Child Intake Packet

Client Information **Today's Date: _____**

First Name: _____ **Middle Name**: _____ **Last Name**: _____

Note: Please spell name as spelled on your insurance card

Mailing Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Email: _____ **Age**: _____ **DOB**: _____ **SS#**: _____-_____-_____

☐By check marking this box, you are giving Tueller Counseling Services permission to contact you via electronic forms of communication (i.e. text and/or email).

Primary Language: _____ **Do you need an interpreter?** ☐Y ☐N **Location to be seen**: _____

Gender Identity: ☐ Male ☐Female ☐ Transgender ☐Genderqueer ☐Declined ☐ Other_____

Note: If divorced, please supply us with legal documentation of custody to ensure that privacy rights can be enforced.

Ethnicity: ☐Native American ☐African American☐ Latino☐ Asian☐ Pacific ☐Caucasian ☐Other_____

Parent(s)/Guardian(s): ****The person completing the intake needs to be listed first****

Note: If divorced, please supply us with legal documentation of custody to ensure that privacy rights can be enforced.

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Partner ☐ Widow ☐ Remarried (# of times _____)

☐ Other _____

1st Parent/Guardian Full Name: _____ DOB: _____

Are you the insured party? Relationship to client: _____ SS#: _____

Employer: _____ Employer contact and #: _____

2nd Parent/Guardian Full Name: _____ DOB: _____

Are you the insured party? Relationship to client: _____ SS#: _____

Employer: _____ Employer contact and #: _____

Emergency Contact Information ****Please ensure a Release of Information is filled out for any contact listed****

Name: _____ **Number**: _____ **Relationship**:_____

Name: _____ **Number**: _____ **Relationship**:_____

Referred by: _____ **What reason?** _____

Legal

Has your child ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No

If yes, explain: _____

Are you currently on Probation? ☐ Yes ☐ No If yes, with who?_____

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Approved Pick-Up Persons **Please note that all individuals picking up will be asked to show ID. If not on this list, client will not be allowed to leave the facility**

Name	Relationship

Insurance Information: **Please bring all insurance cards and photo ID to the 1st appointment**

Primary Insurance Carrier:

Name: _____

Phone: _____

Policy holder (PH):_____

Relationship of PH to you: _____

PH DOB: _____ PH SS#_____

Policy ID: _____

Group #: _____

Secondary Insurance Carrier:

Name: _____

Phone: _____

Policy holder (PH):_____

Relationship of PH to you: _____

PH DOB: _____ PH SS#_____

Policy ID: _____

Group #: _____

Health Insurance Waiver/Self-Pay Agreement **Please Initial the one that applies to you**

_____**INSURED:** I understand that Tueller Counseling will bill my insurance as a courtesy. I understand that I will be responsible for any remaining balance that my insurance company does not cover. Including any deductible, coinsurance, co-payments, etc.

_____**Magellan Other State funding:** If you are eligible for state funding, please provide Magellan with proof of denial of Medicaid within 30 days to ensure continued service coverage. Failure to do so will result in Magellan discontinuing services, and you will be responsible for the cost of any services rendered after coverage is terminated. Client is responsible for any co-pay or co-insurance as outlined in their funding source.

_____**BPA Funding**: I understand that I can use BPA funding as long as I have a current authorization and that Tueller Counseling will inform me when that authorization will be coming to an end.

_____**UNDERINSURED and UNINSURED:** For any services provided outside my plan limits, I agree to pay in full. ***(Sliding Fee Discount Program available)***

_____**SELF-PAY:** I understand that as of the date of service I am not eligible for coverage under my insurance. I choose to receive services provided and agree to pay out of pocket. I have decided at this time to not utilize my health insurance to cover the cost of services received through Tueller Counseling. I opt to be fully responsible for payment for all charges incurred.

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_____INTERN: I understand that as of the date of service I will be receiving services from a supervised intern at Tueller Counseling. Intern services are free of charge. However, if at any time, I choose to be seen by a licensed clinician, I understand that I will be fully responsible for payment for all charges incurred.

_____THIRD PARTY AGREEMENT: I understand that where I am over 18 years of age, if another party (Parents, Bishop, Family Crisis Center, Etc.) agree to be financially responsible for counseling services I receive through this provider, that I must provide written documentation of our financial agreement in the form of a letter. This letter must include contact information, number of sessions approved, and payment arrangement. I understand that in the event that I do not furnish the letter I am ultimately responsible for full payment of services rendered. (Bishop Clients) I understand that I need to provide Tueller Counseling with a letter from my Bishop. The letter must contain my Bishop's contact information (Name, Phone Number, Address, Ward, Stake) as well as the specific payment arrangements.

