Collage Counseling Center 23332 Orchard Ld Rd Suite E Farmington Hills, MI 48336

Child/Adolescent Registration Form

Name of Child: _____ Age: _____Birth Date: _____-_____-____ Gender: ☐ M/ ☐ F

Parent/Guardian Name: _____ Marital Status: ☐ Married/ ☐ Divorced/Separated/ ☐ Single

In the case of Divorce or Separation, please identify the custody status or leave blank if parents are married.

Legal and Physical Custody_____ Visitation Arrangements: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home/Cell: _____ Work: _____

If your son/daughter has a cell phone, please include their number: _____

Name of School/Daycare: _____ City_____ Grade: _____

The reason I am seeking therapy for my child is:

_____

_____

What changes would you like to see as a result of therapy?

_____

_____

What have you already tried to correct or resolve this problem?

_____

_____

Please list any medications your child is currently taking:

_____

Please describe any medical conditions that I should be aware of (allergies, injuries, illnesses, etc):

_____

_____

Please describe your current household composition (names, ages, and relationship of those living with your child):

_____

_____

Child/Adolescent's History

Is your son/daughter child adopted? ----------yes no

Were there any problems or complications during pregnancy or birth?----------yes no
Explain:_____

Has your child received any previous counseling or treatment?----------yes no
Explain:_____

Has your child experienced any form of abuse (physical, emotional, sexual)?----------yes no
Explain:_____

Has your child experienced any significant trauma or loss?----------yes no
Explain:_____

Has your child ever made statements about wanting to hurt him/herself?----------yes no
Explain:_____

Does your child have difficulty at school or daycare? ----------yes no
Explain:_____

Has your child ever received Special Education Services (IEP/504)?----------yes no
Explain:_____

Does your child have unusual eating patterns?----------yes no
Explain:_____

Does your child have unusual sleeping patterns?----------yes no
Explain:_____

Any family members (including extended family) suffer from mental health issues?--------yes no
Explain:_____

Do parents agree on the approaches to discipline? ----------yes no

What are your main approaches to discipline?
Explain:_____

Additional Information you'd like to provide?

Consent to Treat a Minor

Name of Minor Client: _____ Date of Birth: _____

This is to certify that you give permission to the Collage Therapist noted below to provide counseling for your child. This treatment may include individual or group psychotherapy, counseling, and testing. As a rule, there is a tremendous benefit when parents/guardians are involved in the therapeutic process. By signing this consent form, you're agreeing to participate in individual/family sessions.

Although your child is a minor, he/she has the right to confidentiality. This confidentiality is crucial for a child to feel safe and secure in the counseling environment and a necessary ingredient for treatment success. You agree to honor this right to confidentiality. Children age 14 and older have the right to full client privilege. Parents of children younger than 14 have the right to information regarding the minor's treatment so long as it is in the best interest of the child.

Divorced Parents-Please complete this section for additional consent:
My signature below confirms that I have a legal right to ☐ sole or ☐ shared medical/mental health decision making regarding my son/daughter. In cases of joint custody or shared allocation of parental responsibility for medical decisions, a copy of the custody order along with signatures indicating consent from <u>both</u> parents is required in order to treat a minor. In the event custody arrangements are amended by the court, I will immediately notify Vicki Palmer in writing.

Release of Information

The placement of my initials indicates my consent to the disclosure of this information as outlined by the following parameters. This consent is in effect until revoked in writing.

I, _____ on behalf of _____ authorize _____
Parent/Guardian Name Son/Daughter's Name(s) Collage Therapist's Name

_____ Discuss (verbally or in writing) any relevant material that has been brought up during treatment
(Initial here) with the person/s or staff of clinic, office, agency, or institution named below

_____ Obtain any relevant information contained in my records from the person/s or staff of clinic,
(Initial here) office, agency or institution's named below

_____ Provide any relevant information contained in my records to the person/s or staff of clinic, office,
(Initial here) agency or institution's named below

1.Name_____Title/Relationship_____Phone:_____

2.Name_____Title/Relationship_____Phone:_____

3.Name_____Title/Relationship_____Phone:_____

Please inform your Therapist in writing if there are any exclusions to the Education, Psychological or Medical disclosures.

_____ _____ _____
Parent/Guardian Name (please print) Signature of Parent/Guardian Date

_____ _____ _____
Collage Therapist's Name (please print) Signature of Collage Therapist Date

Collage Counseling Center Policies & General Information

• Your son/daughter's participation in Collage Counseling Center (CCC) sessions can result in a number of benefits, including but not limited to, improvement with interpersonal relationships, and resolution of the specific concerns that led you to CCC. Therapy requires the client's active involvement, honesty, and openness in order to achieve optimal results. In addition, your feedback and views on the sessions, progress, and other aspects of counseling is encouraged.

• During therapy, remembering or talking about unpleasant events, feelings, or thoughts may result in discomfort or strong feelings of anger, sadness, worry, anxiety, depression, insomnia, etc. This may challenge some of the current assumptions/perceptions or propose different ways of looking at, thinking about, or handling situations.

• Attempting to resolve issues that brought you to CCC in the first place, may give rise to changes that were not originally intended. CCC sessions may result in decisions about changing behaviors, relationships, schooling, housing, or employment. Sometimes a decision, that is positive for one family member, is viewed quite negatively by another family member.

• Change will sometimes be easy and swift, but more often it will be slow and possibly frustrating. There is no guarantee that these services will yield positive or intended results.

• During the course of therapy, we will draw on various approaches according to the problem that is being treated. These approaches include behavioral, cognitive, coaching, psychodynamic, system/family, developmental (adult, child, family), or educational. If you have any questions about any of the procedures used in the course of therapy, their risks, or about the treatment plan, please feel free to contact me for the answers you're looking for.

TELEPHONE & EMERGENCY PROCEDURES:

• You're welcome to call 248-497-0883. If you leave a message, you can expect a call back asap.

• Please visit http://collagecc.com/about/ to find contact information for our counselors.

• If an emergency situation arises and I am not available to take your call, please call 911 or one of the following for assistance: 24hr. crisis line – Macomb County (586) 307-9100 or Oakland County (248) 456-1991

PAYMENTS & INSURANCE REIMBURSEMENT:

• Clients are responsible for the standard fee set for the services they are receiving, payable at the time of service. Additional services requested by the client (such as writing letters, making phone calls or visits to doctors or schools on the client's behalf, etc.) will be billed at a rate of $25 for every 15 minutes required for such service.

• CCC Therapists accept various forms of payment.
Note: There is a "Returned Check" fee of $25 in the event that a check does not clear.

• Please let us know if you would like a copy of your receipt, which you can submit to your insurance company for reimbursement. The Collage Counseling Center does not guarantee that your insurance company will provide reimbursement for services rendered. Not all issues/conditions/problems, which are the focus of services offered at CCC are reimbursed by insurance companies. In addition, insurance company policies vary with regards to professional licensure requirements required for reimbursement. It is your responsibility to verify the specifics of your coverage and to work out arrangements for reimbursement with your insurance company directly.

•CANCELLATION: Since the scheduling of an appointment involves the reservation of valuable time, a minimum of 24 hours notice is required for rescheduling or canceling an appointment to avoid being charged for the session. Most insurance companies do not reimburse for missed sessions.

Please initial that you have read and understand the CCC Policies _____