Start and Associates Psychological Support

Consent for Treatment

Psychological Support:
Our intent is to offer a calm place where you will feel accepted and understood. Thus, the relationship between you and your therapist is of utmost importance and if the fit does not seem right, please discuss with your therapist or Amanda Tuck our Connections Specialist at 616.607.4476 or amanda@startandassociates.com. We want you to feel settled and comfortable.

Contacting Your Therapist:
Your therapist can be contacted via his/her phone or email for scheduling and other matters. If your therapist is unable to respond and it is an emergency, please phone your physician or 911.

HIPAA/Confidentiality:
We adhere to ethical and legal guidelines regarding HIPAA and confidentiality. Most everything is confidential under these guidelines though we must report to family members(s), hospital, and/or authorities: any abuse or neglect, or threat of abuse or neglect, to another person or animal; threat to harm or kill another person or animal; or threat to harm or kill oneself. There might be times when information is discussed with Dr. Toni Start, Licensed Psychologist and Owner, and/or the therapist's supervisor. Signing this form gives your therapist consent to do so.

Sessions and Fees:
Most sessions are approximately 53 minutes unless otherwise planned and will be scheduled directly with your therapist. We accept private pay and are in-network with most insurance companies. Private pay will be determined between you and your therapist before your first appointment; refer to the Good Faith Estimate information on our website. If you opt to use your health insurance, ***it is your responsibility to understand your specific benefits such as what costs you will accrue for deductibles and co-pays as well as how many sessions are covered.*** Your fees will be paid at session time or in some situations, we will bill you. If your balance exceeds your ability to pay at session time, a payment plan could be considered. ***We may charge a late cancellation (cancellation is within 48 hours) or no-show fee up to $150.00 per incident or the allowed amount per insurance reimbursement rates.*** Please note insurance companies do not provide reimbursement for these incidents.

All therapists here get compensated per session and are not salaried by the group. All therapists' time is valued and needed by many people; therefore, we respect and impose our late cancellation and no-show fee agreement.

If your personal information such as address, phone number, and/or email address change, please let your therapist know ASAP. Your signature below indicates you read, understood, and agree to the terms including the late cancellation and no-show fee agreement. Please ask your therapist any questions regarding this consent for treatment.

Print Name of Client _____ Date _____

Client Signature _____

Parent Signature if Client is a Minor _____

START & ASSOCIATES
PSYCHOLOGICAL SUPPORT

Youth Intake Form: Please be aware of any thoughts and feelings you might experience while completing this paperwork. Keep in mind that writing about your child might be sensitive, therefore, only complete the portions of your choosing.

Child's Name: _____ Date of Birth: _____
Parents' Names: _____
Person(s) completing this form and relationship to child: _____

Full Address: _____
_____
Home Phone: _____ Cell Phone: _____
Business Phone: _____ Other Numbers: _____
Email Address: _____
How would you prefer to be contacted? _____
May your therapist contact you on other numbers? _____
Emergency contact and phone number: _____
How did you hear about us? _____
May we send you a satisfaction survey via email? _____

Primary Insurance Company: _____
Effective Date: _____ Contract #: _____ Group #: _____
Name of subscriber: _____ Relationship: _____
Subscriber's DOB: _____ Subscriber's place of employment: _____

Secondary Insurance Company: _____
Effective Date: _____ Contract #: _____ Group #: _____
Name of subscriber: _____ Relationship: _____
Subscriber's DOB: _____ Subscriber's place of employment: _____

Child's Family of Origin

Names of parents/caregivers: _____

Siblings' names and ages: _____

Please describe your child's relationships with members of his/her family:

Please provide a description of what brings your child here and issues you would like to address:

When did these problems/issues begin? _____

Is your child seeing any other therapists? If so, please list their names, reasons for seeing them, and whether your therapist has permission to contact them if needed:

In infancy or toddlerhood, please circle all that apply:

Prolonged separation
Feeding problems
Sleeping problems
Unusual fears
Night tremors
Medical illnesses
Parental illnesses
Separation problems
Head banging
Self-injury
Aggression
Tantrums
Control battles
Fear of going to others
Colicky

Please circle any that apply to your child in the past or presently:

