Chelsi House, LMHC- Child and Adolescent Therapist
License #LH60859328
North Creek Parkway, Suite 306, Bothell, WA 98011
Office: 425-419-4993/Fax:425-309-5187
www.childpsychservices.org

CLIENT REGISTRATION

Child's Name: ____ DOB ____________________
(Last) (First) (MI) (Nickname)

Gender: M / F Age: _____ Grade Level: ______

Parent/Guardian Information

Father's Name _______________________________ **Mother's Name:** __________________________________

Are parents- Married________Separated__________ Divorced_________ Other ____________________

Please list other immediate family members, and or other's who live in the home:
Name: ______________________________ Age:_________ Lives in home: ______ Lives out of home: ________
Name: ______________________________ Age:_________ Lives in home: ______ Lives out of home: ________
Name: ______________________________ Age:_________ Lives in home: ______ Lives out of home: ________
Name: ______________________________ Age:_________ Lives in home: ______ Lives out of home: ________
Name: ______________________________ Age:_________ Lives in home: ______ Lives out of home: ________

Parenting Plan: Yes No Letter of Guardianship: Yes No Foster/Adopt Yes No

Guardian Ad Lidem: Name____ Ph #____________________

(Copies of any and all custody documents is required prior to a child receiving services; if custody requires both parents consent, this must be obtained prior to child receiving services)

Address

____
(Street/PO Box) (City) (State) (Zip)

Home Phone ____________________________________ **Cell Phone** ____________________________

Work Phone_____________________________________**Email** ____

Employer/Occupation _____________________________________**Job Title** ______________________________

IN CASE OF EMERGENCY NOTIFY:

NAME ____PHONE _____________________

RELATIONSHIP TO CLIENT ______________________________

Referred by:
____

FINANCIAL POLICIES AGREEMENT

INSURANCE BILLING: Child Psychological Services PLLC and Chelsi House, LMHC, is contracted with Premera, Regence, First Choice, and Cigna. As a courtesy, we will bill client insurance companies provided the client has completed the necessary insurance information. We do not bill secondary insurance companies. It will be the client's responsibility to seek reimbursement from a secondary insurance policy. In addition, for whatever reason, client's insurance company does not pay for the services billed, the client shall be responsible for all unpaid portions of service provided. In the event the client's insurance company denies the payment claim; payment arrangements may be requested. For non-contracted insurance plans (out of network), we require payment at the time of service and as a courtesy we will submit your claims to your insurance carrier. **The client is responsible for payment of deductibles, differences in reimbursements and cost of any services not reimbursed by insurance companies. Any necessary referrals must be on file prior to billing of insurance**.

Please submit a copy of your insurance card (front and back) via email to chelsi.house.lmhc@gmail.com prior to your intake visit to process your insurance verification. Please include your child's name and date of birth. We will verify coverage and deductibles.

FINANCIAL RESPONSIBILITY: Full payment is expected at the time of service, unless other contractual arrangements apply. We accept cash, checks, debit and credit cards. All services rendered will be billed to you or to your contracted insurance plan. Co-payments or coinsurance percentages are due at the time of service if we are billing your insurance company. Monthly account statements will be sent showing all payments made and any additional fees owed due to insurance reimbursements. These payments are due within 30 days of the billing date. Accounts over 60 days will be assessed a $15.00 fee, and all further sessions will require full payment at the time of service until the account is brought current. Accounts 90 days and over will occur a monthly fee of $25 until brought current. There will be a $30.00 fee for payments returned as non-sufficient or non-payable.

Please note, if sessions are cancelled by you less than 24 hours prior to the scheduled session, you will be billed for that session in full scheduled fees. No fee will be incurred if the counselor or agency is required to cancel your session.

