NORTHSHORE
CLINIC AND CONSULTANTS

Child Intake Packet

Welcome to Northshore Clinic and Consultants

Thank you for choosing us to provide care for your child. Please complete this packet before your child's first appointment. All information provided is confidential and protected by HIPAA regulations.

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1. Child's Information

- **Patient's Legal Birth Name: _____**
- **Patient's Chosen Name (if applicable): _____**
- **Date of Birth (MM/DD/YYYY): _____**
- **Age: _____**
- **Sex at Birth: _____**
- **Social Security #: _____**
- **Gender Identity: _____**
- **Sexual Orientation (if applicable): _____**
- **Pronouns: _____**
- **Does guardian give permission to contact patient via:**
    - **Phone call or text?** ☐ Yes ☐ No Phone number: _____
    - **Email?** ☐ Yes ☐ No Email address: _____

2. Parent/Guardian Information

- **Guardian's Name (Primary Contact):** _____
- **Relationship to Client:** ☐ Mother ☐ Father ☐ Guardian ☐ Other: _____
- **Date of Birth:** _____
- **Social Security #:** _____
- **Home Address:** _____
- **Home Phone:** (_____) _____ - _____ ☐ OK to leave message? ☐ Yes ☐ No
- **Cell Phone:** (_____) _____ - _____ ☐ OK to leave message? ☐ Yes ☐ No
- **Work Phone:** (_____) _____ - _____ ☐ OK to leave message? ☐ Yes ☐ No
- **Email Address:** _____ ☐ OK to leave message? ☐ Yes ☐ No
- **Does the client reside with you?** ☐ Yes ☐ No
- **Guardian's Name (Secondary Contact):** _____
- **Relationship to Client:** ☐ Mother ☐ Father ☐ Guardian ☐ Other: _____
- **Date of Birth:** _____
- **Social Security #:** _____
- **Home Address:** _____
- **Home Phone:** (_____) _____ - _____ ☐ OK to leave message? ☐ Yes ☐ No
- **Cell Phone:** (_____) _____ - _____ ☐ OK to leave message? ☐ Yes ☐ No
- **Work Phone:** (_____) _____ - _____ ☐ OK to leave message? ☐ Yes ☐ No
- **Email Address:** _____ ☐ OK to leave message? ☐ Yes ☐ No
- **Does the client reside with you?** ☐ Yes ☐ No

3. Emergency Contact Information

- **Emergency Contact Name:** _____
- **Phone Number:** (_____) _____ - _____
- **Relationship to Child:** _____

4. Insurance Information

- **Insurance Provider:** _____
- **Subscriber Name:** _____
- **Date of Birth:** _____
- **Subscriber ID:** _____
- **Employed By:** _____
- **Secondary Insurance?** ☐ No ☐ Yes (Present card if applicable)

5. Custody and Legal Considerations

- **Is this your birth child?** ☐ Yes ☐ No
    - If adopted, at what age? _____
    - If foster, how long? _____
- **Comments about custody or visitation arrangements (if applicable):**

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6. Treatment Agreement and HIPAA Consent

By signing below, I acknowledge that I understand Northshore Clinic's policies and procedures, including the confidentiality of records under HIPAA. I authorize Northshore Clinic & Consultants to release necessary information to my insurance company for billing purposes. I also authorize the assignment of insurance payments to the clinic.

I am aware of the clinic's cancellation policy, financial responsibility, and the expectation of providing payment for missed or improperly canceled appointments.

- **Guardian Signature:** _____
- **Date:** _____
- **Therapist Signature:** _____
- **Date:** _____

7. Personal History

- **Child's Name:** _____ Age: _____
- **Date of Birth:** _____
- **Referred By:** _____
- **Date of Assessment:** _____

Symptom/Problem Checklist

(Check any symptoms that are a concern)

☐ Frequent tantrums
☐ Impulsive
☐ Social fears
☐ Suicidal thoughts
☐ Anxiety/panic attacks
☐ Difficulty following rules
☐ Aggressive behavior
☐ Nightmares
☐ Substance use
☐ Other: _____

8. Family History

- **Are parents married?** ☐ Yes ☐ No
- **Are parents divorced?** ☐ Yes ☐ No – How long? _____
- **Any family history of mental health issues or substance abuse?** ☐ Yes ☐ No
    - If yes, please explain:
      _____

9. Medical History

- **Child's Primary Physician:** _____
- **Last Visit:** _____ Reason: _____
- **Any current medications or medical conditions?** ☐ Yes ☐ No
    - If yes, please explain:
      _____

10. Developmental History

- **Mother's health during pregnancy: _____**
- **Any significant developmental delays (speech, walking, etc.)?** ☐ Yes ☐ No
    - If yes, please explain:

      _____

11. Goals for Treatment

- **What do you expect from treatment?**

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12. Consent for Treatment and HIPAA Agreement

I hereby consent for my child to receive mental health services at Northshore Clinic & Consultants. I understand that the information provided is confidential, in compliance with HIPAA guidelines. I also understand that the therapist may discuss my child's case with other professionals within the clinic for consultation purposes.