Anxiety
Depression
Restless sleep
Suicidal thoughts
Suicide attempts
Illegal drug use
Substance abuse
Anger
Workaholic
Perfectionism
Social withdrawal
Irritability
Food addiction
Sex addiction
Gambling/spending addiction
Relationship issues
Communication issues
Having many fears
Impulsivity
Distractibility
Procrastination
Nervousness
Dislike self
Chronic guilt
Bullying others
Being bullied
Memory loss
School refusal
Learning problems
Running away
Defiance
School suspensions
Usual or excessive rituals
School failure
Parents' death/illness
Fire setting
Cruelty to animals
Thief
Physical trauma
Sexual trauma
Emotional trauma
Emotional neglect

Please circle any of the following words that would describe your child:

Happy
Lonely
Worthwhile
Healthy
Confused
Attractive
Overwhelmed
Confident
Helpless
In control
Hopeless
Loveable
Feeling trapped
Hardworking
Useless
Trustworthy
Worthless
Intelligent
Unlovable
Open-minded
Successful

Health Data

Physician's Name: _____ Phone Number: _____

Is your child being treated for any medical problems: _____

_____

_____

What medications is your child taking? Please include name, amount, when she/he began taking the medication, and reason(s) prescribed:

_____

_____

_____

Please list any injuries, surgeries, or other medical concerns your child has experienced in the past:

_____

Has she/he ever been hospitalized for emotional reasons? If so, please provide places, dates, and circumstances:

_____

_____

Has she/he received outpatient psychotherapy or inpatient psychological services in the past? If so, where, when, and reasons why:

_____

Developmental History

Pregnancy history with child: _____

To term or early: _____

Birth weight: _____

Complications: _____

Prenatal exposure to drugs and/or alcohol? _____

Maternal postpartum depression: _____

School Information

Please provide pertinent school information such as: which school does your child attend, current grade level, name of a contact person there if need be:

_____

_____

_____

_____

Additional Information
Please provide any other information about the child:

Thank you for your disclosure. Please sign below.

Signature Date

Child's Signature Date

Youth's Name: _____ Date: _____

Person completing this form: _____

Instructions: Read each statement carefully. Mark the circle that best describes how true the statement has been during the past 7 days. Mark only one answer for each statement. You may discover some of the items do not apply to your current situation. If so, please do not leave these items blank, instead, mark the "never/almost never" category. When you begin to complete this form, you will see you can easily make yourself as healthy or unhealthy as you wish. Please be as honest and accurate as possible; it will be more likely you will receive the help you are seeking. For parents/guardians completing the questionnaires for children under 12, please respond to the statements as if each began with "My child…" or "My child's…" rather than "My…" or "I…" It is important that you answer as accurately as possible based on your own observations and knowledge.

1. I have headaches or feel dizzy.
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

2. I don't participate in activities that used to be fun.
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

3. I argue or speak rudely to others.
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

4. I have a hard time finishing my assignments or do them carelessly.
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

5. My emotions are strong and change quickly.
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

6. I have physical fights (hitting, biting, or scratching) with family or others my age.
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

7. I worry and can't get thoughts out of my head.
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

8. I steal or lie.
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

9. I have a hard time sitting still (or I have too much energy).
   O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

10. I use drugs or alcohol.
    O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

11. I am tense and easily startled or jumpy.
    O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

12. I am sad or unhappy.
    O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

13. I have a hard time trusting family members or other adults.
    O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

14. I think others are trying to hurt me even though they are not.
    O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

15. I have threatened to run away from home or have run away from home.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

16. I physically fight with adults.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

17. My stomach hurts or I feel sick more than others my age.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

18. I don't have friends or I don't keep friends for very long.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

19. I think about suicide or feel I would be better off dead.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

20. I have nightmares, trouble getting to sleep, oversleeping, or waking too early.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

21. I complain about or question rules, expectations, or responsibilities.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

22. I break rules, laws, or don't meet others' expectations, or responsibilities.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

23. I feel irritated.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

24. I get angry enough to threaten others.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

25. I get in trouble when I'm bored.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

26. I destroy property on purpose.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

27. I have a hard time concentrating, thinking clearly, or staying on task.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

28. I withdraw from my family and friends.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

29. I act without thinking and don't worry about what will happen.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

30. I feel that I don't have any friends or that no one likes me.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

Please list reasons why seeking treatment: _____

_____

START & ASSOCIATES
PSYCHOLOGICAL SUPPORT

AUTHORIZATION TO RELEASE AND/OR OBTAIN HEALTHCARE INFORMATION

Client Name: _____ Date of Birth: _____
Previous Name(s): _____
I request and authorize Start and Associates Psychological Support to release and/or obtain healthcare information of the person named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other _____

_____
Signature Date

_____
Parent/Guardian's Signature Date

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS REVOKED IN WRITING.