

Summit Counseling Center

6400 Lee Highway, Suite 106

Chattanooga, TN 37421

423-855-0402

PARENTAL CONSENT FORM

I _____ do hereby give my
(Name of Parent or Legal Guardian)

Parental/ Custodial consent for _____
(Name of Minor Counselee)

to receive counseling from _____
(Name of Counselor or Intern)

at the Summit Counseling Center.

Signed _____ *Date* _____

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423-648-9369, fax

Important Information! Please READ, then INITIAL Below

Financial Policy:

We expect payment in full before your session begins. We accept cash and checks, along with VISA, Master Card & Discover. If you know you will be unable to pay at the time of service, please call us to make prior arrangements or to reschedule your appointment.

Insurance Policy:

Our Counselors work independently—not all of our counselors accept insurance.

- *Please check with our office staff for a list of Summit Counselors who are currently accepting insurance and to find out which insurance company each is contracted with.*
- *Some of our counselors are in-network with Blue Cross Blue Shield and United HealthCare*
- *We are not in-network with any other insurance company so if you wish to file under an insurance plan other than BCBS & UHC, you will need to call the number on your card to find out if you have out of network benefits for behavioral health.*
- *Some of our counselors accept TennCare through AmeriChoice, BlueCare & Premier*

WE ARE UNABLE TO ACCEPT MEDICARE (as Medicare requires that patients see a Psychologist or Psychiatrist) – we are NOT allowed to file Medicare at all.

Those whom we file insurance for must understand that you are **responsible for the full fee until your deductible is met**, co-pays and non-covered charges.

Appointments:

Our patients are seen by appointment Monday—Thursday.

We require a 24-HOUR NOTICE OF CANCELLATION. THE STANDARD FEE WILL BE CHARGED IF YOU CANCEL THE APPOINTMENT WITHIN 24-HOURS OF THE SCHEDULED TIME OR IF YOU CHOOSE TO SIMPLY NOT SHOW FOR THE APPOINTMENT.

HIPPA Rules and Regulations:

Summit Counseling Center is in compliance with HIPPA Confidentiality Rules and Regulations.

Client's Initials (Parent or Legal Guardian if patient is a minor) _____



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Nature of Counseling Services

In fulfilling its explicit mission, this counseling center offers counseling services to individuals, couples and families who are seeking Biblically based counseling. The type of counseling provided is Biblical in nature, orientation, and application. The counselor follows a cognitive-behavioral approach that is grounded in Biblical truth. A fee is charged for certain services including testing and counseling sessions.

Confidentiality

By its nature, counseling is personal and often involves delicate issues. Information discussed in counseling sessions is held in confidence. There are three exceptions to this rule of confidentiality:

Information may be disclosed under the conditions of an order of the court.

Information will be shared if there is reason to suspect that a counselee poses a threat to self or to others and cases involving suspected child abuse. Legal statute and professional ethics mandate such reporting.

In the case of a minor, certain information may be shared with a parent(s) when it is deemed to be necessary for the best interest of the minor. This information will be discussed with the minor prior to disclosure to the parent.

Any other sharing of information will take place only upon the written request of the counselee or by prior written permission for purposes of consultation or supervision of the counselor.

Client Disclosure

All successful counseling involves honest communication between a counselee and counselor. Specifically, the counselee must believe that full self-disclosure is of paramount value with a professional and confidential relationship.

There are two areas of critical importance:

The counselee must disclose any human relational services (e.g. psychiatric, psychological, etc.) received concurrently with counseling. This includes information regarding psychotropic medications and other relevant medical services.

It is essential for the potential counselee to disclose, prior to beginning counseling, any past, current, or potential future legal involvement that may pertain to current counseling issues. (example: any impending custody disputes, civil suits, etc.)

Client Agreement

I have read the above information carefully, and I fully understand the nature of the counseling services involved.

Signature (or parent, if minor) _____

Date _____

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Payment Policy

Payment is due when services are rendered unless arrangements have been made previously with the office staff.

Agreement:

In signing below, I attest to having read the above information carefully, and fully

Print Name (of client) _____

Signature (parent or legal guardian, if patient is a minor) _____

Date _____

Counseling Inventory

Personal & Confidential Data

Instructions: Complete entire form (as much as applies)

Client Information- General

Client's Name _____ Home Phone _____ Cell Phone _____
 Address _____ City _____ State _____ Zip _____
 Do you (*child, not parent*) have a job? (circle one) YES NO If so, where? _____
 Position Worked _____ Number of hours worked each week _____ Work Phone _____
 Age _____ Birth date _____ Grade in school _____ Name of School _____
 Who referred you to counseling? _____ Phone number _____
 E-mail address (for appointment reminders) _____

Client's Health Information

Rate patient's current health: (check one) Excellent ____ Good ____ Average ____ Declining ____ Poor ____
 Are you (*client*) currently taking any medications? ____ If yes, please list _____

