

The BabbCenter
Client Information Form for Youth/Children

CONFIDENTIAL

About the Youth/Child

Name _____ Gender M or F Birthdate ___/___/___ Age _____
School _____ Teacher _____ Grade _____
Home Phone ___/___/___ Address _____
Reason for coming to counseling today _____

Responsible Party Information

Name _____ Relationship to the youth/child _____
Occupation _____ Place of employment _____ Phone ___/___/___
Do we have your permission to call you at work if necessary? yes no
cellphone ___/___/___

Spouse's name _____ Relationship to the youth/child _____
Occupation _____ Place of employment _____ Phone ___/___/___

Biological Mother _____
Occupation _____ Place of employment _____ Phone ___/___/___

Biological Father _____
Occupation _____ Place of employment _____ Phone ___/___/___

Step-Mother _____
Occupation _____ Place of employment _____ Phone ___/___/___

Step-Father _____
Occupation _____ Place of employment _____ Phone ___/___/___

Marital status of the biological parent (s) married separated divorced widowed
If divorced, please answer the following questions:
Year of divorce _____ Which parent is the primary residential parent? _____

What are the visitation arrangements for the other parent? _____

Has either parent remarried? Mother: yes no If yes, year of remarriage _____
Father: yes no If yes, year of remarriage _____

Please list any biological siblings this child may have in order of their births.

_____ Age _____ Are they an active part of his/her life? yes no
_____ Age _____ Are they an active part of his/her life? yes no
_____ Age _____ Are they an active part of his/her life? yes no

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Please list any step-siblings this child may have in order of their births.

_____ Age _____
_____ Age _____
_____ Age _____

Are they an active part of his/her life? __yes __no
Are they an active part of his/her life? __yes __no
Are they an active part of his/her life? __yes __no

Medical/Counseling History

Name of medical doctor _____
For what medical problems is the child being treated currently? _____

Please list all medications currently being taken and the reason they have been prescribed.

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____

If you or your child has seen a counselor before, please give the counselor's name and the reason pursuing counseling.

Counselor	Reason
_____	_____
_____	_____
_____	_____
_____	_____

What do you hope to achieve through this counseling experience?

By whom was this child referred for counseling? _____

Note: Please take younger children to the restroom before session begins and do not leave the building during the time your child is with counselor.

The session will be fifty (50) minutes in length and the last ten minutes of the hour can be used to discuss the progress of your child.

(Signature) _____ / _____ / _____
(Date)

For therapist use only

I have reviewed the intake paperwork with the client and he or she has agreed to proceed with counseling.

Yes _____ No _____ _____ Therapist Initials

The **Babb**Center
105 Music Village Boulevard
Hendersonville, Tennessee 37075

AUTHORIZATION TO COUNSEL MINOR CHILDREN

I (We), _____ give my (our) permission to
[Name of Parent(s) or Guardian]

_____ to see my our son/daughter,
(Counselor)

_____ for counseling with and/or
(Name of Minor Child)

without me being present in the same session. I (We) understand that we are the holder of confidential privilege – the right to withhold disclosure or private counseling information about my child. However, in the interest of developing a trust relationship between the counselor and my (our) child(ren), I (we) give the counselor permission to reveal or withhold information which, in his/her clinical judgment, is necessary to protect my (our) minor child. The only exception to this discretion would be in the case of

_____.

I(We) have legal custody of the child and have authorization to provide counseling for the child named above.

The child's other birth parent _____ is _____ is not aware of this counseling.

(Parent/Guardian Signature) (date) / ____ / ____

(Parent/Guardian Signature) (date) / ____ / ____

(Counselor/Witness Signature) (date) / ____ / ____

The BabbCenter
A Ministry Extension of First Baptist Church, Hendersonville, Tennessee
GENERAL COUNSELING INFORMATION

CREDENTIALS

All counselors, with the exception of practicum students, at The BabbCenter have master's degrees or doctoral degrees with competence in the area of counseling. All counselors are Christians and members of local churches.