- **Guardian Signature: _____**
- **Date: _____**
- **Therapist Signature: _____**
- **Date: _____**

13. Electronic Signature Authorization Form

By signing this form, I agree that my electronic signature, in any font or format, is the legally binding equivalent of my traditional handwritten signature. I understand that this electronic signature may be used on all applicable documents related to my child's care at Northshore Clinic and Consultants, including, but not limited to:

- Initial Assessments
- Diagnostic forms
- Treatment Plans
- Progress Notes

I give consent for my Clinician/Therapist to use my electronic signature in conjunction with these forms and any other clinical or administrative documents required during the course of my child's treatment.

- **Guardian Name (Printed): _____**
- **Date of Birth: _____**
- **Guardian Signature: _____**
- **Date: _____**

14. Informed Consent for Counselor Intern Services

I understand that my child may receive services from a Counselor Intern who is in the process of completing their training under the supervision of a licensed clinician. The licensed supervisor will have access to my child's records and may review session notes or recordings for supervision purposes. I understand that I can request to work with a licensed clinician at any time.

By signing below, I consent for my child to receive services from a Counselor Intern.

- **Guardian Name (Printed):**
  _____
- **Date of Birth: _____**
- **Guardian Signature): _____**
- **Date: _____**

15. Telehealth Consent Form

Telehealth involves the use of electronic communications to enable clinicians to connect with patients for remote healthcare services. By signing below, I agree for my child to receive telehealth services from Northshore Clinic and Consultants.

- **I understand that I have the right to withhold or withdraw consent to telehealth at any time without affecting my child's right to future care or treatment.**
- **I understand that telehealth may involve risks such as technology failures or unauthorized access to data.**
- **I agree that telehealth is not appropriate for emergencies and that I will contact 911 or go to the nearest emergency room in such cases.**
- **I understand that I may be responsible for co-pays or fees associated with telehealth services.**

By signing below, I consent for my child to participate in telehealth services.

- **Guardian Name (Printed):**
  _____
- **Date of Birth: _____**
- **Guardian Signature: _____**
- **Date: _____**

16. Email and Texting Consent Form

By signing below, I consent to receive non-urgent communications from Northshore Clinic and Consultants regarding my child via email and/or text. I understand the potential risks of email and texting, including the possibility of unauthorized access. I agree to safeguard any communications I receive.

- **Guardian Name (Printed):**
  _____
- **Date of Birth: _____**
- **Email Address: _____**
- **Phone Number for Texting:** (_____) _____ - _____

- **Guardian Signature: _____**
- **Date: _____**

17. Informed Consent for Counselor Intern Services

I understand that my child may receive services from a Counselor Intern who is in the process of completing their training under the supervision of a licensed clinician. The licensed supervisor will have access to my child's records and may review session notes or recordings for supervision purposes. I understand that I can request to work with a licensed clinician at any time.

By signing below, I consent for my child to receive services from a Counselor Intern.

- **Guardian Name (Printed):**
  _____
- **Date of Birth: _____**
- **Guardian Signature): _____**
- **Date: _____**

18. Financial Policy

Payment and Insurance

- **Payment is due at the time of service unless prior arrangements have been made.** We accept cash, checks, and major credit cards.
- **Insurance:** We accept many insurance plans and will submit claims to your insurance company on your behalf. However, it is your responsibility to:
  - Verify your insurance coverage prior to your first appointment.
  - Pay any co-pays, deductibles, or co-insurance as required by your insurance plan.
  - Understand that any amount not covered by your insurance is your responsibility.
- **Self-Pay Clients:** For those without insurance or those who prefer not to use insurance, payment is due in full at the time of service. We offer a sliding fee scale in certain cases—please discuss this with our office.

Cancellation and Missed Appointment Policy

- **Cancellations:** If you need to cancel or reschedule an appointment, please notify us at least **24 hours** in advance. Failure to do so may result in a cancellation fee of **$50**.
- **Missed Appointments:** Appointments that are missed without notification ("no-shows") will be charged a fee of **$75**. This fee is your responsibility and will not be billed to your insurance company.

Late Payment and Returned Check Policy

- **Late Payments:** Payments not made within 30 days of receiving a bill will be considered past due. If your account becomes delinquent, we reserve the right to suspend or terminate services until the balance is paid.
- **Returned Checks:** A fee of **$35** will be charged for any returned checks due to insufficient funds.

Credit Card on File

For your convenience, we require a credit card on file to cover co-pays, fees, and any outstanding balances. Your card will only be charged if:

- You fail to pay your balance by the agreed-upon due date.
- A cancellation fee or missed appointment fee is incurred.

By signing below, I acknowledge that I have read and understand Northshore Clinic and Consultants' Financial Policy. I agree to the terms and understand that I am financially responsible for all charges incurred, whether or not paid by insurance.

- **Patient Name (Printed): _____**
- **Date of Birth: _____**
- **Patient Signature: _____**
- **Date: _____**
- **Credit Card: _____**
    - **Card Type: _____**
    - **Ex. Date: _____**
    - **Sec.Code**: **_____**

*Full Financial Policy and Fee Schedule Provided at time of first appointment and available online