Kimberly Ledwa, LCPC, ACADC
1965 S. Eagle Road., Suite 120
Meridian, ID 83642
208-856-8776

Client intake information (Child/teen version)

Please fill out as completely as possible about your child. Include your child in providing answers as much as you feel is appropriate. This information is part of your child's confidential file.

Identification

Name_____Age_____ Birthdate_____
Home address_____Apt _____
City _____ State _____ Zip_____
Primary phone _____ Type: **cell home work**
Email _____ Any contact restrictions? _____
Preferred method of reminder for sessions (circle one): **email text phone call**
Gender_____Ethnicity:_____Religious Preference_____
Other means you identify yourself that you consider important _____
Family military experience _____

Emergency Contact

Name _____phone #_____relationship_____

Referral

How did you learn about counseling with me?_____

Chief concern

Please describe the main difficulty that has brought you to see me. _____
_____
_____

School

Name of school _____ Current grade ____ Teacher/advisor_____
Achievements/challenges _____
_____
Favorite subject(s) _____
Least favorite subjects(s)_____
Academic concerns _____
Behavioral concerns _____
Any developmental or milestone challenges, past or current? _____
_____
_____

Family of origin history

List who is in your home & who has been in the home in the past

Name Relation to child Current age (or age at death) Describe how relationship has impacted child

_____
_____
_____
_____
_____
_____

Child's parent's relationship with each other _____
_____
Any significant event(s) that impacted child? _____
_____
_____

Any significant family members with current or past depression, bipolar disorder, anxiety disorder, obsessive compulsive disorder, ADHD, substance abuse problems, suicide, trouble with the law, developmental disorders, or any other mental condition? **Yes** **No** If yes, please list.

Name ***Relationship to child*** ***Condition*** ***Current Mental Status***

_____

_____

_____

_____

If any family members, friends, pets, or other important creature is/are deceased, please list below.

Name ***Relationship*** ***Age at Death*** ***Cause of Death*** ***Impact on child***

_____

_____

Trauma/Abuse History

Please indicate if your experienced any of the following forms of abuse:

Physical ___ Sexual ___ Neglect ___ Emotional ___ Domestic violence ___ Witnessing abuse ___

Any traumatic event(s) that affected your child _____

_____

Past relationships (includes important adults, friends, dating (if child is older)

Briefly describe any <u>significant</u> relationship history _____

_____

_____

_____

Present relationships

*Briefly **<u>describe</u>** your child's <u>current relationships</u> with the following:*

Friends _____

_____

Family members _____

_____

Extended family _____

_____

Romantic interests (if applicable) _____

_____

List any strengths or concerns you have about your child's social interactions _____

_____

Treatment:

Has your child ever received counseling before? **Yes** **No** If yes, when?_____

Counselor's name/location _____

What was helpful? _____

What was not helpful? _____

It is helpful for me to know what past experiences has been and if you need more information about what counseling can be.

Any previous mental health diagnoses? _____

Has your child ever been hospitalized for mental health or substance abuse reasons? _____ If yes, please complete:

1. Hospitalization dates _____Hospital _____
   Reason _____ Outcome _____
2. Hospitalization dates _____Hospital _____
   Reason _____ Outcome _____

Have your child ever attempted suicide?_____ If yes, when?_____

Please describe circumstances and method: _____

_____

Has your child ever self-harmed or intentionally taken risks likely to cause significant injury?___ If yes, please describe:

_____

_____

Physical wellness

Circle child's present state of health: **Excellent** **Good** **Fair** **Poor**

Any diagnosed medical conditions_____

_____

Any current medications? **Yes** **No** If Yes, please list below.