_____INSUFFICIENT PROOF OF COVERAGE: I understand that I have arrived at my appointment without sufficient proof of insurance (discrepancy in insurance coverage/invalid insurance card). I am aware that ultimately, I am responsible for services rendered at this time and choose to receive them willingly. If I provide sufficient proof of being insured *within in a **timely** manner* (within 5 Business Days), I understand that I may be reimbursed for payment of today's services after my claim has been processed and paid for by the insurance. If I do not provide proof of insurance within a timely manner I understand that I will be responsible for today's visit in full.

I acknowledge that I have had the opportunity to receive and understand the Financial Policy of Tueller Counseling Services, Inc. and agree to the policy.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Telehealth Informed Consent

I _____, consent to receiving counseling sessions via telehealth. I understand that the telehealth platforms being used by Tueller Counseling Services, Inc. are HIPAA compliant.

I understand that the purpose of telehealth is to provide quality service over a distance as a service to me as the client. I understand that I am responsible for keeping my session private and HIPAA compliant at the originating site (where the client is located). I understand that I can receive telehealth services only in states where my provider is licensed to practice (or as a state mandate allows). I understand that I am responsible for disclosing my location to my provider to ensure that I can receive services ethically without putting the provider's license at risk. I understand that my provider will refuse services if disclosed that I am located in a place that they are not licensed to practice. I also understand that the financial policy and attendance policy are still in effect with telehealth.

By signing this form, I acknowledge that I understand and agree with the above conditions.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Financial Policy Acknowledgement

Tueller Counseling Services, Inc. is dedicated to providing the best patient-centered care, ensuring our clients have improved access to care, and making sure that no client will be denied behavioral health services due to an inability to pay. We offer discounted care for those who are uninsured or underinsured through our Sliding Fee Discount Program. Please ask our team if you would like to apply.

Child Intake Packet

We participate in most major health plans and hold contracts with many insurance companies and government agencies, including **Medicare** and **Medicaid**. Our office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. If you have secondary insurance, we will file a claim with them after your primary insurance has processed, provided all necessary information is on file.
Note: Not all secondary insurance accepts electronic claim submission and additional processing times may apply.

Your insurance company requires us to collect co-payments at the time of service, otherwise your appointment may be rescheduled. Please help us in upholding the law by paying your co-payment at each visit. It is the policy of Tueller Counseling Services Inc. to treat all patients in an equitable fashion related to account balances. We strictly adhere to state and federal laws, as well as agreements with participating insurance companies, and therefore do not waive or discount co-payments, co-insurance, deductibles, or other patient financial responsibilities. Full or partial financial responsibility may only be waived in accordance with the practice's Sliding Fee Schedule Policy. Any outstanding balance on your account after contractual insurance adjustments will be billed to the responsible party.

You are responsible for notifying your insurance plan(s) and coordinating benefits when acquiring, renewing, or updating coverage. If your insurance company processes a claim out-of-network, charges may be higher, and you will be responsible for any balance not covered. It is your responsibility to provide all necessary insurance, financial information and/or updates to Tueller Counseling at **each date of service**. If you do not have an insurance card with you, payment in full for each visit may be required, unless we can verify your coverage.

Any discharged clients' balances that are more than 65 days overdue may be considered for collections (in compliance with the Idaho Patient Act: Chapter 3 Title 48). If payment is the responsibility of a third party or is split (e.g., divorced parents), each party must complete/provide the required documentation prior to services.
Nonpayment by one party does not release the other's obligation. A $40.00 no-show fee applies if you miss a scheduled appointment, cancel less than 2 hours before your appointment or clinic opening, or arrive more than 15 minutes late; this fee must be settled before or during your next visit.

For your convenience we utilize Phreesia to collect payments electronically. You may receive a payment request via **text**, **email**, or you will be prompted to **complete payment during digital check-in**. This allows you to pay using your preferred method (**debit, credit, HSA/FSA card, or bank account)** from your personal device at your convenience. If needed, we also accept in-person payments via cash, check, or credit/debit card.

By signing this document, I acknowledge that I have read and understand the Tueller Counseling Services, Inc. Financial Policy. **I accept financial responsibility for services rendered and agree to comply with the terms outlined above.**

Client Name: _____ Signature: _____ Date: _____

Acknowledgement of Orientation Manual

By signing this document, I acknowledge that I was given an opportunity to review the Tueller Counseling Services Inc. Orientation Manual, which includes the following items:

Commented [ZH1]: List a contact number/email/ or other means to contact billing?

