CATHOLIC FAMILY SERVICES
Caring for People

CFS Child Client Information Sheet

Do you receive Medicaid? (Circle) Yes or No
Today's Date: E-mail Address:

Last Name:	First Name:	Middle Initial:	SS#
Street Address:			
City: State: Zip Code:			
County:		Home Phone:	
If we need to contact you by phone regarding appointment changes, is this ok? __Yes____No		Cell Phone:	
Marital Status (Circle One): Single Married Widowed Divorced Separated			
Date of Birth: (month, day, year)		Age:	Race:
Gender (Circle One) : M/F	Number of dependent children (age 19 and under) living in your home:		
Are you Employed: Yes__ No__ Work Phone:_____ If yes, place of Employment: _____		Retired: Yes__ No Student: Yes__ No	
Do you have health insurance? (Circle one) Medicaid Yes No			
If yes, does your health insurance cover mental health? (Circle one) Yes No			
Yearly Household Income: $			
Emergency Contact Name:		Relationship to you:	
		Emergency Contact Phone #	
Services Requested from CFS: Counseling Services Adoption Services Birth Mother Other:_____			
Who Referred you to CFS?		Religious Preference:	
What agency is this person from?			

Fee set per session (see Fee Schedule): $ _____

Beginning 5-1-15, any counseling client who fails to keep a scheduled appointment, without at least 24 hours' notice, will be charged a missed appointment fee. This fee will be the agreed upon fee listed above. The missed appointment fee for the psychiatrist is your normal fee of $35.

We reserve the right to reschedule you if you arrive late for your appointment.

Office Use Only:		*Social Worker:*
Date Opened:	*Appointment Time:*	*Date Closed:*

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CATHOLIC FAMILY SERVICES
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Client's Rights and Responsibilities

WELCOME to Catholic Family Services. Please be assured that our staff will do our utmost to be helpful to you. We offer Individual, Marriage and Family Counseling, Unplanned Pregnancy Counseling, Adoption and Child and Foster Care Services.

Your Rights:

1. You will receive competent professional services without discrimination due to race, color, creed, age, religious beliefs, national origin, economic status, sex, or disability.

2. Information will be provided to you about all our services and any questions you have will be answered in terms that you can understand.

3. You will have input into the design and implementation of an individualized treatment plan.

4. The information you disclose to Catholic Family Services about your problems is confidential. The exceptions to this are:

   a) when child or elder abuse or neglect is suspected or reported;
   b) when your life or the life of another person is in danger;
   c) when a properly executed Court subpoena is issued;
   d) when The State of Alabama Code does not recognize counselor/client privilege.

5. You have the right to review, in the presence of a staff member, any information about you in the agency's records.

6. You may request a change of counselor through discussion of your request with your counselor.

7. You can refuse or change a course of treatment or terminate services with this agency unless you are ordered by law or the court, in which case, the court or a representative of the law enforcement agency will be notified of your refusal or request to change your course of treatment, or to terminate our services, and the law or the court may or may not order its approval.

8. You may address any concerns about the services you receive to the Director of Catholic Social Services.

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Your Responsibilities:

1. To keep your appointments or to **cancel 24 hours in advance**. For clients who pay a fee, we reserve the right to charge for late cancellations or missed appointments. For clients who do not pay a fee, there will be a $20 fee charged for repeated failure to cancel or missed appointments.

2. For Dr. Paoletti Psychiatrist appts cost is $40 and for the counseling sliding scale. We have a two (2) no show/cancellation policy that states if you cancel or no show for two (2) consecutive appointments, your services will be terminated with Catholic Family Services effective the date of the second no show. This will also include termination with Dr. Paoletti.

3. To pay for your services at the time of your appointment or make arrangements for a delayed schedule of payment. A sliding scale fee is charged for counseling services. Fees may be reduced or waived for those unable to pay a fee. There are no fees for Unplanned Pregnancy Counseling or Foster Care. Adoptive families will receive fee information at the first appointment.

4. To be actively involved in the planning and execution of your treatment plan.

CONDITIONS UNDER WHICH CATHOLIC FAMILY SERVICES MAY DENY FURTHER SERVICES.

1. If you are two sessions behind in your fee payments.

2. If you have missed two appointments.

3. If you are not actively participating in your treatment plan.

4. If you display violent or threatening behavior or language.

5. If you are using mood altering substances during the course of your sessions and it interferes with your progress.

6. If it is your counselor's professional judgment that you would be better served at another agency.

7. If the nature of your symptoms indicates the need for medication and you refuse to consult a

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physician for assessment.

8. If you are actively involved in therapy with another therapist outside the agency who is not working cooperatively with our counselor for your benefit.

9.If you are delinquent in fees, your social worker will advise you of this and work with you on a method to remedy the situation.

10.If you are unwilling to remedy the problem, the social worker will work with you to find another resource for services.

Should you feel that your rights have not been respected, please discuss this first with your counselor.