Medication Dosage Name of Prescriber Date started Reason for taking the medicine

_____

_____

_____

_____

Please check if your child has experienced the following during the past six months:

___Severe headaches	___Frequent tiredness	___Severe backaches/body aches
___Frequent trouble sleeping	___Stomach problems	___Dizziness or fainting
___Eating Problems	___Panic attacks	___Seizures
___Hearing voices	___Hallucinating	___Fearfulness
___Excessive worry	___Nervous	___Sadness
___Significant change in contact with others	___Feeling guilty	___Discouragement or hopelessness
___Significant change/loss in friends	___Anger/irritability in teens	___Hurting self
___Large weight gain/loss	___Physically hurting others	___Trouble concentrating
___Speeding thoughts	___Unable to relax/sit still	___Loss of interest in enjoyable activities
___Not completing important work/tasks	___Easily startled	___Thoughts about dying/death
___Difficulty remembering past events	___Not feeling happy as expected	___Flashbacks of past events

Other problems not listed (Please specify):_____

_____

Chemical use *(This is important to consider before diagnosing a child/teen due to the impact it can have on behavior)*

1. Amount of caffeinated drinks (tea, soda, coffee)? _____ energy drinks? _____
2. Any medications or other substance to get to sleep? _____ stay awake? _____
3. Any tobacco/nicotine use (smoked, chewed, vaping)? _____
4. Any known beer, wine, or other alcohol use? _____
   Any known huffing or other substance use? _____
   a. Family history of alcohol/substance abuse or addiction? **Yes** **No**
   b. Others around child that abuse alcohol, drugs, or medications? **Yes** **No**
   c. Does your child have access to alcohol, medications, or drugs? **Yes** **No**
   d. Does your child have friends that use alcohol, drugs, or abuse medications? **Yes** **No**

   Concerns:_____

Legal/School disciplinary/Academic intervention

1. Is your child attending this appointment for any legal reason(s) or requirement(s)? **Yes** **No** If yes, please explain:_____
2. Any legal history? _____
   _____
   _____
3. Any school detention, suspension, or expulsion history? _____
   _____
4. Any 504/IEP plans or behavioral interventions at school? _____

Counseling planning

Stressors

Please check any stressors that are a part of your child's life.

___Personal illness	___Health problem in family	___Money problems
___Lack of employment	___Parent discord	___Death of family member
___Parent divorce	___Parent separation	___Sexual abuse
___Physical abuse	___Discrimination	___Death of a friend
___Loneliness	___Unhappy childhood	___Rejection from others
___New baby	___Parent remarriage	___Educational problems
___School change	___Teacher conflict	___Bullied by others
___Unmet basic needs	___Lack of health care	___Bullying others
___Victim of crime	___Conflict with siblings	___Conflict with parent(s)
___Recent move	___Other (specify)_____	

Your child's needs

1. What are your reasons for seeking therapy?_____
   _____
   _____

   Anything your child wants to get out of therapy? *(parent and child often have different expectations, but I will ask more about this in the first session)*_____
   _____
   _____

2. When did this these reasons become a problem? _____

3. What made you decide to seek therapy now?_____
   _____
   _____
   _____

4. How much do you feel your child needs counseling right now?

   i. **Extremely** **Very much** **Somewhat** **Not very much** **Not at all**

5. Any challenges that would affect your child's counseling progress? _____
   _____
   _____
   _____

6. Do you or your child have any questions or concerns about counseling? Talking about these in the session can help you and/or your child feel more comfortable. _____
   _____
   _____

7. What else do you think is important for me to know? _____
   _____
   _____

Kimberly Ledwa, LCPC, ACADC
1965 S. Eagle Road., Suite 120
Meridian, ID 83642
208-856-8776

Financial Policies Statement

Thank you for choosing me as your Mental Health Care Provider. I am committed to providing excellent mental health care for you. The following is a statement of my financial policy, which I require that you read and sign prior to beginning any treatment. If you have any questions about my financial policy please do not hesitate to ask me.