Commented [ZH2R1]: As a service we verify your responsible for the eligibility.

Commented [ZH3R1]: Add email/phone

Child Intake Packet

Things you need to know
What to expect from Community Services
Attendance and Cancellation Policy
Transportation Information
Staff Information
Financial Policy
Client's Legal and Human Rights
Complaint & Problem-Solving
What to expect from counseling
Notice of Privacy Practices: HIPAA
Crisis Planning

I was given an opportunity to ask questions regarding the services available to me and the policies outlined above.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Service Animal Release

Definitions:

Service Animal: Dogs that are individually trained to do work or perform tasks for people with disabilities. Service animals are working animals, not pets and not therapy animals. The work or task a dog has been trained to provide must be directly related to the person's disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

☐ Yes, I am willing to receive services from a provider that utilizes a service dog. Please sign the acknowledgement below.

☐ No, I am not comfortable with animals and wish to be with a provider who does not utilize service animals.

The purpose of this form is to review the policies and procedures, as well as request your consent for the presence of a service dog.

Policies and Procedures
No pets allowed. Service animals specifically trained to aid a person with a disability are welcome. Emotional support animals are not permitted.

Therapy Animal: Therapy dogs are not permitted to be used as part of any service rendered by a provider of Tueller Counseling

Service Animals: Tueller Counseling Services, Inc. will only allow certified service animals for employees and/or clients. Every client will sign a consent form that dictates liability and that the client accepts the risk of present service animals. Client reserves the right to change providers at any time if concerns arise regarding service animals.

Service Animal: The following procedures will be followed in regards to Service Animals.

- Service Animals as defined under ADA will only be allowed to function as a service animal. Counselors are responsible for ensuring that Service Animals are NOT used in the course of treatment of clients or in any capacity that may fall under "therapy animal." This includes, but not limited to interacting with clients in any capacity.
- Any employee who utilizes a Service Animal will be asked to fill out an acknowledgement form of this policy as well as a short questionnaire.
- Service Animals must be under the control of its handler. Under ADA, service animals must be harnessed, leashed, or tethered, unless the individual's disability prevents using these devices or these devices interfere with the service animal's safe, effective performance of tasks. In that case, individuals must maintain control of the animal through voice, signal, or other effective controls.

- Allergies and fear of dogs are not valid reasons for denying access or refusing service to employees using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room, both parties will be accommodated to the best of Tueller Counseling Service's ability.
- An employee with a disability will not be asked to remove the service animal from the premises unless;
- The dog is out of control and the handler does not take effective action to control it, or;
- The dog is not housebroken.
- People with disabilities that utilize service animals cannot be isolated, treated less favorably or charged fees.

I understand that service animals may be present during therapy, but are not utilized as part of the therapy process. Furthermore, I am not aware of any fear, allergy, skin or respiratory sensitivity, or other medical condition I have that would be harmful to my health if within close proximity to a service dog. I understand and agree to the policies, procedures, and risks associated with the service animals.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Medical Release Form – Statement and Consent

In the event if an emergency or non-emergency situation requiring medical treatment, I,_____ hereby grant permission for any and all medical and/or dental attention to be administered to my child/self, in the event of an accidental injury or illness, until such time as an emergency contact can be reached. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Refusal of ConsentPrint Name**: _____ **Signature**: _____ **Date**: _____

Information Disclosure and Consent

Purpose: To provide a safe, structured environment that is supportive in which to explore individual needs, concerns, and goals.
Hours services are provided: Normal office operating hours are Monday through Friday from 9:00am-6:00pm. In the event that services are provided outside this time frame, the client and parent is notified and agree upon meeting times.
Confidentiality: Information disclosed to a licensed counselor is a privileged communication and cannot be disclosed in any civil or criminal court proceeding in Idaho without the consent of the client. However, under the Idaho Rule of Evidence 517(d) there is no privilege for the following acts:

- Civil Action: In a civil action case or proceeding by one of the parties to the confidential communication against each other.
- Proceedings for guardianship, conservatorship, hospitalization: As to a communication relevant to an issue in proceedings for the appointment of a guardian or conservator for a client with mental illness, or to hospitalize the client for mental illness.
- Child-related communications: In a criminal or civil action or proceedings as to a communication relevant to an issue concerning a physical, mental, or emotional condition of or injury to a child, or concerning the welfare of a child including, but not limited to, the abuse, abandonment, or neglect.
- Licensing board proceedings: In an action case or proceeding under Idaho Code 54-3403.
- Contemplation of crime or harmful act: If the communication reveals the contemplation of a crime or intention to commit a harmful act.
- Insurance, Medicaid, and other payment companies: Information needed for billing purposes.

