To fill in this form you must have Adobe Reader otherwise you will not be able to fill out or submit this form.

If you need Adobe Reader click icon below, this is a free software.

Office: 210-757-3150
Fax: 800-508-0086

Rapha Counseling

MINOR INTAKE PACKET

PATIENT INFORMATION:

FIRST & LAST NAME: _____ INT: _____

ADDRESS: _____

CITY: _____ STATE: Texas ZIP: _____

CELL: _____ HOME: _____

CAN WE LEAVE A TEXT AND/OR MESSAGE? YES ◯ NO ◯

DOB: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

EMAIL: _____ WHO DOES THE MINOR LIVE WITH?:

IS THERE A DIVORCE DECREE OR CUSTODY ISSUES? ◯ YES ◯ NO

EMERGENCY CONTACT NAME: _____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE NUMBER: _____ CELL ◯ LAND LINE ◯

INSURANCE INFORMATION:

FIRST & LAST NAME: _____ RELATIONSHIP TO INSURED: _____

EMPLOYER: _____ PLAN NAME: _____

INSURANCE COMPANY: _____

SUBSCRIBER ID: _____

GROUP NAME: _____ DEDUCTIBLE: _____ CO-PAYMENT:_____

Your co-pay amount is sometimes listed on front of card as an office visit.
If unsure, please call your insurance company to find out.

We strongly suggest calling your insurance company to find out how much of a deductible, copay, co-insurance amount you will need to pay prior to seeing any provider.

We do not submit to secondary insurances. We can print a receipt so you can submit for reimbursement.

10615 Perrin Beitel Rd Ste 801
San Antonio, TX 78217

400 N loop 1604 E Ste 115B
San Antonio, TX 78232

WWW.RaphaSA.com .

SHARING INFORMATION ABOUT CHILD/ADOLESENT CLIENTS WITH PARENTS

Terms of the Confidentiality Contract

Basic Legal principle that parents have the rights to make medical decisions for minor children.

Children have same confidentiality rights as adults.

1. Therapy needs to be a safe place for all participants and the parents need to know information about their children that allows them to fulfill their responsibilities as parents.
2. The therapist will keep all information learned from and about a child/adolescent confidential unless the child agrees that it will be shared.
3. Therapist will encourage and assist child/adolescent in sharing information with parents where appropriate.
4. Parents will receive regular reports form the therapist about how therapy is going.
5. If the therapist believes that a child is at serious risk or harm (suicide) or is at serious risk of harming another person (threatening to hurt someone else) he/she may non-consensually (without consent) Breach the child's confidentiality.
6. Termination of this contract proceeds after mutual agreement or if sessions are no longer being scheduled.

By signing below, you indicate that you have read and understood this document.

Every box must be filled in.

_____	_____	_____
Name of Client	Relationship to Client	Date

_____	_____
Name of Parent or Guardian signing	Type Name of Parent or Guardian to Sign

Parents Marital Status: Married ◯ Divorced ◯ Widowed(er) ◯

If divorced, is there a divorce decree? Yes ◯ No ◯

Primary residence of Children: _____

About Minor:

YES ◯ NO ◯ Do you work? Occupation? _____

Position? _____

How long have you worked there? _____

Current level of education ◯ Elementary ◯ Middle School ◯ High school ◯ Trade School

YES ◯ NO ◯ Are you in school now? Where? _____

YES ◯ NO ◯ Do you smoke cigarettes? What age did you start smoking? _____

How much? _____ How Often? _____

YES ◯ NO ◯ Do you drink alcohol? What age did you start drinking? _____

How much? _____ How Often? _____

Have You:

YES ◯ NO ◯ Had a DWI Year/s: _____ Had a DUI Year/s: _____

YES ◯ NO ◯ Do you take illegal drugs?

Which drugs? _____

How often? _____

YES ◯ NO ◯ Ever been arrested?

What for? _____

YES ◯ NO ◯ Are you on probation?

What for? _____

YES ◯ NO ◯ Are you currently, or do you expect to be involved in any court related matters? If yes, please describe: _____

_____

Are You?