PROFESSIONAL FEES

- $185 per 60 minute initial intake session/mental
- $145 per 50-55 minute session for individuals, couples, or families.
- $200 per 60 minutes for any preparation and/or attendance at court proceedings including my requested appearance is by another party
- $145 per hour for written reports and prepared documents
- Telephone consultations that exceed 5 minutes will be prorated at $145.00 per hour. If you need to contact me between sessions, please leave a message on my voice mail or email me, and I will reply as soon as I can.

PAYMENT

Full payment is due at the time of each service. I accept cash, personal checks, most credit cards, or money orders. A $25.00 service charge will be assessed for any returned checks.

CANCELLATIONS AND MISSED APPOINTMENTS

Please make every effort to keep your appointment time. Reminder text/emails may be provided, but your scheduled session is reserved for you unless you or I make changes. 48 hours notice for canceling appointments is preferred. **Unless I hear from you at least 24 hours in advance, I will unfortunately charge you the full fee ($145.00) for a missed or uncanceled appointment.** Cancellations can be made by contacting me by email at info@kimberlyledwa.com or 208-856-8776 to leave a voicemail.

Initials of person responsible for payment: _____ Date of initials: _____

Your initials indicate that you understand this policy and agree to follow this policy.

INSURANCE

- As a courtesy to you, I will file a claim with your insurance provider. This does not guarantee either full or partial payment. You are fully responsible for all charges regardless of your insurance benefits.
- Accurate and updated information is required at the time of service to file a claim with your insurance provider.
- Your insurance provider will determine what services are considered "non-covered," "reasonable and necessary," or "out of network." They will also determine what applies to any "deductible" or what your "co-pay" amount will be. Your insurance policy is a contract between you and your insurance provider. My access to this information is often limited.
- It is your responsibility as the policy holder to know if/when your insurance provider requires prior authorizations.
- Your insurance provider may require your confidential information to use your insurance policy for my services.

EMPLOYEE ASSISTANCE PROGRAM (if applicable)

Name of your EAP: _____ Authorization #: _____ # of sessions: ___

INSURANCE/THIRD PARTY PAYERS

***A copy of your insurance card and identification is required before your first session begins.

A. BILLING AUTHORIZATION

I authorize the release of any information necessary to process my claim to Third Party Payers that provide financial reimbursement for requested services of Kimberly Ledwa, LCPC, ACADC. I authorize direct payment to my service provider from my Third Party Payer. I permit a copy of this form to be used in place of the original.

Client signature: _____ Date _____

B. PAYMENT AGREEMENT

I have read the financial policy. I understand and agree to comply with this financial policy. I have been given a copy of this policy. I agree to pay for all services rendered and any legal expenses incurred should my account be turned over to another party for collection.

Client signature: _____ Date _____

Client's printed name: _____

C. INSURED PERSON FOR POLICY:

If you are insured under another's insurance policy, please provide the following to allow us to be able to bill your insurance provider:

Insured person's name: _____ Your relationship to insured person: _____

Insured person's employer: _____ Insured person's date of birth: _____

Insured person's address: _____

Kimberly Ledwa, LCPC, ACADC
1965 S. Eagle Road., Suite 120
Meridian, ID 83642
208-856-8776

AUTHORIZATION FOR RECURRING CREDIT CARD CHARGES

For convenience and to reduce the need for billing statements, your credit card will be on file to pay for charges from therapy sessions not covered by your insurance provider or EAP. You are welcome to pay by check, cash, or a different card at any time. Unless other arrangements have been made, you will be automatically charged for copays or deductible amounts not covered that your insurance provider shares with me. The charge will be made under the name of Kimberly Ledwa, LLC.

You agree that no prior notification is necessary unless the amount billed each time exceeds $145.00 (per session charge) and $185.00 for intake session. If charges are higher, you will receive notification in advance.