Release of Information: Information pertinent to care and treatment may be released to insurance companies and other entities for reimbursement purposes, as well as others indicated on signed releases, to be updated annually.

Child Intake Packet

Fees: The private pay fee for services is $200 for initial intake appointment, $70 for 30 minute session, $120 per hour individual session and $120 for family session, and $25 per hour for group. Portions of rendered services may also be covered by insurance, Medicaid, Medicare, etc. The fee for services is $0.00 per Medicaid. Fees for insurances will vary depending on eligibility and benefits of the client.

Documentation: Documentation is maintained regarding the services received through Tueller Counseling Services Inc./ Unified HealthCare of Idaho. These records are confidential and cannot be released without your consent. You have the right to access your clinical records.

Professional Standards: Professionals adhere to the NASW code of ethics. The bureau of occupational licensing regulates the practices of professionals. The licensure of any individual under the licensing laws of Idaho does not imply or constitute an endorsement of that counselor, nor guarantee the effectiveness of the treatment.

Second Opinion: At any time in treatment, you may seek a second opinion. It is the responsibility of the client to choose the provider. The client may terminate services at any time unless treatment is court-ordered.

Time-out and Restraints: Fostering healthy relationships and adaptive social behaviors is role-modeled, taught, and practiced. When behaviors are dangerous or noncompliant, time out and sentences are used as negative consequences. If a client becomes dangerous to themselves, others, or property, a human restraint is implemented by those qualified.

Medication Administration: Administration of medication may be provided as directed by a doctor, by qualified personnel.

Transportation: Transportation to mental health services may be provided by parental choice of transportation to Tueller Counseling Services Inc. **Risks:** Treatment is not guaranteed to cause positive results. Risks of treatment may include worsening of behaviors, conditions preceding potential improvement.

Allowing Pickup of Child: Referring to the Intake Assessment, those listed are approved to pick up my child.

Emergency/Crisis Plan and Resolution: In the event of an emergency, call 911 or go to your local emergency room. Crisis Line available 24/7/365 at (208) 520-9630.

Right to Refuse Services or Choose Alternate Provider: Treatment may be refused or consent revoked at any time, if desired by the client. There are many providers from which to choose. Tueller Counseling Services Inc. is only one of those providers.

Statement of Understanding: I understand my rights as a client and have asked any questions regarding the above information. I willingly agree and consent to treatment through Tueller Counseling Services Inc./ Unified HealthCare of Idaho with the understanding of the previously stated disclosures.

Notice of Privacy: We are dedicated to protecting your confidential information. We create records of the services provided and forwarded copies of records provided by other service providers. We are required to use and disclose confidential information as required by law, maintain the privacy of your information, give you this notice of our legal duties and privacy practices for your information, and to follow the terms on the current HIPPA guidelines that are currently in effect.

Right to Review and Copy: You have the right to review and copy your clinical information as allowed by law. You may request any documentation completed by Tueller Counseling Services Inc. Information provided by another agency or entity will need to be requested from that agency or entity. You may be subject to a fee to cover any costs associated with the request.

Use of AI-powered tools: Mental health providers often spend a considerable amount of time documenting care on computers—time that could otherwise be focused directly on clients. As part of our ongoing commitment to providing the highest quality care, we're excited to share a new technology we're using to enhance our services. We've implemented an AI-powered tool to assist with the formatting of clinical documentation. This tool helps streamline the documentation process, allowing our licensed professionals to be more present and focused during your sessions. It's important to note:

- The AI tool does not listen to or record any part of your session.
- Your licensed clinician remains fully engaged in your care and is solely responsible for all clinical decisions.
- No client names or personally identifiable information are ever entered into the AI tool.
- The tool is fully HIPAA-compliant, ensuring your privacy and data security are protected.

While this tool helps us deliver more efficient care, you have the right to decline the use of AI assistance at any time. Please be aware that doing so may impact how quickly documentation is completed.

Right to Amend: You have the right to ask to make changes to your information if you feel the information we have is incorrect or incomplete. A Request of Amend Records form is available for your use. You must complete the form and return it to the front office for processing. Our office will respond to your request within 10 days. We may deny your request if you ask us to change information when the document was not created in our office, when the information is derived from a court document, when the data is historical in nature and is from the perspective of a biological family member or a member within the family, when we

determine the information in court ordered mental health assessment completed by a clinician is an objective cultural representation of the client's current mental health information and diagnosis currently at this time.

