

PEMBERTON COUNSELING SERVICES, PSC

PARENT COVER

PATIENT INFORMATION

Patient's Name: _____ SS# _____ - _____ - _____ Sex: Male Female

Date of Birth: _____ Age: _____ Cell Phone: _____

Home Address: _____

Home Phone: (_____) _____ Cell Phone: _____

School: _____ School Phone: (_____) _____

School Address: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____ Relation to Patient _____

SS# _____ - _____ - _____ Date of Birth: _____ Home Phone: (_____) _____

Home Address: _____

Cell Phone: _____ Work Phone: (_____) _____

Marital Status: Single Married Separated Divorced Widowed

E-mail Address: _____

Does anyone else have access to your email address? Yes No

Do we have your permission to use email to correspond? Yes No Signature _____

INSURANCE BILLING: We do not bill insurance. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement. Patients/Responsible Parties are responsible for all charges whether or not they are covered by insurance. **Therapists of Pemberton Counseling Services, PSC are not Medicare providers.**

PAYMENT POLICY: Pemberton Counseling Services, PSC require payment for services at the time they are rendered. Payment may be made by cash, personal check or credit card (American Express, MasterCard or Visa). As patients are expected to maintain a zero balance our office does not send patients statements on a regular basis. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 60 days old are routinely reviewed for submission to our collection agency.

FEES CHARGED: The fees charged by doctors/therapists at Pemberton Counseling Services, PSC are based on the amount of time scheduled for dealing with patient issues. The minimum amount of time scheduled/charged by our therapist is for a half session (20-30 minutes in length). If additional time beyond the scheduled time is taken to assist patients, there will be a charge for the amount of time used. In addition, patients are charged for time spent with a patient on the telephone and time taken to write reports or correspondence on patient's behalf.

CONFIDENTIALITY: Interactions between client and counselor are confidential. Unless the therapists of Pemberton Counseling Services, PSC have permission, we will not discuss anything that transpires between us with anyone. There are four major exceptions to confidentiality that Kentucky Law requires all mental health professionals to report:

1. Incidences of child or elder abuse or neglect
2. Intent to commit suicide.
3. Threats to do harm to yourself or another person.
4. Court order.

Additionally, in the event of a billing dispute, names, dates and lengths will be disclosed.

APPOINTMENT CANCELTATION POLICY: Pemberton Counseling Services, PSC require that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (Monday through Friday 8:00am to 5:00pm). **Unkept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee at the discretion of your therapist or doctor.** This fee can equal but will not exceed the therapist/doctors fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge.

I have read and understand the above stated policies of Pemberton Counseling Services PSC.

Signature of Responsible Party (required): _____

PEMBERTON COUNSELING SERVICES, PSC

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www.pembertoncounseling.com

Parent Intake Questionnaires

Parents, in order for us to be able to fully evaluate your child or teenager, we request that you fill out the following intake form and questionnaires (as they pertain to your child) to the best of your ability. Any questions that require additional space to answer, please note on question and finish answer on the back. We realize that there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information that you do not want in your child's or teenager's medical chart, it is ok to refrain from entering it here. Thank you!

CHILD'S IDENTIFICATION

Name _____ First Appointment Date _____
 Birth Date _____ Age _____ Sex _____
 School _____ Grade _____
 Natural Mother _____ Natural Father _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone # _____ Parent Work # _____ (specify) mom or dad
 Who is the child currently living with? _____

REFERRAL SOURCE

Referral Source _____
 Referral Address _____ Phone # _____
 Do we have your permission to release information to the referring professional when it is appropriate?
 Yes ___ No ___

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

What do you want this clinic to do for your child, yourself or your family?

PRIOR ATTEMPTS TO CORRECT PROBLEMS

Have you had previous counseling or psychiatric help? Please check all that apply.

Individual Counseling:
If yes, when and where did you receive counseling and what were the issues? Did you feel that this helped?

Group Counseling:
If yes, when and where did you receive counseling and what were the issues? Did you feel that this helped?

Hospitalization
If yes, when and where did you receive counseling and what were the issues? Did you feel that this helped?

MEDICAL HISTORY

MEDICATION	DOSAGE	START DATE	END DATE

Any history of head trauma? (describe): _____

Any seizures or seizure like activity? _____

Any periods of spaciness or confusion? _____

Prior hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc.: _____

Allergies/drug intolerances (Please list): _____

Present Height _____ Present Weight _____ Change in last 3 months _____ # meals per day _____

Current Stresses (please list current factors that are a source of stress in the family)

FAMILY HISTORY

Family Structure (who lives in the current household with the child)

NAME	AGE	RELATIONSHIP TO CHILD

Current Marital Situation/Satisfaction of Parents _____

Family Development (include marriages, separations, divorces, deaths, traumatic events, losses, etc.)

Natural Mother's History: age _____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc.) _____

Has mother ever sought psychiatric treatment? Yes ___ No ___

If yes, for what purpose? _____

Mother's alcohol/drug use history _____

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including things such as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?