Name of Client_____

Account Type: __ Visa __ MasterCard __ Discover
Cardholder Name: _____
Account Number: _____
Expiration Date: _____
Billing Zip Code: _____
CVV (3-digit number on back of Visa, MasterCard, or Discover): _____

I authorize Kimberly Ledwa, LLC to charge this credit card for professional services and associated charges as agreed below. These charges may include:

- Co-pay and/or co-insurance for session: $185.00 for initial intake session and $145.00 for the following sessions
- Self-pay for session or payment for session not covered due to deductible: $185.00 for initial intake session and $145.00 for the following sessions
- Charge for cancellation without 24 hours' notice: $145.00
- Other charges [specify]:
  _____ $_____
  _____ $_____

I understand this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

Signature of Authorized Credit Card User: _____ Date: _____

Kimberly Ledwa, LCPC, ACADC
1965 S. Eagle Road., Suite 120
Meridian, ID 83642
208-856-8776

Informed Consent and Disclosure Statement

Confidentiality
In compliance with applicable Federal Laws and regulations, along with the State of Idaho statutes (Chapter 34, Title 54-3410B, Idaho Code), all the information obtained during your counseling sessions will be kept confidential, as required by law. Information gathered during your counselling sessions will not be revealed to anyone beyond the purposes of your authorized billing information except in the following situations when disclosure as required by law:

- When there is reasonable suspicion or report of abuse to vulnerable populations, including children, elderly persons, and individuals who are unable to advocate for themselves.
- When you present serious and foreseeable harm to yourself or others.
- If we receive a court ordered subpoena or as part of legal proceedings which may include but is not limited to legal complaints filled by you against your provider.
- In specific cases of law enforcement emergency for national security issues.

Litigation Limitations

I do not offer court work, such as testifying in divorce, custody disputes, injuries, lawsuits, or other legal issues. If you need these services, please consult with your legal representative for referrals to forensic psychologists who specialize in these cases. As your counselor, I will do my best to protect your confidential information from the intrusiveness of legal proceedings.

To be in counseling with me, you must agree that neither you, your attorney, or anyone acting on your behalf, will call on me to testify in court or at any other proceeding. You must agree that no requests for legal proceedings for any disclosure of counseling or treatment records will occur.

This is in your best interest for the following reasons:

1. If you place your mental status as an issue in litigation initiated by you, the defendant (other side) has the right to obtain your counseling records and/or testimony by your counselor. Your adversary would have the right to know everything you have talked about in counseling.
2. I am not an expert in forensic psychology (custody evaluations, workers comp, lawsuits, etc.)
3. If you are involved in legal proceedings, subpoenaing a counselor without forensic expertise to testify could hurt your case more than help. Forensic psychologists do assessments, not counseling, and are trained as expert witnesses.
4. The goals of legal proceedings are focused on winning a case. This is inconsistent with the goals of ongoing counseling, which focuses on exploring conflicted emotions and behavior in a safe, protected place. Whenever possible, counselors are required to avoid dual roles since this may interfere with the client's counseling process.
5. If you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party or this requirement is changed after time and expenses have accrued. Fees are listed in the Financial Policies Statement.

I understand and agree to this litigation limitation.

_____ _____
Client or Legal guardian Date

Counseling Process
I am dedicated to giving you the best care that I can. It is my conviction that for effective counseling to occur, a partnership between the counselor and client must exist. As such, you will be expected to be actively involved in choosing the course of your treatment. While specific outcomes for your counseling goals are not guaranteed, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards of practice as adopted by the American Counseling Association and the Idaho Counselor Licensing Board.

My therapeutic orientation is Adlerian therapy. With this approach, I effectively integrate other techniques from many treatment modalities including cognitive-behavioral, existential, solution-oriented, client-centered, behavioral, and family systems. Depending upon the challenges you face, your length of treatment will vary. However, this is your process and you control many aspects of this. You may end our counseling relationship at any point, and I will be supportive of your decision. If counseling is successful, you will feel that you are able to face life's challenges in the future without my support or intervention. At some time during the counseling process, you may feel a variety of unsettling emotions. Be aware that this is normal. Please feel free to bring up any uncomfortable counseling experiences with me. In the event you are dissatisfied with my services for any reason, please let me know.