If this does not resolve the problem satisfactorily, you may put your concern in writing to your counselor's supervisor. If you are still dissatisfied, you may write the Director of Catholic Social Services in Birmingham and request a personal review.

The address is:
1515 12th Ave South, Birmingham, AL, 35205

You will also have the right in this process to appeal to someone outside the agency to act as an advocate for you.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE CLIENT RIGHTS AND RESPONSIBILITIES.

SIGNATURE: _____ DATE:

GUARDIAN SIGNATURE: _____ DATE:

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CATHOLIC FAMILY SERVICES
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CHILD COUNSELING INTAKE QUESTIONNAIRE

IDENTIFYING INFORMATION

Child's name:_____

Date of birth:_____ Age: _____ Grade: _____

Race/ethnicity:_____Religious affiliation:_____

Social security number:_____

Referred by: _____

Child's custodian/guardians(s) is/are: _____

Child's Home address: _____

City_____State:__Zip Code:_____ Home

Telephone: _____Other Phone (specify type):_____

Is it OK to contact you/child at home? OK to leave a message? Yes ( ) No ( ) Special instructions?

_____

Emergency Contact Name:_____Relationship to Child:_____

Address:_____

City: _____State:_____Zip Code:_____ Home Telephone:_____

Other Phone (specify type):_____

Insurance Information_____

Do you have health insurance coverage for this child? Medicaid Yes No
(Circle one) (If covered by Medicaid, please provide a
copy of the card.)

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Name of person the health insurance is under.

Father's Name:_____

Mother's Name:_____

Other:_____

Name of health insurance company: _____

Person (s) completing this form:_____

MOTHER'S INFORMATION

Mother's Name:_____Date of birth:_____

Home phone:_____ Address: _____

City: _____State:_____Zip Code:_____ Home Telephone:_____

Other Phone (specify type):_____

Race/ethnicity:____Religious affiliation:_____ Highest Grade Completed:_____
Marital/relationship status (Check one):

[ ] Married [ ] Live with Partner [ ] Single [ ] Separated/Divorced [ ]Widowed or [ ] Other:_____

Employment status (Check all that apply):

[ ] employed [ ] retired [ ] disabled [ ] student [ ] homemaker [ ] unemployed If/When employed, what type of work does mother do?_____

Current employer is:_____

Years on Current Job:_____

Business Phone:_____

Is it OK to contact mother at work? Yes [ ] No [ ] OK to leave a message?

Special calling instructions:_____

FATHER'S INFORMATION

Father's name: _____Date of birth:_____Home Phone:_____

Address: _____

City: _____State:_____Zip Code:_____ Home Telephone:_____

Other Phone (specify type):_____

Race/ethnicity:_____Religious affiliation:____

Highest Grade Completed:____

Martial/relationship status (Check one):

[ ] Married [ ]Live with partner [ ]Single [ ]Separated/Divorced [ ]Widowed or Other:_____

Employment status (Check all that apply):

[ ] employed [ ] retired [ ] disabled [ ] student [ ] homemaker [ ] unemployed

If/When employed, what type of work does father do?_____

Current employer is: _____

Years on Current Job?___Business Phone:_____

Is it OK to contact father at work? Yes [ ] No [ ] OK to leave a message? Yes [ ] No [ ]

Special calling instructions?_____

STEP-PARENT'S INFORMATION

Step-parent's Name: _____ Date of birth:_____

Home phone: _____ Address: _____

City: _____State:_____Zip Code:_____ Home Telephone:_____

Other Phone (specify type):_____

Race/ethnicity:_____Religious affiliation:_____ Highest Grade Completed:___

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Marital/relationship status (Check one):

[ ] Married [ ] Live with partner [ ]Single [ ]Separated/Divorced [ ]Widowed or

[ ]Other:_____

Employment status (Check all that apply)

[ ] Employed [ ] retired [ ] disabled [ ] student [ ] homemaker [ ] unemployed

If/When employed, what type of work does stepparent do?_____

Current employer is: _____ Years on Current Job:____

Is it OK to contact stepparent at work? Yes [ ] No [ ] OK to leave a message? Yes [ ] No [ ]

Special calling instructions?_____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing:

_____

_____

_____

_____

What has happened to cause you to seek help now?

_____

_____

_____

_____

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What do you hope to be able to do or achieve as a result of treatment?

_____

_____

_____

What do you consider to be other stresses in your child's life?

_____

_____

_____

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem (s) that brought you to the clinic today?

_____

How often does the problem occur?_____ How long does it last?_____

Does your child have any thoughts of harming him/herself? No [ ] yes [ ] If yes, please explain:

_____

_____

_____

Has your child ever had previous therapy/counseling of any kind? No [ ] Yes [ ] If yes, when and for how long?

_____

_____

_____

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What concerns were addressed in therapy:_

_____

_____

_____

Was this experience helpful (please explain)?

