Dear Parents/Guardians,

Welcome to The Maple Counseling Center! We are committed to providing the highest quality services to help children, adolescents and families grow, heal and thrive.

In order to move forward with counseling, we need the parents/guardians to complete the attached packet of forms. This information is important for you in understanding the counseling process, is confidential, and will assist your counselor in best supporting your needs. Once we receive the completed packet your counselor will contact you to schedule the parent/guardian intake meeting. A counselor cannot begin working with you until we have the completed packet. Please complete within one week.

In order to process the paperwork quickly, please note the following:

- As a nonprofit community mental health agency, we are grateful that we can provide services based on the ability to pay. Therefore, to set your specific fee for your ongoing therapy, we need proof of income. Examples may include last year's tax form, a current pay stub or if no income, or a written monthly budget. Please email attachments to intake@tmcc.org with Patient Name. Or you can mail copies to 439 N. Canon Drive, Ste 209, Beverly Hills, Ca 90210.

- Additionally, if the parents are separated or divorced, we need both parents to complete and sign the forms or show court documents noting a different custody agreement.

Thank you and we look forward to supporting you and your family.

Child/Adolescent Intake Form

I am seeking: ☐Individual Child/Adolescent Therapy ☐Family Therapy ☐Individual Parenting Support

CLIENT INFO	PARENT/GUARDIAN INFO
Child's Name: _____ Date of Birth: ____/_____/_____ Age: _____ Name: _____ Preferred Name: _____ Preferred Gender Pronouns: _____ Gender: M ☐ F ☐ Other: _____ Child lives with: School: _____ Grade: Teacher: _____ **History of Problem** Please describe your concerns about your child and why you are seeking support: _____ _____ Child's Strengths: _____ _____ Hopes for treatment: _____ _____ Have you obtained services from TMCC before? ☐Yes ☐No If yes, when? _____ Are you currently affiliated with any of TMCC's volunteer or adjunctive programs? ☐Yes ☐No	**Parent/Cg's Name:** _____ Relationship to client: _____ Address: _____ City: _____ Zip: _____ Email: _____ I would like to receive email updates from TMCC ☐**Yes** ☐**No** Home #: _____ Cell #: _____ Work #: _____ Other #: _____ On what number may we leave a **confidential message**: ☐Home ❑Cell ☐Other I am: ❑ Single ❑ Married ☐ Separated ❑ Divorced **Parent/Cg's Name:** _____ Relationship to client: _____ Address: _____ City: _____ Zip: _____ Email: _____ I would like to receive email updates from TMCC ☐**Yes** ☐**No** Home #: _____ Cell #: _____ Work #: _____ Other #: _____ On what number may we leave a **confidential message**: ☐Home ❑Cell ☐Other I am: ❑ Single ❑ Married ☐ Separated ❑ Divorced

How did you hear about TMCC?

☐ Referral from relative, friend or TMCC Client
☐ Therapist, Psychiatrist, Physician or Hospital Staff
☐ Community Agency/ Organization: *(name)* _____
☐ Another Counseling or Mental Health Treatment Center: *(name)* _____
☐ Internet Search
☐ Social Media
☐ Department of Children and Family Services (DCFS)
☐ Other: _____

EMERGENCY CONTACT INFO

Emergency Contact: _____ Phone: _____
Relationship to client: _____

CHILD/TEEN HEALTH AND MEDICAL

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

ADDITIONAL INFO

Parent/Caregiver Information

Are there any other agencies involved with the family that we should be aware of (DCFS, Child Welfare, Courts, etc.)? _____

_____

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)_____

_____

Is ex-spouse (biological parent) aware that you are bring their children to TMCC? ☐**Yes** ☐**No**

If not, please explain._____

_____

If adopted, does child know of adoption? ☐**Yes** ☐**No**_Age of Adoption?_____

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT? (☑ all availability)						
50 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
9am, 10am, 11am, 12noon						
1pm, 2pm, 3pm, 4pm						
5pm, 6pm, 7pm, 8pm						

For your reference the **Child, Adolescent and Family (CAF) Program** offers the following services. Please let us know if you are interested in any additional services:

Individual Child/Adolescent Therapy: These weekly 1-hour sessions are designed to focus on concerns such as; self-esteem, peer relationships, developmental challenges, academic concerns, and family discord.