YOUNG CHILDREN: Play therapy, art therapy, and other expressive therapies are used with children since this is their language to express themselves. The first session allows the child to explore the toys while the assessment process is completed between me and the parent/guardian with the child sharing whatever they would like. After this, I strongly encourage parents to provide updates at the start of the session and then step out into the

lobby. Depending on the child, this may take more than one session. However, the goal is for the child to participate in counseling fully so they can get the full benefit of the therapy process. In this process, a parent's presence will interfere with a child's focus and effort to engage. If you have any questions about this, please ask and feel free to research how play therapy helps children too young to talk for 50 minutes about their feelings and thoughts.

Client Rights: You have the right to:

1. Accept or refuse any treatment and understand the implications of refusal
2. Receive fair & equal treatment in all circumstances regardless of your age, race, gender, sexual orientation, or religion
3. Be treated with respect, consideration, and dignity in a safe environment
4. Privacy of care
5. Be informed of my training and qualifications, including the limits and restrictions of my qualifications
6. Receive accurate, easily understood information about your mental health concerns and the treatment you receive
7. Be informed of the purpose, goals, techniques, procedures, limitations, potential risks, and benefits to treatment
8. Ask questions about your treatment
9. Work with me on a treatment plan that you are comfortable with and will adhere to
10. Request to be referred to another therapist
11. Confidentiality of your records and make written changes to a release of your information
12. Request that your records be sent to another professional or agency. Your written request will be fulfilled with promptness, provided there is no outstanding balance on your account. Minor children: My obligation for confidentiality is to the child. Depending on legal circumstances and the child's unique situation, information is released according to ethical and legal statutes.
13. File a complaint without retaliation

Client Responsibilities: You are responsible for**:**

1. Providing an accurate information regarding your health and mental health history
2. Being an active participant in your care
3. Asking questions for clarification if you do not understand your treatment plan or other aspects of treatment
4. Following the treatment plan
5. Keeping your appointments and arriving on-time
6. Canceling or rescheduling appointments as far in advance as possible so that time can be used to treat others
7. Communicate with your provider if your symptoms worsen or does not follow the expected course
8. Providing useful feedback about services and policies
9. Providing accurate information for payments and billing
10. Fulfilling your financial obligations and pay for care as promptly as possible
11. Being involved as a parent in the therapy of your child when a child is a minor

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region 10
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11 Seattle, WA 98121-1831
Phone (800) 368-1019, Fax (206) 615-2297, TDD (800) 537-7697

Provider Rights: I have the right to:

1. Establish and maintain mutually respectful relationships with my clients
2. Terminate a relationship with a client if that client's care is outside my scope of practice, if the client is a safety concern, or if client's needs/care creates ethical dilemmas in providing professional standards of care. In these cases, clients will be provided appropriate referrals that would best meet their needs.

Provider Responsibilities: I am responsible for**:**

1. Adhering to all statutes, licensing board rules, and codes of ethics in my profession
2. Present clients with documents related to my professional qualifications upon request
3. Provide quality services and involve clients in their plan development and evaluation of treatment goals
4. Ensure confidentiality of client's clinical information whenever possible
5. Inform clients of my qualifications, education, areas of expertise, and to practice within those standards
6. Respect clients regardless of client's age, race, ethnicity, gender, sexual orientation, religion, and socioeconomic status

Our Professional Counseling Relationship

Our counseling relationship is a professional relationship. I will assist you in exploring and resolving difficult life issues. Our sessions may be very intimate. However, it is important that our relationship remain professional and limited to the paid session you have with me. You will be best served if our relationship remains professional and focus exclusively on your concerns. Additionally, I will maintain your confidentiality outside of our counseling sessions if we do happen to meet in a public setting.

Financial Policy
Please read and sign the financial policy. Payment in full is expected at each visit. Please ask if you have any questions.