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR) INFORMATION

1. *Guarantor Name: ____ Birth Date ____________________
   (Last) (First) (MI)

2. Guarantor Address: ____
   (Street/PO Box) (City) (State) (Zip)

3. Guarantor Relationship to Client (Circle One):

Spouse Mother Father Sibling Guardian Other

4. Home Phone ____________________ 5. SS# ________________________________
5. Drivers License # ____
6. Guarantor's Employer ____
   Work Phone __________________ Occupation ____

AUTHORIZATION TO BILL INSURANCE

I hereby give my consent for Child Psychological Services, PLLC to bill my insurance company for services rendered to me and my child by health care provider, Chelsi House, LMHC. I authorize my insurance company to pay medical benefits directly to Child Psychological Services, PLLC / Chelsi House, LMHC. I authorize, Child Psychological Services, PLLC to release necessary medical information to my insurance company and/or to their designated managed care company as is required by my insurance company to process my insurance claims. I understand that if I leave therapy with an unpaid balance, Child Psychological Services will make every effort to collect these debts. Any attorney fees or costs resulting from collection efforts will be an additional charge to my balance owing. I understand my obligations under this agreement, and fully agree to pay for my service at my established rate.

AGREED AND ACCEPTED:

____
Guarantor Signature Date

____
Spouse / Parent / Guardian Signature Date

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Client Information and Consent to Treatment Agreement

Thank you for choosing Child Psychological Services, PLLC. We are committed to giving you the best care possible. To acquaint you further with the procedures and policies, we are providing the following information.

APPOINTMENTS: If you need to cancel an appointment, a minimum of 24 hours notice is required; otherwise, you are subject to full charge for the appointment. In the evenings and on weekends, you may leave a message on the voice mail, which will accurately record the date and time you placed the call. We will do our best to be punctual for your appointment unless there is an emergency. We ask that you be punctual as well. If you are late, for any reason, please call our office to inform us. This is necessary so we can see following patients at their scheduled times. ***Please note***: Insurance does not cover missed appointment charges.

EMERGENCIES: We do not provide 24/7 crisis counseling services. The number for the King County Crisis Center is (425) 461-3222 and for the Snohomish County Crisis Center is (425) 258-4357.

CONFIDENTIALITY: Your client records are the property of Child Psychological Services, PLLC and shall be treated as confidential according to state and federal law. No information about you is released from this agency to anyone without your written permission, except as required by law or court order. We are required by law to report suspected child abuse (regardless of when it occurred), and clear, concrete evidence of planned acts of violence. **Exception: If you have requested your records be available to a third party, you will need to complete, sign and date an "Authorization to Release (Verbal/Written) Information" form that details information to be disclosed and provides a specific time frame for this to occur.**

WRITTEN RECORDS: Child Psychological Services, PLLC maintains written files about your service for seven (7) years, or till your child reaches age 21 years-old. You have the right to review your file and provide written documentation if you disagree with the contents which will be kept with the file. If so desired, please arrange such a review with Chelsi House, LMHC.

I/We, the undersigned, certify that the information concerning my resources is correct. I have read and understand my rights and responsibilities as outlined in this document and other supplementary documents completed as addendum to this document. I do hereby request and consent to treatment for my child with Child Psychological Services PLLC, and with Chelsi House, LMHC. I will participate in the development of a treatment plan that best addresses my child's needs or situation. I also verify that I have received the required state disclosure information. I understand that nothing in this Patient Information and Consent to Treatment agreement shall be interpreted to limit or modify my rights and obligations under the State Required Disclosure Form. I understand I may stop services when I choose, with no obligation to continue if I so choose.

____
Client Signature   Date

____
Parent / Guardian   Date

____
Parent / Guardian   Date

____
Therapist   Date

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CONSUMER RIGHTS STATEMENT

As a client or a prospective client of Child Psychological Services PLLC, you have the right to:

1. Be treated with respect, dignity, and privacy;
2. Develop a plan of care and services which meets your unique needs;
3. The services of a certified language or sign language interpreter and written materials in alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;
4. Refuse any proposed treatment, consistent with the requirements in Chapter 71.05 and 71.34 RCW;
5. Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;
6. Be free of any sexual exploitation or harassment;
7. Review your clinical record and be given an opportunity to make amendments or corrections;
8. Receive an explanation of all medications prescribed, including expected effect and possible side effects;
9. Confidentiality, as described in Chapters 70.02, 71.05, and 71.34 RCW and regulations;
10. All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in Chapter 388-04 WAC;
11. Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;
12. Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;
13. Lodge a complaint with the OMBUDS, Regional Support Network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The OMBUDS may, at your request, assist you in filing a grievance. The OMBUDS' phone number is: 1-800-790-8049.
14. As a Medicaid client /consumer (including parents/foster parents, assigned/appointed guardians of children and youth) are able to choose a participating mental health PCP to comply with WAC 388-865-0345, or any successor, and in accordance with the approved Medicaid waiver or any successor.
15. As a consumer, you have the right to request disenrollment from the prepaid health plan.

Client Signature: ______________________________ Date: ________________

Parent /
Guardian Signature: ______________________________ Date: ________________

Therapist Signature: ______________________________ Date: ________________

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Comprehensive Child Clinical History Form

Date: ______________________________ Patient is: ☐left-handed ☐right-handed ☐ambidextrous

Child's Name:____
Last First Middle Initial

Gender:______DOB: ________________Age: ____ Ethnicity:______________ Language:__________________

What are your main concerns? ____

____

____

____

____

____

____

____

What strategies have been used to address these problems? (check those that apply and circle those that have been successful):

Verbal Reprimands	Time Outs	Remove Privileges	
Reward system	Physical punishment	Giving in	_____
Avoiding issues	Other________________________________		

How would you rate your child's overall functioning? (circle)

10	9	8	7	6	5	4	3	2	1
unable to function in all areas		unable to function in in most areas		serious difficulty functioning		mild to moderate difficulty		minimal difficulty	no difficulty

5. What are your goals for treatment and desired outcome? ____

____

____

____

____

____

____

____

PREGANCY/INFANCY HISTORY

Please check the following for the mother of the child:	True	Not True	Don't Know
1. Had bleeding during the first 3 months	_____	_____	_____
2. Had bleeding during the second 3 months	_____	_____	_____
3. Had bleeding during the last 3 months	_____	_____	_____
4. Grained less than 15 pounds, specify:	_____	_____	_____
5. Gained more than 30 pounds, specify:	_____	_____	_____
6. Had pre-eclampsia or toxemia	_____	_____	_____
7. Had to take medications; list	_____	_____	_____
8. Took narcotic drugs; list	_____	_____	_____
9. Drank alcohol; amount	_____	_____	_____
10. Had previous miscarriage; number	_____	_____	_____
11. Had premature baby(ies)	_____	_____	_____
12. Smoked 1 pack or more of cigarettes daily	_____	_____	_____
13. Labor lasted less than 2 hours	_____	_____	_____
14. Labor lasted more than 12 hours	_____	_____	_____
15. Had a difficult labor	_____	_____	_____
16. Was put to sleep for delivery	_____	_____	_____
17. Was given medication for labor; specify	_____	_____	_____
18. Delivery was normal	_____	_____	_____
19. Delivery was breech, caesarian, forceps, induced	_____	_____	_____

20. How was the mother's health during the pregnancy of this child? ___good ___fair ___poor ___don't know
21. How old was the mother when this child was born? _____________
22. Was this child born on schedule? ___8 mths. or earlier ___term (8-10 mths) ___after 10 mths ___don't know
23. What was this child's birth weight? ___pounds ____ounces
24. Is this child adopted? ___yes ___no If yes, at what age?_______
25. Number of previous pregnancies:_______________
26. Number of living children:_______________

