale
Ashley Davis, LPC————————Sliding scale
Bonny Pierce, CTPSC————————$45.00/session
All Lay Biblical Counselors————No charge

Sliding Scale

Gross Family Income	*Fee*	
$65,000 or more	$85	□
$50,000-$64,999	$75	□
$40,000-$49,999	$65	□
$30,000-$39,999	$55	□
$0-$29,999	$45	□

Please indicate what the appropriate fee would be for your child, based on your family income.

Payment is typically made at the time of the session. We accept cash, checks, and debit or credit cards. If you have concerns or unanswered questions your counselor will be glad to spend time discussing the fee structure with you. Often payment arrangements can be made if the cost represents a difficulty for you.

Insurance

If your child is covered under a managed care insurance plan that requires pre-certification, please contact your insurance provider to determine whether or not your child's counselor is a network provider and to verify benefits. If you are out of network, we will provide a receipt upon request so that you may file for reimbursement.

Cancellation of Appointments

Due to scheduling demands, we require a 24 hour notice to cancel or reschedule a session. Because we understand that emergencies do occur, whether or not you are charged for insufficient notice will be at the discretion of your counselor.

Informed Consent

I understand issues may be discussed during counseling that could be upsetting in nature and that this may be necessary to help my child resolve his or her problems.

I understand records and information collected about my child will be held and released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require my child's therapist to report all cases in which there exists a danger to others or my child, such as suspected abuse or neglect of minors or vulnerable adults.

I understand there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand if I have a managed care insurance plan that offers reimbursement for counseling services, I must indicate that at the time I complete my child's initial paperwork and call my insurance company to authorize therapy sessions. If I am out of network, I understand it is my responsibility to file for reimbursement. Steve Barns & Associates will supply a receipt that will have all information needed to process the claim.

I agree to pay my child's counseling fees in a timely manner as arranged at the time of his or her first session. Should a third party other than insurance agree to pay for the sessions, I agree to allow Steve Barns & Associates to release billing information to the third party.

I have read and understand the above terms and conditions of my child's treatment and agree to the content of this document.

_____ ____ /____ /____
Signature of parent or legal guardian Date

_____ ____ /____ /____
Counselee Name Today's Date

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Health insurance information

Fill out only if you have insurance that will pay for your child's counseling.

Name of insured _____

_____ _____ _____
Street or P.O. Box City State, Zip

Counselee's relationship to the insured: □ Son/Daughter □ Other _____

Insured's birth date: ____ /____ /____ Insured's SS #: __ ___-_____-_____

Insured's ID #: _____ Group #: _____

Insured's phone: (____) _____-_____ Insured's email: _____@_____

Insured's employer: _____

Insurance company: _____

Claim form address: _____ _____ _____
Street or P.O. Box City State, Zip

Insurance company phone: (____) _____ _____

Deductible amount to be met: $_____.

Co-pay amount per session: $_____.

Provide the following information to your insurance company:

Provider's name:
Steven Barns, LPC, LMFT, or Robert Steven Barns, LPC, LMFT
2300 E. University Dr.
Denton, TX 76209

Billing CPT codes (if requested):
Initial visit—90791
Subsequent visits—90834

Authorization to release information to process claims

I hereby authorize direct payment of mental health benefits to Steve Barns & Associates for services rendered through this office.

I understand that I will be financially responsible for any balance not covered by insurance.

I □ do □ do not want my child's primary care physician or pediatrician notified.

Physician or Pediatrician: _____

Address: _____ _____ _____
Street or P.O. Box City State, Zip

_____ _____ /_____ /_____
Signature of parent or legal guardian Date

_____ ____ /____ /____
Counselee Name Today's Date