RISKS IN COUNSELING

Counseling may be tremendously beneficial, while at the same time there are some risks. The risks may include the experience of intense and unwanted feelings, including sadness, fear, anger, guilt, or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the counseling process. Other risks of counseling may include: recalling unpleasant life events, facing unpleasant thoughts and beliefs, increased awareness of feelings, values and experiences, alteration of an individual's thinking, and calling into question some or many of your beliefs and values. Your counselor will be available to discuss any of your assumptions, problems, or possible side effects of your work together.

CLIENT RIGHTS (See "Notice of Privacy Practices" for additional information.)

You have the right to ask questions about any part of the counseling session.

You have the right to end counseling at any time without any moral, legal, or financial obligations other than those already accrued.

You have the right to review the information in your files at any time with proper notification and in consultation with your counselor except in cases where to do so would not be in your best interest as determined by the counselor.

You have the right to request a release of the information in your counseling files to any person or agency you designate.

GRIEVANCES/COMPLAINTS

We are aware that problems with our service may occur, and we will work with you to resolve the problem. If, however, you have discussed your concern with your counselor and remain dissatisfied, please contact our BabbCenter administrator. He along with The BabbCenter director will be glad to discuss your concerns and hopefully resolve them to your satisfaction.

Initial Here _____ Date _____

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TERMINATION

Termination of counseling may occur at any time and may be initiated by either the client or the counselor. We request that if a decision to terminate is being made that there be a minimum of a seven day notice in order that a final termination session may be scheduled.

CLIENTS WHO ARE DEPENDENTS

If you are requesting our services as the guardian or parent of a child or a dependent adult, the same general principles as above will apply. However, as your child's counselor it is important that your child be able to completely trust the counselor. As such, we keep confidential what the child says in the same way we keep confidential what an adult says. As the parent or guardian you have the right and responsibility to question and understand the nature of our progress with your child, and we must use our discretion as to what is an appropriate disclosure. In general, we will not release specific information that the child provides to us; however, we feel it is appropriate to discuss your child's progress in broader terms and value your participation in their counseling experience. You will be asked to sign a "Consent to Treat" form for your child.

WELCOME! WE LOOK FORWARD TO OUR WORK TOGETHER, AND WE ANTICIPATE THAT IT WILL BE A VERY POSITIVE AND BENEFICIAL EXPERIENCE FOR BOTH OF US.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA (The Health Insurance Portability and Accountability Act) and state law very clearly defines what kind of information is to be included in your "designated medical record" as well as some material known as "Psychotherapy Notes" which is not available to outside sources and in some cases, not to the client.

HIPAA provides privacy protections about your personal health information, which is called "protected health information" which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations.

TREATMENT refers to activities provided by a counselor to coordinate your health care.

PAYMENT refers to cases where reimbursement is sought from an outside source. Since we do not file insurance this situation would be extremely rare.

HEALTH CARE OPERATIONS refers to activities that relate to the operation of the counseling center.

The use of your protected health information refers to activities that The BabbCenter conducts for scheduling appointments, keeping records and other tasks within The BabbCenter related to your care. **DISCLOSURES** refers to activities you authorize which occur outside The BabbCenter such as sending your protected health information to other parties such as your primary care physician or in the case of children to the school guidance counselor.

Initial Here _____ Date _____ OVER

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING AUTHORIZATION

Tennessee requires authorization and consent for treatment, payment, and healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. With your consent The BabbCenter may disclose personal health information for the purposes of treatment, payment, and healthcare operations. You have signed this general consent to care and authorization to conduct services associated with this care.

Additionally, if you ever want The BabbCenter to send any of your protected health information to anyone outside The BabbCenter, you will always sign a specific **authorization to release** information to this outside party. A copy of the authorization form is available upon request. The requirement of you signing an additional authorization form is an added protection to help insure that your protected health information is kept strictly confidential.

There is a **third, special authorization** provision potentially relevant to the privacy of your records: **psychotherapy notes**. In recognition of the importance of the confidentiality of conversations between the counselor and the client in treatment settings, HIPAA permits keeping "psychotherapy notes" separate from the overall "designated medical record". "Psychotherapy notes" are not the same as your "progress notes" which provide general information about your care and progress each time you have an appointment at The BabbCenter. Any time that psychotherapy notes are requested this will require an additional authorization for their release. When psychological testing is completed please be aware that actual test questions or raw data of psychological tests is protected by copyright laws and is not part of your "designated mental health record..