Family Therapy: Parents and children of all ages receive assistance in improving communication, establishing healthy boundaries, and learning and practicing effective conflict resolution skills. Your counselor will be an active participant facilitating conversation and providing psycho-education as needed.

Parent Support/Consultation: Weekly or biweekly ongoing support just for parents! Learn effective parenting strategies based on current brain science to reduce stress and ease communication.

Parent Education Series: We offer a 4-week parenting series group that focuses on common parenting challenges such as; effective and conscious discipline, productive communication, helping to manage sibling relationships, etc. This is also a great opportunity to connect with other parents.

The Maple Counseling Center Statistical Information

We gather this data to have overall information about our client population, and to inform our funders about who TMCC serves.

If you "prefer not to state," you may leave any section blank. Thank you.

Beverly Hills Information	**West Hollywood Information**	**Completed Education Level**	**Income Level**
Check all that apply	Check all that apply	Check One	Check One
☐ Live in Beverly Hills	☐ Live in West Hollywood	☐ Grade school	☐ Less than $10,000
☐ Work in Beverly Hills	☐ Work in West Hollywood	☐ High School	☐ $10,000 to $14,999
☐ Beverly Hills City Employee	☐ West Hollywood City Employee	☐ AA degree	☐ $15,000 to $19,999
Position:	Position:	☐ Bachelor's degree	☐ $20,000 to $29,000
☐ Beverly Hills Student	☐ Fire Department employee	☐ Graduate degree	☐ $30,000 to $49,999
Grade:	☐ Police Department employee		☐ $50,000 to $99,999
☐ Fire Department employee			☐ $100,000 and above
☐ Police Department employee			
☐ BHUSD employee			

Ethnicity

Check all that apply			
☐ African, African-American, Black	☐ Asian, Asian-American	☐ Latinx, Hispanic origin	☐ White, Caucasian
☐ Middle Eastern	☐ South Asian	☐ Iranian, Persian	☐ Unwilling to be identified by race
☐ Mixed Race	☐ American Indian or Alaska Native	☐ Pacific Islander, Native Hawaiian	☐ Other: _____

Religion / Cultural Affiliation

Check One			
☐ Christian, Protestant, or Catholic	☐ Jewish	☐ Muslim	☐ Atheist
☐ Buddhist	☐ Hindu	☐ Mormon	☐ Agnostic
☐ Sikh	☐ Orthodox (i.e. Greek, Russian)	☐ Other: _____	☐ No religion

Consent for Treatment

Please read carefully

This is to certify that I give permission to The Maple Counseling Center (TMCC) for my family or child's participation in therapy. The names of the family members in therapy are outlined below.

Name of Child: _____ Date of Birth: _____ Age: _____

Name of Child: _____ Date of Birth: _____ Age: _____

Mother's /Legal Guardian's Name: _____ Date of Birth: _____

Father's/Legal Guardian's Name: _____ Date of Birth: _____

Fees and Appointments:

- Appointments are 50 minutes, and take place one time per week. Your family/child's specific hour is held by their counselor from week to week. If your family/child is unable to keep an appointment, please contact their counselor to cancel as soon as possible. **TMCC has a 24-hour cancellation policy**. If you cancel your appointment with less than 24 hours notice, or you fail to show up for a scheduled appointment, you will be charged for the session. Rescheduling an appointment for another time, even with 24 hours notice, is dependent on the counselor's availability and it may not be possible to have a session in that week. You are encouraged to cancel or request changes as early as possible in advance. We ask that you pay prior to your session each week and you sign up for automatic payment. We reserve the right to suspend therapy if services are rendered and not paid for after three sessions.
- There will be a $14.00 service fee for any returned checks. If determined that therapy will continue, you must agree in writing to a specific payment plan to reduce your overdue balance to zero, while continuing to pay the weekly agreed upon fee.
- You can and should discuss any concerns regarding your financial status with your counselor especially if your financial situation should change or improve. Additionally, once per year your fee will be reevaluated and if it is determined you are able to pay more, your fee may be adjusted

