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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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 APPOINMENT 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 _____________________

Child

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? ____

____

____

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Name:____

Check List

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

___Stress	___Sexual Abuse
___Fears	___Physical Abuse
___Anxiety	___Authority Conflict
___Anger	___Marital Problems
___Feelings of Guilt	___Family Conflicts
___Loneliness	___Dating Conflicts
___Unhappiness	___Poor Social Relationships
___Shyness	___Eating Problems (explain____________)
___Inferiority	___Change in Appetite
___Self Esteem/ Self Worth Issues	___Vomiting
___Strange Thoughts	___Physical Health Issues (explain_______
___Body Image Concerns	___________________________________
___Death and Grief	___________________________________)
___Depression	___Nightmares
___Suicidal Thoughts	___Tiredness
___Homicidal Thoughts	___Excessive Sleep
___Spiritual Concerns	___Insomnia
___Procrastination	___Irritability
___Academic Problems	___Headaches
___Career/Major Choice	___Loss of Memory
___Lack of Goals	___Unable to Concentrate
___Poor Self Discipline	___Tightness of Chest
___Self Injury Abuse	___Shakiness
___Drug Abuse	___Rapid/Skipping Heartbeat
___Internet Abuse	___Excessive Perspiration
___Pornography	___Other (explain_________________________
___Gender Identity Problems	___________________________________
___Sexual Problems	___________________________________)