15 Cypress Branch Way, Suite 207D
Palm Coast, FL 32164
(386) 585-5955

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# Child-Adolescent Intake

Please provide the following information about your child:

| | |
|---|---|
| Child's Full Name: | Nickname: |
| Birth Date: | Today's Date: |
| Child's Address: | Phone: |
| Parent(s) names or primary guardian: | Parent(s) contact numbers:<br>Home:<br>Cell:<br>Work: |
| In case of emergency, who may I contact on your behalf? | Name: |
| Phone number: | Relationship: |

## Education History

| | |
|---|---|
| School child attends: | Teacher's Name: |
| Current Grade Level: | Has your child ever repeated a grade? YES/ NO If so which one(s)_____ |
| Favorite Subject: | Least Favorite Subject: |
| Does your child receive special education service?<br><br>YES /NO | Does your child receive tutoring?<br><br>YES/ NO |
| Is your child in a gifted/talented/honors program?<br><br>YES/ NO | Does your child like school?<br><br>YES/ NO |
| Has your child experienced any of the following at school? (please circle all that apply)<br><br>Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, drug/alcohol, poor attendance, behavior problems, detention, poor grades | |

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| |
|---|
| Has your child been the victim of bullying or bullied other children? YES/ NO.<br>If yes, please describe: |
| Please, use the space to provide any other additional information regarding your child's education or developmental history that you find significant: |

## Medical History

| | |
|---|---|
| Pediatrician's Name: | Phone: |
| Is child under the care of another medical specialist? YES/NO<br>If yes, type of specialist _____ | Phone: |

**Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:**

| Illness/Disability: | Dates: |
|---|---|
| | |
| | |
| | |

**List all medications that your child is currently taking:**

| **Medication:** | **Dosage:** | **Treating:** |
|---|---|---|
| | | |
| | | |
| | | |

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## Therapy / Psychiatric Experience

| | | | |
|---|---|---|---|
| Is your child *currently* seeing another therapist? YES / NO | | | |
| If yes, who are you seeing? | | | |
| Has your child ever been in therapy in the past YES/ NO | | | |
| If yes, please fill out the following on your previous therapy experience(s) | | | |
| Therapist | Location | Dates | Reason |
| | | | |
| | | | |
| | | | |
| Has your child ever had a psychiatric hospitalization? YES/ NO | | | |
| If yes describe briefly and indicate dates and circumstances | | | |
| Is your child under the care of a psychiatrist: YES/ NO | | If yes, Psychiatrist name: | |
| Phone: | | Address: | |

## Other History

| |
|---|
| Has your child ever experienced any type of abuse (physical, sexual, or emotional)? YES/ NO<br>If yes, please describe: |
| Has your child ever made statement of wanting to him/her self or seriously hurt someone else? YES/ NO<br>Has he/she purposely hurt himself or another? YES/ NO<br>If yes, to either question please describe the situation: |

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| |
|---|
| Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? YES/ NO.<br>If yes, please explain: |
| Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets him/her in trouble? YES/NO. If yes, please describe: |
| Are there any behaviors that your child fails to do as often as you would like or when you would like? |
| Please list positive strengths of your child: (What do you like about your child? What do others like about your child?) |
| How would you describe your child's self-esteem? |
| Briefly describe your reason(s) for seeking help at this time? |
| What goals do you wish to accomplish during the therapy process as a parent? |
| What goals does your child wish to accomplish during the therapy process? (can be different than parent's response) |

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## Family History

| Mother's Name<br><br>Occupation: | | Father's Name:<br>Occupation: | |
|---|---|---|---|
| Step-Mother? | | Step Father? | |
| Who does your child currently live with? | | | |
| Names | Age | Relationship to child | Grade/Job |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Who are your child's significant others NOT living with your child? | | | |
| Names | Age | Relationship to child | Grade/Job |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Are child's parents'? Married Separated Divorced Widowed (please circle one)<br>If parents divorced/separated please list dates: |
|---|
| Who in the family is your child closest too? |
| What are some of the strengths of your family? |

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| |
|---|
| |
| Has anyone in the child's family been diagnosed with a mental illness? YES/ NO<br>If yes, please describe: |
| Is there anything else that you think would be important for me to know about your child, you, or your family? |
| How did you hear about our services? Internet search? Website? |

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# Notice of Privacy Practices

Client Name_____ ID:_____

I, _____ have received a copy of the Kascel Therapy, LLC Notice of Privacy Practices

I, the undersigned, have read and understand the Notice of Privacy Practices as required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

I understand that discussions initiated by me/my child about therapy services other than in a private setting, may result in others overhearing about my child's private health information.