_____

_____

_____

Has your child ever been hospitalized for emotional/behavioral problems? No [ ] Yes [ ]

If yes, when/where was this:

_____

_____

_____

_____

Has your child been prescribed medications to control emotional/behavioral problems? No [ ] Yes [ ]

If yes, please list medications, when prescribed, and by whom:_____

To your knowledge, has your child experimented with alcohol/drugs? No [ ] Yes [ ]

Are you concerned that your child might have or be developing a problem with alcohol or drugs? No [ ] yes [ ] If yes, please explain:

_____

_____

_____

_____

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FAMILY

Is this child adopted? No [ ] Yes [ ]

Has this child ever experienced any parental separations, divorced, or death? No [ ] Yes ( ]

If yes, when?_____How old was the child at the time? _____

Please describe the circumstances.

_____

_____

_____

_____

If parents are separated or divorced, who has custody of this child?_____

How often does the other parent see this child? Weekly

__ Once or twice a month

___ Few times a year

___ Never

Family and Household Information: People living in the home with child

Name	Age	Relationship	Known to Client as

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Please list the age and sex of each sibling (including those deceased, and step-siblings):

Age	Sex	Relationship to Child	Living at home?
			No Yes
			No Yes
			No Yes
			No Yes
			No Yes
			No Yes

Has anyone in the child's family had treatment for emotional problems? No [ ] Yes [ ]

If yes, please briefly explain (who/when):

_____

_____

_____

_____

Has anyone in your family ever **attempted** or **committed suicide**? No [J Yes [J
If yes, please briefly explain (who/when):

_____

_____

_____

_____

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What kinds of stressful events has your child recently experienced?

_____

_____

_____

_____

What kinds of stressful events have family members experienced recently?

_____

_____

_____

_____

Child's Education:

School (name): _____ Grade_____Age_____

Describe any difficulties or problems your child is having in school:

_____

_____

_____

_____

CHILD'S DEVELOPMENT

Did bed-wedding occur after toilet training? No [ ] Yes [ ] Days:_____Nights:_____ Did soiling

occur after toilet training? No [ ] Yes [ ] If yes, until what age:_____ Describe sleep patterns or problems:

_____

_____

_____

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Language Difficulties? No [ ] Yes [ ] If yes, describe:

_____

Delays with child's walking? No [ ] Yes [ ] If yes, describe:

_____

As a young child, did your child have problems getting along with others? No [ ] Yes [ ) if yes, describe:

_____

_____

_____

_____

CHILD'S MEDICAL CARE

Child's physician:_____Telephone:_____

Address: _____

How often does this child see a doctor?_____Date of last visit:_____ Is this child currently on any medication? No [ ] Yes [ ]

If yes, indicate type and reason

_____

_____

CHILD'S INTREST AND ACTIVITES

is this child involved in any extracurricular activities, such as school sports or music programs, clubs or religious organizations? No [ ] Yes [ ] If yes, please describe **:**

_____

_____

_____

_____

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Please describe your child's strengths and positive characteristics:

_____

_____

_____

Other information you feel is important and wasn't asked about:

_____

_____

_____

_____

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Counseling Fees

INCOME		FEE
$0-	$10,000	$2
$10,001-	$20,000	$5
$20,001-	$25,000	$10
$25,001-	$30,000	$20
$30,001-	$40,000	$30
$40,001-	$50,000	$55
$50,001-	$60,000	$60
$60,001-	$70,000	$70
$70,001-	$80,000	$80
$80,001-	AND UP	$90
Dr. Paoletti's (Birminghamm-fee will be a flat rate of $40).		

I agree to pay Catholic Family Services the sliding fee scale $____ for **counseling sessions**.

I understand if at any time I am unable to pay the fee, I should discuss my situation with my social worker who **will have to get approval from Executive Director.**

Please sign: _____

Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:_____Client Address_____

Phone Number:_____Date of Birth:_____

This Authorization Applies for the Following Information:
____ALL information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or sensitive health information and I expressly consent to the release of this information.
____ **ONLY** the following records or types of information:_____

Treatment Dates: From (month/day/year)_____to (month/day year)_____

The information may be released as follows:

From: Sending Agency _____

Address/Phone:_____

To: External Individual/Agency/Organization
_____

Adress/Phone:_____

Purpose of Release:___Continuity of Treatment____ Other (specify)_____

I understand that information released will be limited information necessary to fulfill the need or purpose for disclosure. If I have authorized the disclosure of information to a recipient who is not subject the Health Insurance Portability and Accountability Act of 1996 (RIPA), then the recipient may re-disclose it and it may no longer be protected under HIPA federal privacy law. This Authorization is valid for one hundred eighty (180) days from the date of signature, unless otherwise noted. This authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this Authorization, the revocation will not apply to information that has already been released in response to this Authorization. I understand the patient's health care and the payment for this information described on this form if I ask for it, and I may release a copy of this form after I sign it. Before requesting medical copies, please ask about a copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

_____ _____

Client/Parent/Legal Guardian Printed Name Parent/Guardian Signature Date

_____

Witness Signature Date

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