Prohibition of Re-disclosure statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse of patient.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Medication Management/Dr. Ronald Zohner Agreement

*Please initial that you acknowledge and agree to the following policies:

- ___ Dr. Zohner accepts clients ages 5+
- ___ For clients with commercial insurance visits are subject to deductibles and copays. Private pay fees are as follows: New child- $600, New adult - $475, Follow-up $200.
- ___ Dr. Zohner is only in our offices a few days a month. It is best to think ahead and reschedule your follow up appointments right away preferably following your appointments, or you may be subject to having a longer wait time for your next follow up appointment.
- ___ New adult appointments are scheduled for an hour.
- ___ New child appointments are scheduled for an hour and a half. Parent/legal guardian must attend all appointment with the child or teen. NO EXCEPTIONS!
- ___ Follow up appointments are scheduled for 30 minutes. If a client is more than 10 minutes late the appointment will need to be rescheduled.
- ___ Clients must be seeing one of the counselors within our agency consistently for 3-4 appointments prior to being put on Dr. Zohner's schedule. Exceptions are made in extreme cases.
- ___ Once on Dr. Zohner's schedule, clients must continue seeing a counselor twice a month or the appointment may be cancelled with the option to reschedule after the client has been seen by their counselor. This is non-negotiable. Office staff will contact the client/guardian before moving the client from the schedule.
- ___ Clients should receive a confirmation call a day or two prior to the appointment. The client must confirm the appointment to stay on the schedule for the day of the appointment. Space on Dr. Zohner's schedule is limited and fills up fast. We do have a waitlist in case of cancellations.
- ___ Two no-shows and client will no longer be eligible to see the psychiatrist through our agency. No-show visits are also subject to a fee of $200.00-$300.00 per missed visit.
- ___ Please let the office staff know of cancellations at least 24 hours in advance so that we can try to fill the time with another client from the waitlist.
- ___ Please remember to let the office staff make a copy of any prescriptions at check out. This is also a great time to schedule your follow up appointment.
- ___ If you have any prescription refills or medication reactions, please call Dr. Zohner's office at (208) 552-5707.
- ___ Appointments may be subject to change from in person to telehealth. I have read and acknowledged the Telehealth Consent Form.
- ___ I have reviewed and acknowledge the terms and conditions of this agreement.

Parent/Guardian Name: _____ Signature: _____ Date: _____

****Refusal of consent**** **Signature: _____ Date: _____**

Reason for refusal, if applicable: _____

Mental Health Providers

I understand that I may choose any agency to provide services. I have chosen to be provided services at Tueller Counseling Services, Inc.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Intern or Wait List

I understand by selecting Tueller Counseling Services I have been offered to be referred out to another agency and accept being placed with an intern or on the wait list if a counselor is not available at the time of this signature.

Client Name: _____ **Signature**: _____ **Date**: _____

Consent for Intern or Shadow

Tueller Counseling Services participates in educational programs with area colleges and universities to give students engaged in coursework related to the counseling field experience in clinical practice and community work. Tueller Counseling employees have agreed to permit students to observe and participate in client care under the employee's direct supervision.

_____ (initial) I agree to permit students to observe my child

_____ (initial) I DO NOT agree to permit students to observe my child

Parent/Guardian Name: _____ Signature: _____ Date: _____

Release of Information

I give permission to release my medical/mental health information to be disclosed for purposes of communicating results, findings and care decisions to the establishments listed below:

Name	Relationship	Phone Number
Tueller Counseling SUDS Department	SUDS Health Services	208-524-7400
Tueller Counseling ACT Department	ACT Health Services	208-241-1396

Client may revoke or modify this specific authorization – the revocation or modification must be in writing.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Refusal of Consent Signature: _____ Date: _____

Survey

I acknowledge that I may be asked to participate in surveys to better the services at Tueller Counseling Services.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Child Intake Packet

Medical Information **Accurate information assists the provider with determining appropriate care**

Patients' Primary Care Physician: _____ **Most Recent Visit**: _____

Previous Mental Health/Substance Use Disorders Treatment

Have you ever been a client at Tueller Counseling Services? ☐Y ☐N
If yes, When? _____ **Provider name?** _____
Are you currently receiving any community services at another agency? ☐Y ☐N If yes, please provide name of service, provider name, contact information, agency name and ROI (see ROI at end of packet)
_____
_____
_____

Medications Currently Prescribed **Accurate information will expedite assignment of medical provider**

Physical Health Medications	Dose	Mental Health Medications	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____

Substance Abuse History

Check all that apply within the last 6 months.