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done.

BUSINESS ASSOCIATES DISCLOSURES

HIPAA requires that The BabbCenter train and monitor the conduct of those performing ancillary administrative services. These business associates would include receptionists and cleaning staff. The receptionists only have access to the information that pertains to financial arrangements and information related to establishing and maintaining contact with the client. The counselor is the only person who has access to the protected health information. In compliance with HIPAA, the receptionists and cleaning personnel have signed confidentiality agreements that stipulate that protecting your mental health information is an absolute condition for employment. The BABBCENTER trains personnel in privacy practices, monitors their compliance, and correct any errors, if they should occur.

USES AND DISCLOSURES NOT REQUIRING CONSENT NOR AUTHORIZATION

By law, protected health information may be released without your consent or authorization for the following:

Child abuse

Suspected sexual abuse of a child

Adult and domestic abuse

Court order

Serious threat to health or safety – “Duty to Warn” law

Workers Compensation claims – All of your protected health information is automatically subject to review by your employer and/or insurer(s).

CLIENT’S RIGHTS AND BabbCenter DUTIES

You have a right to the following:

The right to request restrictions on certain uses and disclosures of your protected health information which your counselor may or may not agree to but if the counselor does, such restrictions shall apply unless our agreement is changed in writing;

The right to receive confidential communication by alternative means and at alternative locations;

The right to inspect and copy your protected health information in your designated medical record set for as long as protected health information is maintained in the record except in cases where it would not be in your best interest as determined by the counselor.

The right to amend material in your protected health information, although counselor may deny an improper request and/or respond to any amendment(s) you make to your record of care;

The right to an accounting of non-authorized disclosures of your protected health information;

The right to a paper copy of notices/information from your counselor, even if you have previously requested electronic transmission of notices/information;

The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

Initial Here _____ Date _____

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COMPLAINTS

Dr. Ray Cleek, Administrator/Assistant Director of The BABBCENTER is the "Privacy Officer" for HIPAA regulations. If you have any concerns related to your privacy rights, please do not hesitate to speak to him immediately about this matter.

EFFECTIVE DATE: APRIL 14, 2003

CONFIDENTIALITY POLICY

The **BabbCenter**
A MINISTRY EXTENSION OF FIRST BAPTIST CHURCH
HENDERSONVILLE, TENNESSEE

The counselors at the BabbCenter strive to provide each client with the highest quality of counseling services, including a level of confidentiality that makes the counseling experience safe and comforting to the client. Counseling session information will not be released without your prior consent or the one who has the legal authority to consent on your behalf.

There are national and state laws that define necessary limits to that confidentiality. Counselors at The BabbCenter are committed to conforming to these laws that require a counselor to report any suspicions of abuse of a child or incapacitated adult and threats of homicide or suicide. In addition, occasionally judges will subpoena a counselor for testimony or order the release of confidential information in court proceedings. In these instances, the client is notified of the subpoena and/or court order, and every effort is made to protect confidential information.

If you understand these disclosure statements and desire to proceed with the counseling relationship, please indicate this below with your signature and today's date. If you have any questions please feel free to ask our staff.

Thank you.

Client Print Name & Signature

Date

Parent if Minor –Print Name & Signature

Date

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CLIENT NOTIFICATION OF PRIVACY RIGHTS

The **BabbCenter**

The Health Insurance Portability and Accountability Act (HIPAA) have created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides client protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of client record ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care and providers, including mental health care, and providers and health care agencies throughout our country are now required to provide clients with a notification of their privacy rights as it relates to their health care records.

Please read this document as it is important that you know what client protections HIPAA affords all of us. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, we are required to secure your signature indicating that you have received this Client Notification of Privacy Rights Document. Thank You for choosing The BabbCenter.

I, _____ (Print Your Name), understand and have been provided a copy of the Client Notification of Policy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights concerning these matters. I understand that I have the right to review this document before signing this acknowledgment form.

Client Signature or Parent if Minor or Legal Charge

Date

If Legal Charge, describe representative authority: _____