Kascel Therapy, LLC may discuss my child's health information with _____

---

Parent/Guardian _____
Date_____

Date: 08/01/2017

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# Record Release Form

I hereby authorize Kascel Therapy, LLC to give or receive treatment records (including reports, progress notes, discharge summary, etc.) regarding _____ _____

(Client's Name) (Date of Birth)

This consent will be in effect for one year from the date of authorization unless stated otherwise _____

Information should be released to:

_____

(Name)

_____

(Address)

_____

(City, State, Zip)

_____

(Client/Parent/Guardian)

_____

(Date)

Revised: 08/01/2017

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# Pediatric Therapy Guidelines

Kascel Therapy, LLC believes our clients achieve their greatest potential by recognizing and including their families as much as possible.

In order to maximize your child's success in our program, the following guidelines have been established:

1. Be on time for therapy. Our therapists have an active schedule and on time regular attendance will ensure your child receives all the therapy ordered by your physician.
2. Attend therapy regularly. Consistency is very important for your child to progress and maintain skills learned. If you miss two (2) consecutive appointments without prior notice or attend only 80% of scheduled therapy sessions, your child may be removed from the regular therapy schedule. Your child will then be scheduled on a week-to-week basis.
3. Notify Kascel Therapy, LLC of absences. Please call us as soon as you know that you will not be able to keep an appointment. We will reschedule your child so their benefits from therapy will not be compromised.
4. Observe therapy sessions when possible. This is a great opportunity for you to share your input and ask the therapist questions about your child's progress and goals, and learn about how you can help your child at home, between therapy appointments.
5. Stay on site. If you bring your child for therapy, you are expected to remain at Kascel Therapy, LLC until your child has completed their therapy session.
6. Express your opinions and concerns. We know that you are truly the expert on your child and your input is very valuable. Our therapists are interested in your input and want to answer questions about your child's progress.
7. We will notify you of any cancelled appointment due to illness or unavailability of your therapist as soon as possible. We will make every effort to provide another therapist so the benefits of therapy are not interrupted.
8. You are the key to the success of your child's therapy by being on time for appointments, keeping regular scheduled appointments, maintaining a healthy home environment and encouraging your child to use skills learned at home.

I understand and agree to these guidelines

_____ _____

Parent/Guardian Kascel Therapy, LLC Representative

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# Pediatric Home-Based Therapy Guidelines

Kascel Therapy, LLC believes our clients achieve their greatest potential by recognizing and including their families as much as possible.

In order to maximize your child's success in our program, the following guidelines have been established:

1. Be on time for therapy. Our therapists have an active schedule and on time regular attendance will ensure your child receives all the therapy ordered by your physician.
2. Attend therapy regularly. Consistency is very important for your child to progress and maintain skills learned. If you miss two (2) consecutive appointments without prior notice or attend only 80% of scheduled therapy sessions, your child may be removed from the regular therapy schedule. Your child will then be scheduled on a week-to-week basis.
3. Notify Kascel Therapy, LLC of absences. Please call us as soon as you know that you will not be able to keep an appointment. We will reschedule your child so their benefits from therapy will not be compromised.
4. Observe therapy sessions when possible. This is a great opportunity for you to share your input and ask the therapist questions about your child's progress and goals, and learn about how you can help your child at home, between therapy appointments.
5. Express your opinions and concerns. We know that you are truly the expert on your child and your input is very valuable. Our therapists are interested in your input and want to answer questions about your child's progress.
6. We will notify you of any cancelled appointment due to illness or unavailability of your therapist as soon as possible.
7. You are the key to the success of your child's therapy by being on time for appointments, keeping regular scheduled appointments, maintaining a healthy home environment and encouraging your child to use skills learned at home.

I understand and agree to these guidelines

_____ _____

Parent/Guardian Kascel Therapy, LLC Representative

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# Assignment of Benefits Form

Client Name _____

Named Insured (print) _____

Social Security Number _____ - _____ - _____ Birth Date: ____/ ____/ ____

I, the named insured hereby assign payment of insurance benefits directly to Kascel Therapy, LLC at the address listed hereon.

I agree that if my insurance company refuses to accept assignment of benefits or for whatever reason sends the payment to me, I will bring or send those payments to Kascel Therapy, LLC immediately.

I authorize the release of any medical or other information necessary to determine insurance benefits and in the processing of my insurance claims. A copy of this authorization will be sent to my insurance company, if requested. The original authorization will be kept on file with Kascel Therapy, LLC.

## Policy on Insurance Assignment

Kascel Therapy, LLC is pleased to accept your insurance assignment subject to verification of your coverage. Verification of your insurance benefits does not guarantee payment. Kascel Therapy, LLC will file your claims as a matter of courtesy to you. However, it must be fully understood that the authorization is between the named insured and the insurance company and you are fully responsible for any amount not covered or paid by your insurance.

By signing this document, I understand and agree that I am financially responsible to Kascel Therapy, LLC for any charges not covered or paid by insurance benefits. I agree to pay the portion of charges not covered by insurance company in advance or at the time of services are incurred. I acknowledge it is my responsibility and obligation to notify Kascel Therapy, LLC of any changes in insurance coverage and that I am responsible for handling any disputes with the insurance company as it pertains to my coverage or claims management.

_____ ____/ ____/ ____

Signature of Named Insured Date