- ☐ Tobacco
- ☐ Caffeine
- ☐ Alcohol
- ☐ Marijuana
- ☐ Cocaine/crack
- ☐ Ecstasy
- ☐ Heroin
- ☐ Inhalants
- ☐ Methamphetamines
- ☐ PCP/LSD
- ☐ Spice
- ☐ Bath Salts
- ☐ Prescription Pain Meds
- ☐ Prescription Anxiety Meds

Presenting Problems and Concerns

Describe the concern that brought you here today:

_____
_____
_____

Child Behavior Checklist ****Mark any words that apply****

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/Confusion
- ☐ Season Mood Changes*
- ☐ Sadness/Depression
- ☐ Loss of pleasure/Interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/Shame
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Phobia
- ☐ Swearing
- ☐ Lying
- ☐ Lack of motivation*
- ☐ Withdrawal from people
- ☐ Anxiety/Worry
- ☐ Panic attacks
- ☐ Fear ways from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/Fights
- ☐ Frequent arguments
- ☐ Irritability/Anger
- ☐ Homicidal Thoughts
- ☐ Flashbacks*
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/Paranoia
- ☐ Racing thoughts
- ☐ Defiance
- ☐ Curfew violations
- ☐ Truancy
- ☐ Excessive energy*
- ☐ Wide mood swings
- ☐ Sleep problems*
- ☐ Nightmares*
- ☐ Eating problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories
- ☐ Peer/Sibling conflict
- ☐ Stealing
- ☐ Destroys property
- ☐ Running away
- ☐ Other: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Child Intake Packet
Release or Exchange of Information

Client Name: _____ **Client Date of Birth**: _____

****Please INITIAL each category that applies. Do not leave any space blank. Write N/A (not applicable)****

This certifies that I hereby authorize Tueller Counseling Services, Inc to:

_____ Release information to _____ Obtain information from _____ Exchange information with

Primary Care Physician: _____

****Only 1 person/entity may be written here. Please fill out a different ROI for each person/entity****

Specific Information to be released:

_____ Dates of treatment
_____ Assessments/Evaluations
_____ Psychiatric and treatment record
_____ Progress and behaviors
_____ Health Connections Referral/History and Physical
_____ Treatment Planning
_____ Oral communication as needed
_____ Other as specified: _____

For the following purpose:

_____ Coordination of treatment/care _____ Academic considerations _____ Other: _____

In understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) Any revocations must be delivered in writing to each of the treatment providers listed above. I also understand that my records are protected under specific Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. Furthermore, I understand that Tueller Counseling Services, Inc. is released from all legal liabilities which may arise from the release of this information.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent anytime, by either written or verbal notification, except to the extent that action has been taken in reliance on it.

****THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF YOUR SIGNATURE****

Print Name: _____ Signature:_____ Date: _____

Refusal of Consent Signature: _____ Date: _____

Child Intake Packet
Release or Exchange of Information

Client Name: _____ **Client Date of Birth**: _____

****Please INITIAL each category that applies. Do not leave any space blank. Write N/A (not applicable)****

This certifies that I hereby authorize Tueller Counseling Services, Inc to:

_____ Release information to _____ Obtain information from _____ Exchange information with

Name of entity/person: _____ **Relationship**: _____
****Only 1 person/entity may be written here. Please fill out a different ROI for each person/entity****

Specific Information to be released:

_____ Dates of treatment
_____ Assessments/Evaluations
_____ Psychiatric and treatment record
_____ Progress and behaviors
_____ Health Connections Referral/History and Physical
_____ Treatment Planning
_____ Oral communication as needed
_____ Other as specified: _____

For the following purpose:

_____ Coordination of treatment/care _____ Academic considerations _____ Other: _____

In understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) Any revocations must be delivered in writing to each of the treatment providers listed above. I also understand that my records are protected under specific Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. Furthermore, I understand that Tueller Counseling Services, Inc. is released from all legal liabilities which may arise from the release of this information.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent anytime, by either written or verbal notification, except to the extent that action has been taken in reliance on it.

****THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF YOUR SIGNATURE****

Print Name: _____ Signature:_____ Date: _____

Refusal of Consent Signature: _____ Date: _____