Newborn Infant Problems

(first month of life)	True	Not True	Don't Know
1. Born with cord around neck	_____	_____	_____
2. Injured during birth	_____	_____	_____
3. Had trouble breathing	_____	_____	_____
4. Jaundiced (turned yellow)	_____	_____	_____
5. Cyanosis (turned blue)	_____	_____	_____
6. Was a twin or triplet	_____	_____	_____
7. Had an infection	_____	_____	_____
8. Had seizures	_____	_____	_____
9. Was given medications, specify:	_____	_____	_____
10. Needed oxygen	_____	_____	_____
11. Was in hospital more than five days	_____	_____	_____
12. Born with a heart defect	_____	_____	_____
13. Born with other defect(s), specify	_____	_____	_____
14. Had trouble sucking	_____	_____	_____
15. Had skin problems	_____	_____	_____
16. Colic	_____	_____	_____
17. Sleep problems	_____	_____	_____

Comments:____
____
____
_
____

DEVELOPMENTAL FACTORS

When did this child do the following: (If you cannot recall the age, write either early, normal, or late.)

	No	0-3 mo	4-6 mo	7-12mo	13-18 mo	19-24 mo	2-3 yrs	3-4 yrs	4-5 yrs	5-7 yrs	7+ yrs
1. Hold up head											
2. Roll front to back											
3. Sit alone											
4. Crawl											
5. Walk alone											
6. Speak single words (not mama/dada)											
7. String two or more words together											
8. Toilet trained (bladder control)											
9. Toilet trained (bowel control)											
12. Have difficulty separating from parents											
13. Thumb-sucking											
14. Fears (what?)											
15. Nightmares											
16. Hurt self, others, animals											
17. Play with fire											
18. Run away											
19. Temper tantrums											
20 Open Masturbation											
22. Behavior problems at school											

MEDICAL HISTORY

Please rate your child in each of the following areas:

	GOOD	FAIR	POOR
1. Health			
2. Hearing			
3. Vision			
4. Gross Motor Coordination			
5. Fine Motor Coordination			
6. Speech Articulation			

Any Sensory Issues – Please describe:
Tactile (touch)

Visual
Auditory
Movement____
Smell ____
Taste/Food aversions____

Has this child ever had any Occupational &/or Speech Therapy? If so, please identify:
With whom: ____
What was the reason?

With whom: ____
What was the reason?

Please identify any past medical injuries and illnesses/beginning with most recent:

Description	Date	Age	Effects/Impact

Please check the following problems:	YES	NO	DON'T KNOW
• Suspicion of alcohol/drug use	_____	_____	_________
• History of physical/sexual abuse	_____	_____	_________
• Sleeping problems	_____	_____	_________
• Is this child a restless sleeper	_____	_____	_________

Does this child have bladder/bowel control problems?

	YES/NO	DAY (how often)	NIGHT (how often)	When did this begin?
Bladder				
Bowel				

Please list any prescription or non-prescription medications this child is presently taking.

Medication	**Dosage**	**Purpose**

When was this child's last medical exam? ____
With whom:____
Phone: ____
What was the reason? ____
____

Has this child ever had any psychological testing or counseling? If so, please identify:
a) With whom: ____
Phone:____
What was the reason? ____
____
Any previous Diagnosis?

b) With whom: ____
Phone:____
What was the reason? ____

SCHOOL HISTORY

School:____ Grade: __________

Please summarize the child's progress in school: ____

____

____

Has the child ever been in any type of special educational program (IEP/504), and if so, how long?

____

Learning Disabilities: ____

Advance Placement:____

Check any of the following that apply:

	In what grade	(please write in details)
Afraid to attend school	______	
Been bullied	______	
Bullied others	______	
Disrupt class		
Inattentive in class	______	
Refuse to go to school	______	
Fail to turn in work	______	
Detention	______	
In-school suspension	______	
Out-of-school suspension	______	
Expelled from school	______	

4. Have any additional instructional modifications been attempted? ____ none ____behavioral program

______daily/weekly report card ______ other ____

5. Has this child had any educational testing? ____Yes ____No

If yes, what? ____ (please bring in copies)

Extracurricular Activities? (current and history) ____

____

____

SOCIAL HISTORY

1. How does this child get along with his/her siblings? ___ No siblings ___Better than average

___ Average ____Worst than average.

2. How easily does this child make friends? ___Very Easy ____Average ____Not very Easily.

3. On average, how long does this child keep friendships? ____less 6 mths ____ 6mths to year ____ 1+ year

4. Is the child able to form close relationships? ____ Yes ____No

Does your child seem to miss social cues (e.g. not understand when she/he is being teased, not understanding humor, not recognizing when children are disinterested in what she/he is talking about, perceives hostility when there is none)?

