CHILD INTAKE FORM

Please complete on behalf of your child

Child's Info

Name:_____ Age:_____ DOB:_____

Male_____ Female_____ Grade: _____ Typical Grades: _____

Legal Guardian Info

Parent/Legal Guardian 1

Name: _____ Relation to child: _____

Phone:_____ Email:_____

Parent/Legal Guardian 2

Name: _____ Relation to child: _____

Phone:_____ Email:_____

Does the child live with both parents? Y / N

If no, please explain legal custody agreement concerning decision making:

_____

_____

What is the reasoning for your visit today?

_____

_____

_____

What do you hope your child receives from counseling?

_____

_____

How intense is your child's emotional distress?

(mild) 1 2 3 4 5 6 7 8 9 10 (severe)

If any, how much does this affect your child's ability to perform in school, get along with others, and perform daily tasks?

(mild) 1 2 3 4 5 6 7 8 9 10 (severe)

When did these problems start? Where there any identifiable triggers at that time?

Medical History

If any, please list any medical problems and the date your child was diagnosed:

If any, please list any psychiatric diagnoses and the date the child was diagnosed:

Please list any medications your child takes and what they are taken for:

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Disclosure Statement

Kimberly Harter
Mental Health Counselor Intern

Training and professional background:
Kimberly has a B. S. in Psychology from the University of Central Florida in Orlando, Florida. Kimberly is currently a practicum/intern student in the process of earning her master's degree at Liberty University in the Clinical Mental Health Counseling program. She is under the direct clinical supervision of Janean Byrne who is a Licensed Mental Health Counselor in the state of Florida #MH15525. Kimberly has training in counseling techniques, counseling theories, multicultural counseling, human growth and development, group therapy, psychopathology, diagnosis, and assessment She also has experience working with children, adolescents with behavior disorders.

Theoretical orientation and approach to counseling:
Kimberly's theoretical approach is rooted in attachment theory. Her clinical interest has been working with trauma, women and women's issues, children, and group therapy. In therapy, her focus is on the whole person in gaining insight to Grief, Anxiety, Depression, Relationships, Parenting skills, Self-Esteem, Boundaries and Self-confidence, as well as many other hindrances that inhibit us from reaching our best potential and enjoying life. Kimberly believes in taking a holistic approach to therapy, while considering an individual's health, sleep patterns, spirituality, relationship dynamics, etc. Her strengths are in relationship building and her clinical approach is that of refocusing thought processes that hinder our healing and development in relationships and beyond.

The rights of clients in counseling:
It is appropriate for clients to raise questions about the counselor, the therapeutic approach, the progress of the therapy and the cost. As informed consumers, it is the client's responsibility to choose the counselor and counseling modality which best suits their needs. Clients have the right to request a change in counseling approach, referral to another counselor or termination at any time.

Kimberly Harter is bound by the ethical codes of her respective professional organizations, by the laws of the State of Florida, as well as by agency policy regarding the special nature of the therapist-client relationship. It is expected that the counselor will continue to be aware of the influential position they hold in the relationship with clients, using this influence in a constructive way. If a client thinks his/her counselor is not meeting this ethical responsibility, he/she is strongly encouraged to address this with the counselor.

Confidentiality:
Counseling sessions are held in strict confidence. It is the client, not the therapist, who determines whether information may be released to persons outside of this office, and only then, with a release signed by the client. If a release is not signed your information will remain confined to this office. Interns work closely with their supervisor Janean Byrne and will frequently discuss client case details to assure proper therapeutic gains. The counselor may be required to break confidentiality in life-threatening situations where the client poses a clear and present danger to self or others or is unable to provide minimum life sustaining self-care. In these situations, the counselor is required to take steps necessary to secure the safety of the client or others.

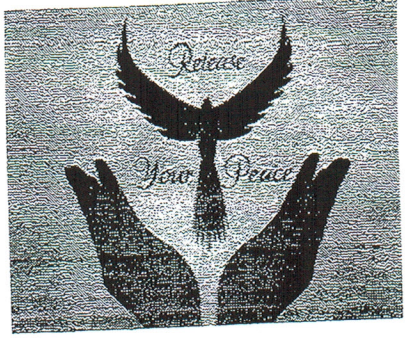
My signature below acknowledges that I am the legal guardian of _____ and have received and understand the Disclosure Statement; thus, consenting to their participation in counseling services at Serenity Counseling Center.