(specify) _____

Natural Father's History: age _____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc.) _____

Has father ever sought psychiatric treatment? Yes ___ No ___

If yes, for what purpose? _____

Father's alcohol/drug use history _____

Have any of father's blood relatives ever had any learning problems or psychiatric problems including things such as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

(If Applicable)

Step or Adopted Mother's History (indicate which): age _____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has step-mother ever sought psychiatric treatment? Yes ___ No ___

If yes, for what purpose? _____

Step or adopted mother's alcohol/drug use history _____

Step or Adopted Father's History (indicate which): age _____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has step-mother ever sought psychiatric treatment? Yes ___ No ___

If yes, for what purpose? _____

Step or adopted father's alcohol/drug use history _____

Siblings (names, ages, problems, strengths, relationship to patient)

CHILD'S DEVELOPMENTAL HISTORY

Prenatal events:

Parents' attitude toward pregnancy _____

Conception – ease _____ planned _____ unplanned _____

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc. _____

Birth and Postnatal period:

Birth weight ___ Length ___ Labor duration ___ Delivery: vaginal ___ C section ___ Problems ___

APGAR scores (if known) ___ Any jaundice? Yes ___ No ___ Time in hospital _____

Complications? _____

Mother's health after delivery _____

Post delivery blues ? _____ if yes, how long? _____

Primary caretaker for child, first year _____
thereafter _____

Feeding history: breast vs bottle _____ age weaned _____ Food allergies _____

Current eating problems _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

Separations from mother and/or father: age, duration, reaction to _____

Toilet training: age reached bowel control: day _____ night _____ bladder control: day _____ night _____
methods used _____ ease _____ current function _____

Sexual development: gender identity _____
any problems _____

Physical/Sexual Abuse: _____

Motor development: (please write in age, parentheses are approximate average limits)
rolls over (3-5m) _____ sit without support (5-7m) _____ crawls (5-8) _____
walks well (11-16m) _____ runs well (2y) _____ rides tricycle (3y) _____
throws ball overhand (4y) _____ current level of activity _____
fine and gross motor coordination _____ compared to peers _____

Language development: (please write in age, parentheses are approximate average limits)
several words besides dada, mama (1y) _____ name several objects-ball, cup (15m) _____
3 words together--subject, verb, object (24m) _____ vocabulary _____ articulation _____
comprehension _____ compared to peers _____
any current problems _____

Social development: (please write in age, parentheses are approximate average limits)
smile (2m) _____ shy with strangers (6-10m) _____ separates from mother easily (2-3y) _____
cooperative play with others (4y) _____
quality of attachment to mother _____ quality of attachment to father _____
relationships to family members _____
early peer interactions _____
current peer interactions _____
special interests/hobbies _____

Behavioral/Discipline: compliance vs non-compliance _____
lying/stealing _____ rule breaking _____ methods of discipline (Please list what methods you
have tried and their effectiveness) _____

other problems _____

Emotional development: early temperament _____
 current personality _____
 mood _____ fears/phobias _____
 habits _____
 special objects (blankets, dolls, etc.) _____ ability to express of feelings _____

Drug/Alcohol History: _____

Do you smoke cigarettes? YES NO How many per day? _____
 Do you consume alcohol? YES NO How many drinks per: Day _____ Week _____
 Do you take any non-prescribed (recreational) drugs? YES NO
 If yes, what and how often? _____

School History: current grade _____ school contact _____
 number of schools attended _____ average grades _____
 homework problems _____
 specific learning disabilities _____
 strengths _____
 what have teachers said about the child/teen _____

Overall Strengths -- as viewed by parents _____

Please bring school report cards and any state, national or special testing that has been performed

INFORMED CONSENT

Welcome to the practice. This document contains important information about the professional services and business policies. Please read it carefully and jot down any questions you have so we can discuss them. Once you sign this, it will constitute a binding agreement between us as well as your consent for us to begin therapy/treatment.

COUNSELING SERVICES

Dr. Charles Pemberton, Ed.D., is a Licensed Professional Clinical Counselor, (LPCC), licensed by the state of Kentucky. Currently all other employees are either licensed, an associate, or operating as a student. Dr. Pemberton currently supervises and oversees all active cases.

We offer a variety of services including counseling/therapy for individuals and couples, children and adolescents and consultation. The type of therapy that we generally prefer is called Cognitive Behavioral. This approach to change emphasizes both how we think and what we do. As we learn new and different ways to look at current situations we eliminate undesirable, unhealthy feelings and behaviors.

As counselors, we do not provide any medication or perform any medical treatments. If medication seems indicated, we maintain close working relationships with a number of physicians and psychiatrists, and will refer you to these practitioners.

When we work with people, one of the goals is to help them identify the underlying thoughts that are associated with undesirable feelings, actions, and behaviors. Unfortunately, there are no guarantees, and there are potential risks. Risks may include experiencing uncomfortable levels of feelings like sadness, anxiety, anger, frustration, etc., and people may recall unpleasant aspects of their personal history. People also sometimes report feeling worse before feeling better

At any time during our work together, you have the right to decide to end treatment, and there is no moral, legal, or financial obligation other than to pay for the services already rendered. If you are thinking about ending therapy, we encourage you to discuss this with us, and if you wish, we will be glad to provide you with the names of other mental health providers.