YES ◯ NO ◯ Under a doctor's care? If so what for?

YES ◯ NO ◯ Are you taking medication?

YES ◯ NO ◯ Have you had any previous Mental Health Therapy?

If yes, please name therapist/s. _____

YES ◯ NO ◯ Have you ever been hospitalized for psychiatric reasons? Year/s: _____

Where? _____

YES ◯ NO ◯ Have you ever attempted suicide?

YES ◯ NO ◯ Are you having suicidal thoughts now?

YES ◯ NO ◯ Do you have a plan? _____

YES ◯ NO ◯ Do you feel Homicidal now?
Please describe. _____
_____

YES ◯ NO ◯ Do you feel like you're in danger?
Explain why_____
_____

OTHER:

Are there any Family concerns?

YES ◯ NO ◯ Is there anger, violence, abuse? alcohol/drug abuse in your family?
If so who and what is the concern? (example: Mother, Brother…)
_____
_____
_____

YES ◯ NO ◯ Does anyone in your family have depression/Anxiety/Bi-Polar/Other? Who?
(example: Father, Sister…) _____
What type of issue?
_____
_____
_____

CONCERNS TO BE ADDRESSED IN THERAPY? (3 GOALS)

1._____

2._____

3._____

Are you requesting Faith based Counseling? ◯ Yes ◯ No Preference

Please Check all that Applies

- ☐ No Appetite
- ☐ Overeating
- ☐ Always Tired
- ☐ Always Sleepy
- ☐ Difficult Concentrating
- ☐ Unable to Relax
- ☐ Grief and Loss
- ☐ Sadness
- ☐ Uninterested in Normal Activities
- ☐ Feelings of Guilt
- ☐ Unable to Have a Good Time
- ☐ Can't Make Decisions
- ☐ Loneliness
- ☐ Negative Outlook
- ☐ Negative Thoughts of Self
- ☐ Feelings of Failure
- ☐ Suicidal Thoughts with a Plan
- ☐ Suicidal Thoughts without a Plan
- ☐ Insomnia
- ☐ Recurrent Dreams/Nightmares
- ☐ Violence
- ☐ Flashbacks
- ☐ Experienced a Traumatic Event
- ☐ Abused as an Adult
- ☐ Memories of a Traumatic Event
- ☐ Emotionally Numb
- ☐ Feel Panicky
- ☐ Abusive Relationship
- ☐ Sexual Abuse/Rape
- ☐ Abused as a Child
- ☐ Over Concerned with Weight
- ☐ Concerns about Eating
- ☐ Excessive Exercising
- ☐ Recent Weight Loss or Gain
- ☐ Problems with Body Image
- ☐ Laxatives/Water pills for wt. loss
- ☐ Vomiting for weight loss
- ☐ Dizziness/Fainting
- ☐ Repetitive Behaviors
- ☐ Shortness of Breath
- ☐ Anxiety or Excessive Worry
- ☐ Racing Heartbeat
- ☐ Sweating, Shaking, Nausea
- ☐ Feel Tense
- ☐ Panic Attacks
- ☐ Perfectionist
- ☐ Excessive Counting
- ☐ Obsessions
- ☐ Feelings of going Crazy
- ☐ Losing Control
- ☐ Hallucinations
- ☐ Fears and Phobias
- ☐ Fear of Being in Crowds
- ☐ Fear of Wide-Open Spaces
- ☐ Afraid of People
- ☐ Afraid of Going Out
- ☐ Fear of Doing Things
- ☐ Afraid of Being Home Alone
- ☐ Social Problems
- ☐ Shy with People
- ☐ Taking Tranquilizers
- ☐ Alcohol Abuse
- ☐ Illegal Drugs
- ☐ Prescription/OTC Drug Use
- ☐ Memory Problems
- ☐ Academic/School Problems

Please Check all that Applies

- ☐ Attention Problems
- ☐ Impulsive
- ☐ Can't Make Friends
- ☐ Driven by a Motor Behavior
- ☐ Issues in School
- ☐ Racing Thoughts
- ☐ Parent Child Conflict
- ☐ Truancy
- ☐ Legal Problems
- ☐ Destruction
- ☐ Runaway
- ☐ Lying/Dishonest
- ☐ Gambling
- ☐ Over-Ambitious
- ☐ Financial Problems
- ☐ Extreme Behaviors (shopping, risk taking, hyper-sexual)