Client (or legal guardian's) signature(s)_____ Date _____

Spouse (or other parent) Signature _____ Date _____

Mental Health Counselor Intern's Signature _____ Date_____

Supervisor's Signature _____ Date _____



Serenity Counseling Center

Patient Treatment Agreement

Payment: Due at the time that the service is provided. We accept credit, debit cards, cash and check. A 3% fee will be applied to credit or debit transactions. The fee for a 50 minute session is $90. As a client, you are agreeing to pay $_____ at the end of each session.

Cancelations: If you are unable to keep your scheduled appointment, you must notify your counselor **24 hours prior to your appointment** or you will be charged a $50.00 cancellation fee. You are giving Serenity Counseling Center permission to contact you via phone call, text or email concerning your appointment, case information or other business pertaining to Serenity Counseling Center.

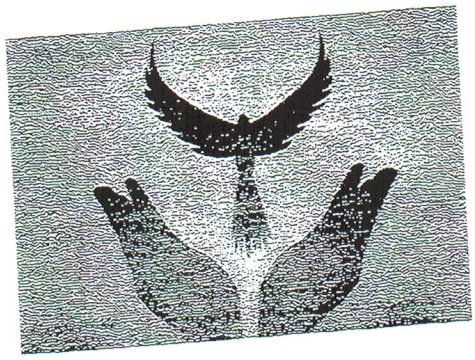
Legal: Our counselors are available for in-office depositions at an agreed upon fee. The counselors are not available, nor will appear in court for testimony regarding a case unless arrangements are made outside of and prior to this initial agreement. By signing you agree that this information has been formally conveyed.

Client Contact: As a client you give permission to personnel at Serenity Counseling Center contacting you through your personal email, text, voice call or leaving a voicemail about appointments and/or other information pertaining to your treatment.

"I, the undersigned, agree to treatment by the providers in this office, and furthermore have read and understand the above policies".

Client Name: _____ Date:_____

Client Signature: _____



Serenity Counseling Center

COVID-19 Liability Release Waiver

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which Serenity Counseling Center adheres to comply.

In consideration of my participation in the foregoing, I acknowledge and agree to the following:

- ☐ I am aware of the existence of the risk on my physical appearance to the venue and my participation to the activity of the Organization that may cause injury or illness such as, but not limited to Influenza, MRSA, or COVID-19 that may lead to paralysis or death.
- ☐ I have not experienced symptoms that of fever, fatigue, difficulty in breathing, or dry cough or exhibiting any other symptoms relating to COVID-19 or any communicable disease within the last 14 days.
- ☐ I have not, nor any member(s) of my household, traveled by sea or by air, internationally within the past 30 days.
- ☐ I did not, nor any member of my household, visit any area within the United States that was reported to be highly affected by COVID-19, in the last 30 days.
- ☐ I have not been, nor any member(s) of my household, diagnosed to be infected of COVID-19 virus within the last 30 days.

Following the pronouncements above I hereby declare the following:

- ☐ I am fully and personally responsible for my own safety and actions while and during participation and I recognize that I may in any case be at risk of contracting COVID-19.
- ☐ With full knowledge of the risks involved, I hereby release, waive, and discharge Serenity Counseling Center , its board, officers, independent contractors, affiliates, employees, representatives, successors, and assigns from any and all liabilities, claims, demands, actions, and causes of action whatsoever, directly or indirectly arising out of or related to any loss, damage, injury, or death, that may be sustained by me related to COVID-19 while participating in any activity while in, on, or around the premises or while using the facilities that may lead to unintentional exposure or harm due to COVID-19.
- ☐ I agree to indemnify, defend, and hold harmless Serenity Counseling Center from and against any and all costs, expenses, damages, lawsuits, and/or liabilities or claims arising whether directly or indirectly from or related to any and all claims made by or against any of the released party due to injury, loss, or death from or related to COVID-19.

By signing below I acknowledge that I have read the foregoing Liability Release Waiver and understand its contents; that I am at least eighteen (18) years old and fully competent to give my consent; That I have been sufficiently informed of the risks involved and give my voluntary consent in signing it as my own free act and deed with full intention to be bound by the same, and free from any inducement or representation.

This waiver will remain effective until laws and mandates relevant to COVID-19 are lifted. Please let us know before future visits if any of this information has changed.

_____ DATE

PRINT NAME

_____ DATE

SIGN NAME