MEETINGS

First appointments generally last about an hour, and subsequent sessions are 50 minutes, although extended appointments are available. Unless 24 hours notice is given, you will be expected to pay for the appointment unless we both agree that you were unable to attend due to circumstances beyond your control and insurance companies/managed care organizations rarely if ever pay for missed appointments. In the event of extremely bad weather such as ice and snow, it is advisable to call just to make sure the office is open.

OFFICE HOURS

Office hours vary according to clients' needs and scheduled meetings. Meetings are scheduled Monday through Friday, 8:00 a.m. until 7:00 p.m. In the event that an appointment is scheduled outside of these times, we reserve the right to apply an after-hour charge.

TELEPHONE CALLS

We strive to return telephone calls between sessions (which is one reason sessions are 50 minutes). We are not interrupted during sessions for incoming calls. Generally, we do not believe that the telephone is the best manner to deal with therapy issues, and telephone calls that exceed five minutes may be charged at the normal therapy fees. In the event of a life threatening emergency, the office or answering service can always reach us or the person who is covering in the event that your therapist is out of town.

PROFESSIONAL FEES

	Licensed Counselor	Licensed Associate Counselor
First appointment	\$100.00	\$80.00
25 minutes	\$45.00	\$25.00
50 minutes	\$80.00	\$40.00
80 minutes – for families/couples	\$120.00	\$70.00

If inpatient treatment is provided fees are billed at the hourly rate, as well as any extended sessions or consultations. Reports for insurance including treatment plans will be billed at the hourly rate.

All fees are subject to change, and in the event of fee changes, you will be notified at least 30 days prior to such changes. There is a \$25.00 service charge on all returned checks.

INSURANCE

Pemberton Counseling does not file insurance claim forms at this time.

LEGAL MATTERS

Should we become involved in any legal matter such as giving testimony, depositions, etc., the fee is \$200.00 per hour for preparation, review of materials, travel time, court time, and any other time involved. A retainer fee based on the estimated time involved will be paid in advance of any work. A minimum charge of \$400.00 for the above work will be assessed.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless previously agreed. Payment schedules for other professional services will be agreed to at the time these services are requested.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I reserve the right to forward your account to GLA Collections. If legal action is necessary, the costs of bringing that proceeding will be included in the claim, and the client or responsible party will be responsible for all costs of collection, litigation, and attorney's fees. In such cases, the only information that is released about a client's treatment would be the client's name, the nature of the services provided (e.g., individual therapy), dates of services, and the amount due.

CONFIDENTIALITY

Within the limitations discussed below, the information you reveal during our professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require that confidentiality and privileged communication be breached including: (1) if you present a danger to yourself; (2) if you present an imminent danger to another person which can include a communicable disease that can be life-threatening to others; (3) if there is reason to believe that child abuse or neglect is present a report must be filed with a state child protection agency; (4) if a legitimate court order is issued; (5) if the treatment is ordered or under the supervision of the court; and (6) an insurance company or managed care company requires you to consent to release of records and/or information to them as a condition for reimbursement. When such is released, we cannot control how the information is treated, nor will Pemberton Counseling or its representatives be responsible for any injury or claim for damages arising from the release of records or information as required by the insurance company or managed care organization.

Information revealed in marital therapy is protected by privileged communication in Kentucky and requires permission of both to waive. When working with couples, we adopt a "no secrets" rule. That is, should we speak individually with either party (e.g., via telephone), we reserve the right to disclose any information to the other party if we believe such information is relevant to the therapy process.

SPECIAL NOTES

When a family is confronted by parental separation or divorce, it is very hard on everyone. It is important then when working as a couple, each person feels safe to speak openly and honestly, without fears that material revealed in therapy will be revealed in court and used in a negative fashion. In order to provide a safe environment for couples work, it is important that you agree not to call us as witness or to attempt to subpoena records in the event you choose to pursue divorce. While a judge may overrule this agreement and issue a court order for information, your signature(s) below reflect your agreement not to call us as a witness nor attempt to subpoena records.

If parents/guardians request or require that they are informed of the issues discussed in individual sessions, we require that the discussion occur in the presence of the child or adolescent.

In order to provide clinical coverage for me when your therapist is out of town, it may be necessary for that therapist to release general information to the licensed counselors, associates and psychiatrists who are covering.

AGREEMENT

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I understand that there are no guarantees stated or implied, and I accept the risks inherent in the course of therapy. I have familiarized myself with the fees and charges for services provided by Pemberton Counseling Services, PSC, and I understand and agree that the counseling services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of services, and I understand I am responsible for all costs of collection and litigation together with attorney's fees if the charges for services must be collected by an action of law. No one can predict the course of human relationships, and as we learn more about each other, it may be necessary to amend prior agreements.

Client Signature _____ Date _____

Complete the following for clients under 18 years of age:

I, _____,
(name of parent/guardian)

to conduct counseling with my _____,
(relationship) _____,
(name of minor)

Parent/Guardian's signature _____ Date _____

Minor's signature _____ Date _____