- ☐ Job Problems
- ☐ Anger/Temper Problems
- ☐ Homicidal Thoughts Self
- ☐ Harming Behaviors
- ☐ Inferiority Feelings
- ☐ Abusive Behavior
- ☐ Parenting Problems
- ☐ Affair
- ☐ Difficult Home Situation
- ☐ Marital Problems
- ☐ Headaches
- ☐ Stomach Problems
- ☐ Bowel Disturbances
- ☐ Asthma or Allergies
- ☐ Sexual Problems
- ☐ Ongoing Physical Pain
- ☐ Other: _____

For Provider Use Only:

Evaluation and Treatment Consent

Below are listed some important facts regarding your treatment and services at Rapha Counseling.

Services Provided: Rapha Counseling provides psychological counseling and case management services, including diagnostic assessments, treatment planning, consultations, individual, group and family counseling, along with information & referral.

Session Length: A session lasts either 45 minutes or (1) clinical hour (55 min) depending on insurance. If your health insurance requires a co-pay, you will be responsible for paying the co- pay prior to the start of each session. Electronic billing will be at the discretion of Rapha Counseling for payment of services through insurances. Rapha Counseling submits claims as a courtesy and is not a requirement of your insurance company.

Cancellation Policy: I understand that it is my responsibility to keep my appointments and **I WILL GIVE AT LEAST A 24 HOUR NOTICE** if I am not able to keep my appointment.

Further understand that if I have **two no-shows**, I may be subject to same day scheduling and will not be allowed to make appointments ahead of time. If you need to cancel an appointment, please notify this office as soon as possible. You may cancel by calling (210) 757-3150.

Confidentiality: All information and records will be kept confidential and will be held in accordance with state and federal (HIPPA) laws regarding the confidentiality of such records and information. However, records and/or information will be released regardless of consent under the following circumstances.

Consent to ART and Sandtray therapy: In the event that I am offered either ART Thereapy(Accelerated Resolution Therapy) or Sandtray Therapy as a course of treatment, I consent to this form of therapy and by signing below I give my consent.

Rapha Counseling will not compromise on the following:

***According to state and local laws, counselors must report all cases of physical and sexual abuse or neglect of minors or the elderly to the appropriate agency.**

***According to state and local laws, counselors must report all cases in which there exists a danger to self or others to the appropriate agency.**

In the event that a patient is in need of emergency services or other medical personnel need to be contacted / In the event that your records may be subpoenaed in court:
Right to Access Records: Adult clients, legal guardians of minors, including managing and processor conservators, can access the record of the services provided to them at Rapha Counseling for a fee.

Treatment of Minors: Treatment of children less than 18 years of age will be provided only with the consent of the legal guardian. By signing this consent form the client acknowledges that he or she is the legal guardian (as established by the state or by divorce decree) of any minor presented for treatment.

Authorization to Release Information: I hereby give authorization to release any information necessary to process medical insurance claims and authorize payments of benefits to the therapist for services rendered. I also give permission to release any information regarding the treatment/case that may be required by TDFPS- Child Protective Services.

I acknowledge I have read this page: Type name to Sign: _____ Date: _____

Rapha Counseling Informed Consent

I understand, as in the case of medical services, no guarantee can be provided that the concerns or issues for which I am seeking services will be resolved. Because mental health treatment is a cooperative effort between me and my provider, I will work with my provider in a cooperative manner to resolve my difficulties.

I understand that it is my responsibility to be honest and provide accurate and complete information about myself.

I understand that during my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my concerns.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information, as is outlined in the Privacy Notice provided to me.

I have read and understand this statement of informed consent. I consent to treatment by Rapha Counseling with the knowledge of the above conditions.

I have read and had explained to me the basic rights of individuals who undergo treatment at Rapha Counseling.