____

____

5. How would you describe a typical day for this child: ____

____

____

____

_

FAMILY HISTORY

Please identify if there are **family members** with the following:

CHILD'S MOTHER - Maternal History	CHILD'S FATHER - Paternal History
Substance Abuse:	Substance Abuse:
Learning Disabilities:	Learning Disabilities:
Psychiatric Diagnosis:	Psychiatric Diagnosis:
Anxiety/Depression	Anxiety/Depression:
Behavior Problems:	Rage/Behavior Problems:
Medical Problems:	Medical Problems:
Physical/Sexual Abuse	Physical/Sexual Abuse:
Arrests:	Arrests:
Autism Spectrum:	Autism Spectrum:

Family members living in home/homes: Please list family members currently living in the child's home and immediate family members living outside of the home:

Name	In/Out	Relation - Biological/Other	Gender	Age	Grade/Job

Who has taken care of the child most of his/her life? ____

Who is the primary disciplinarian in the family? ____

Do parents agree on the issues of parenting, rules, and discipline? _________Are they ___strict ___lenient

Do parents get along with one another? ____ always ____ usually ____ sometimes ____ rarely

To what extent are you (and spouse) consistent with respect to disciplinary strategies?

___ most of the time ___ some of the time ___ none of the time

What would you like to change about your family? ____

Please mark any of the statements below which apply to your family.

	Yes	No
Our family is warm and loving	___	___
People are always fighting	___	___
Everyone goes his or her own separate way	___	___
People say what is on their mind	___	___

Have there been or are there currently any major changes or stressors in the family where the child was raised?
____Yes ______No If yes, please check all that apply:

	In Past	Current (6 mo/less)
Financial	_____	_____
Frequent moves	_____	_____
Job Changes	_____	_____
Drinking/drug usage	_____	_____
Arguments between parents	_____	_____
Separation or divorce of parent's	_____	_____
Remarriage of parent	_____	_____
Separation from sibling's	_____	_____
Separation from other family member's	_____	_____
Frequent physical punishment	_____	_____
Physical confrontations between parents	_____	_____
Separation from significant non-family member	_____	_____
Mental illness in family	_____	_____
Physical illness in family	_____	_____
Psychiatric hospitalization of a parent	_____	_____
Death in the family	_____	_____
Sexual promiscuity of incestual behavior in family	_____	_____
Family feels isolated	_____	_____
Other____________________________________	_____	_____

How has family been changed by the child's problem(s)? _______________________________________
____
____

What is the family's expectation of treatment? ____
____
____

What does the family see as their role in treatment? ____
____
____

What are the family's strengths? ____
____
____

What are the family's weaknesses? ____
____
____

What strategies have been used to address these problems? (check those that apply and circle those that have been successful):

Verbal reprimands	_____	Time outs	_____
Removal of privileges	_____	Reward system	_____
Physical punishment	_____	Giving in	_____
Avoiding issues	_____	Other	_____

How would you rate your child's overall functioning? (circle)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

unable to function in all areas	unable to function in most areas	serious difficulty functioning	mild to moderate difficulty	minimal difficulty	no difficulty

What are your goals for treatment and desired outcome?

Spiritual Orientation

Please describe the spiritual orientation or religion of this child's family?

____
____

How active are spiritual beliefs/religion in the family's life?

____
____

What are other (related) concerns?

____
____
____
____
____
____
____
____
____

I greatly appreciate you taking the time to complete these questions, as the information is very valuable in understanding your child and with development of a comprehensive assessment.

Chelsi House, LMHC
Child and Adolescent Therapist