 Do you know of, or suspect that you may have any chemical imbalance or abnormal body functions? _____
 If so, please explain, describe, or name _____
 Identify any significant past illness, injuries, or handicaps _____
 Have you, your parents, or grandparents ever been involved with the occult or extra-natural activities? (*examples: Satanic worship, Wicca, etc.*) _____ If yes, please name or describe _____

Family Information

Do you (client) live with your biological parents? (circle one) Father and Mother Father only Mother only
 Name of Father _____ Name of Mother _____
 Marital Status of your parents: Never Married ____ Married ____ Separated ____ Divorced ____
 Have your parents ever been separated? (circle one) Yes No I don't know
 If your parents are currently separated or divorced, when did it occur? _____
 If your parents are divorced, has either of them remarried? _____ If yes, (check one) Mother ____ Father ____
 Do either of your parents live with a significant other? _____
 Are you coming to counseling at your parents' insistence or because you wanted to come? _____
 Are your parents willing to come for counseling if needed? _____ If not, please explain _____
 Father's place of employment _____ Position _____ Father's Birth date _____
 Mother's place of employment _____ Position _____ Mother's Birth date _____
 Do either of your parent's have children from another marriage or other relationship outside of marriage? _____
 If yes, do other children live in the same house as you? _____
 Please rate your parents' happiness in marriage on a scale of 1 to 10 (1 = very unhappy, 10 = very happy) _____

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Spiritual Inventory—Child

Spiritual Information (about the child, not the parent)

What church do you (patient) attend? _____ Are you a member? (circle one) Yes No

Do your parents attend church with you? (circle one) Yes No Father only Mother only

May the Pastor be contacted, if needed? _____ If not, please explain _____

Briefly explain what it means to be a Christian _____

Have you (patient) received Christ as your Savior? ___ If yes, do you sometimes have doubts about your salvation that you would like to discuss in counseling? _____

Does either of your parents profess to be a Christian? (circle one) Father only Mother only Both of them

About how often do you (patient) currently attend church each month? 0 1 2 3 4 5 6 7 8 9 10+

Please rate yourself (patient) concerning your involvement in the following activities over the last six months

(R = Regular, S = Sometimes, O = On Occasion, N = Never)

Bible Reading: R___ S___ O___ N___

Family Devotions: R___ S___ O___ N___

Prayer: R___ S___ O___ N___

Scripture Memory: R___ S___ O___ N___

Witnessing: R___ S___ O___ N___

Counseling Information (about the child, not the parent)

Have you (patient) ever been to a counselor before (including Psychologist, Clinical or Social Worker)? _____

If yes, please give name of Counselor and reason(s) why _____

Have you (patient) ever been diagnosed with a psychological disorder? ___ If yes, please describe _____

What brings you to counseling at this time? _____

Who have you discussed this issue with? _____

What do you hope the **counselor** will do in counseling (*What are your expectations?*)? _____

What do **you** (patient) expect to do in counseling? _____

How will you know when counseling is to be completed- what will need to occur before you feel you're through? Below, please list your goals:

1. _____
2. _____
3. _____

Is there any other information you want to share that you feel would be useful in helping me to better understand you or the issues that bring you to counseling at this time? _____

Name: _____

Check List

Instructions: Place a check beside current problems.
Underline anything that has been a problem in the past (last three years)

<input type="checkbox"/> Stress	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Fears	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Authority Conflict
<input type="checkbox"/> Anger	<input type="checkbox"/> Marital Problems
<input type="checkbox"/> Feelings of Guilt	<input type="checkbox"/> Family Conflicts
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Dating Conflicts
<input type="checkbox"/> Unhappiness	<input type="checkbox"/> Poor Social Relationships
<input type="checkbox"/> Shyness	<input type="checkbox"/> Eating Problems (explain _____)
<input type="checkbox"/> Inferiority	<input type="checkbox"/> Change in Appetite
<input type="checkbox"/> Self Esteem/ Self Worth Issues	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Strange Thoughts	<input type="checkbox"/> Physical Health Issues (explain _____)
<input type="checkbox"/> Body Image Concerns	_____
<input type="checkbox"/> Death and Grief	_____)
<input type="checkbox"/> Depression	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Tiredness
<input type="checkbox"/> Homicidal Thoughts	<input type="checkbox"/> Excessive Sleep
<input type="checkbox"/> Spiritual Concerns	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Procrastination	<input type="checkbox"/> Irritability
<input type="checkbox"/> Academic Problems	<input type="checkbox"/> Headaches
<input type="checkbox"/> Career/Major Choice	<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Lack of Goals	<input type="checkbox"/> Unable to Concentrate
<input type="checkbox"/> Poor Self Discipline	<input type="checkbox"/> Tightness of Chest
<input type="checkbox"/> Self Injury Abuse	<input type="checkbox"/> Shakiness
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Rapid/Skipping Heartbeat
<input type="checkbox"/> Internet Abuse	<input type="checkbox"/> Excessive Perspiration
<input type="checkbox"/> Pornography	<input type="checkbox"/> Other (explain _____)
<input type="checkbox"/> Gender Identity Problems	_____
<input type="checkbox"/> Sexual Problems	_____)