On occasions we may need to refer our clients out to determine levels of depression/anxiety/ADHD or other conditions, that may require an official diagnosis by a Psychiatrist, Psychologist, or Medical Physician to determine treatment.

Clients Signature - Please type your name: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL& HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY

Use and disclosures of health information: We use health information about you to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred (Only when you sign a written release giving us permission to do so), unless otherwise indicated on the program specific consent form. Information may be shared by paper mail, electronic mail, fax, or other methods.

We make use of disclosed identifiable health information about you without your authorization for several reasons: Subject to certain requirements, we may provide health information without your authorization for public health purposes, auditing purposes, research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we ask for your written authorization before using identifiable health information about you. If you choose to sign an authorization to disclose information you can later revoke that authorization to stop any future uses and disclosures.

In the event that Rapha Counseling, significantly changes this policy, you will be issued a new Privacy Statement. For more information about our privacy practices, contact Elizabeth Arredondo, MEd., LPC-S, Mental Health Director at (210) 757-3150.

Individual Rights: In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you (unless otherwise specified under the specific contract for which you are receiving services). You also have the right to receive a list of where we have disclosed health information about you for reasons other than treatment, payment of related administrative purposes, and other than where you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information and/or add the missing information.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Elizabeth Arredondo, MEd., LPC-S, Mental Health Director at (210) 757- 3150. You may also send a written complaint to U.S. Department of Health and Human Services. Elizabeth can provide you with the appropriate address upon request.

Rapha Counseling Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in the notice and obtain your acknowledgment of receipt of this notice. If you would like a copy of this notice one can be provided to you at the front desk.

Acknowledgment of receipt of Notice of Privacy Practices:

Please sign and print your name, and date this acknowledgement form

Signature (type name to sign)	Printed Name	Date

Statement of Clients Rights

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law records may be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of treatment.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Rapha Counseling, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights policy.
- Know about advocacy and community groups and prevention services.
- If asked, the provider will act on the member's behalf as an advocate.
- Freely file a complaint and learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made based on treatment needs.
- Received information about Rapha Counseling's staff qualifications and any organization Rapha Counseling has contracted with to provide services.
- Decline participation or withdraw from programs and treatment services.
- Know which staff members are responsible for managing their services and from whom to request a change in services.

Statement of Client Responsibilities

- Treat those giving them care with dignity and respect.
- Give providers and Insurance Companies information that they need. This is so providers can deliver quality care and Insurance Company can deliver appropriate services. To pay patient responsibility costs.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Keep their appointments. Members should call their provider(s) as soon as they know they need to cancel appointments.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report any abuse or fraud.
- Openly report concerns about the quality of care they receive.
- Let your insurance company and their provider know if they decide to withdraw from treatment.

Clients Signature - Please type your name: _____ Date:_____

All Clients

TWO (2) Missed or Rescheduled Appointments

will cancel all future scheduled appointments

EAP Clients: *Due to the nature of the Employee Assistance Program after 2 cancellations you will need to contact your EAP. **RAPHA COUSELING OLNY ACCEPTS 1 EAP APPROVAL PER YEAR. ***

FMLA/Disability:

- *Minimum 6 sessions must take place for documents to be filled out* ***(must notify office on the first visit failure to do so may cause a delay)***
- *There is a $45.00 document fee*
- *Any additional requests made $25.00*

Emotional Support Animals- *Please see your Family Doctor as we do not fill out this type of paperwork.*

Your typed name constitutes you have read and understand this page.

Clients Signature - Please type your name: _____ Date: _____

Please retain for your records

Committed to your Well Being

I know there are a lot of choices when considering a Counseling group, I consider our group one of the best San Antonio has to offer. Every day we strive to improve and bring more options to our clients. In that we also understand everyone is different and "rapport" with their Counselor is essential. If for any reason you don't feel connected to your therapist, call my front office staff and we will assist you in finding another therapist within our organization. We offer many highly qualified therapists that can step right in.

Alex Arredondo
Administrator
Rapha Counseling Business Office
San Antonio, TX
210.757.3150 (o)

Save Submit Print

We use HIPPA compliant email servers