Cancellations, and Missed Appointments
Please make every effort to keep your appointment time that you have reserved. 48 hours notice for canceling appointments is preferred. Reminder calls/texts/emails may be provided to assist you, but this is not guaranteed. Your cooperation with this practice respects my time and allows me to use that appointment time for seeing other clients in need. **Unless I hear from you at least 24 hours in advance, I will unfortunately charge you the full fee ($145.00) for a missed or uncancelled appointment.** Cancellations can be made by calling (208) 856-8776 to leave a message on my confidential voice mail.

Emergency and Crisis Availability
You need to be aware that Kimberly Ledwa, LCPC, ACADC does not provide emergency services, and that in an emergency situation, you are advised to contact your local community mental health center, your physician, emergency room, a crisis counseling hotline, or 911.
Important local crisis numbers are:

Pathways Community Crisis Center of Southwest Idaho 1-833-527-4747
Mobile Crisis Line 208-334-0808
Hays Shelter Home 208-322-2308
St Alphonsus's Behavioral Health 208-367-2175
Suicide Prevention Hotline 1-800-273-8255
Women's and Children's Alliance 208-343-7025

My signature signifies that I have read, I understand, and I accept these conditions and policies, and that I agree to enter therapy. I have been given a copy of these policies. I agree to pay for all services rendered and any legal expenses necessary for collection. I authorize and request that Kimberly Ledwa, LCPC, ACADC provides psychological examinations, treatment and/or diagnostic procedures which may now or during the course of my care as a client are advisable. The frequency and type of treatment will be decided between my counselor and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from counseling but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable. I have read and I fully understand this Informed Consent and Disclosure Form. By signing this, I am giving my consent for treatment.

_____ _____
Print Client Name Client Signature (Required at age 14 and older)

_____ _____
Print Parent/Guardian Name Parent/Guardian Signature

_____ _____
Counselor Signature Date

Kimberly Ledwa, LCPC, ACADC
1965 S. Eagle Road., Suite 120
Meridian, ID 83642
208-856-8776

RELEASE OF CONFIDENTIAL INFORMATION

*This form is **optional** and allows Kimberly to share only the information you indicate.*

Client Name_____ DOB _____
Other names used _____
I, _____, authorize Kimberly Ledwa., LCPC, ACADC to
__ disclose to or __ request from _____

The following information:

__ Diagnosis and Treatment Plan
__ Admit and Discharge Summary
__ Consultation Notes
__ Lab Reports
__ Legal History
__ Other (specify)_____
__ Psychological Evaluation or Psychiatric Evaluation
__ Social History
__ Emergency Room Report (date)_____
__ Substance Abuse Evaluations
__ Probation/Parole/H&W Stipulations

The purpose or need for such disclosure:

__ Diagnosis and Treatment Plan
__ Coordinate Care
__ Determine eligibility for services
__ Other (specify)_____
__ Discharge Plan

I am aware that the specific type of information requested, as well as the benefit and disadvantages of releasing the information, if known. Also, I am informed that treatment services are not contingent on my decision concerning this release. I understand that my records are protected under the Federal Confidentiality Regulations (American Counseling Association, B.1.a and Federal Drug and Alcohol Regulations 42 CFR Part 2) and HIPAA and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the information disclosed pursuant to the authorization may potentially be redisclosed by the recipient and may no longer be protected by state and federal privacy laws.

If an agency has taken an action on my behalf, which relies upon this release, I understand that I will abide by the stipulations of that action. I also understand this consent is subject to revocation at any time and unless otherwise specified continues for six months after the end of treatment. I release Kimberly Ledwa, LCPC, ACADC from any and all responsibility and liability concerning the release of information I have consented to above. I permit a copy of this release to serve as original.

I understand that my health information may include information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information unless I have crossed it out and initialed here. _____Initials

Client/Parent/Legal Guardian_____ Date_____
signature

Witness_____ Date_____

NOTE TO AGENCY/PERSON IN RECEIPT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CRF Part 2 and HIPAA) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.