Confidentiality:

- Communication between you and your family/child's counselor is both privileged and confidential. This means that without your written permission the counselor cannot discuss your family/child's case orally or in writing, except with **The Maple Counseling Center** clinical supervisors and staff.
- Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:
    - If there is a reason to believe there is an occurrence of child, elder or dependent adult abuse or neglect.
    - If there is reason to believe that your child or a member of your family has serious intent to harm themselves, someone else, or property by a violent act they may commit.
    - If <u>you</u> introduce a family member's emotional condition into a legal proceeding, or your counselor is subpoenaed to give testimony.
        - If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
        - If there is a court order for release of your records.

Training and Supervision:

- The Center is a training center for Masters or Doctoral level counseling and psychology interns and for paraprofessionals. All Interns are under the direct supervision of licensed mental health professionals.
- In order to ensure that counselors receive the best possible training, and that clients are well served, some sessions will be video or audio taped. Tapes are viewed by **The Maple Counseling Center** counselors and clinical supervisors only, and are erased in a timely manner. There will be advance notice of a taping and it will be with your full and complete awareness. You must agree to have your family/child's sessions taped in order to receive services at **The Maple Counseling Center**.
- The intern who is assigned to you is on a time-limited, contractual basis with TMCC. Therefore, it is possible that the intern may leave TMCC prior to the end of your therapy. If this does occur TMCC will do everything possible to ensure a smooth transfer to another counselor

Counselor Availability and After-Hours Emergencies:

- Counselors check for voice mail messages during normal business hours. Messages left outside of normal Maple Center hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department.

Child Care Release:

- The Center does not provide child care and is not responsible for children and adolescents left unsupervised. If you must leave your child in the waiting room during a session, please be advised that children under 10 must have appropriate supervision. Children over the age of 10 will be allowed to wait in the waiting room at the discretion of The Center staff.

Client Rights and Responsibilities:

- You have the right to end your family/child's therapy at any time, for whatever reason, without any obligation except for fees already incurred.
- You have the right to question any aspect of your family/child's treatment with your counselor and to expect that we will work with you to meet your needs for adjunctive or alternative treatment.
- If your child sees a counselor individually, you have the right to expect that their counselor, as requested, will communicate with you about your child's therapy. However, as the establishment of trust between your child and their counselor is important for a successful therapeutic outcome, we ask you to keep in mind your child's need for privacy.
- *I realize that if my child is seen in therapy, both parents will be asked to participate in the treatment. This may involve family treatment, parent meetings between you and your child's therapist, or individual therapy for each parent. Your therapist may share information regarding issues that arise in the course of the therapy with either parent.*
- You have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, which would greatly compromise the therapeutic relationship.
- The Center does not provide psychological testing, acting as a witness in court cases, or report writing of any kind (except for providing evidence of attendance, upon request). I agree that I will not request any of these services from **TMCC**.
- Therapy involves a partnership between therapist and client. Your family's therapist will contribute knowledge, skills, and a willingness to do his/her best. The determination of success, however, is largely dependent upon your commitment to your family's personal growth and care. Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to **TMCC** to provide counseling services and that this contract is binding for all future sessions you may have with this agency.

Patient Information and Informed Consent for TeleCounseling Service

TeleCounseling is providing therapy/counseling services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

A computer and a webcam with microphone to video conference using a HIPAA compliant online company specializing in telemedicine. As with any medical procedure, there may be potential risks associated with the use of TeleCounseling. These risks include, but may not be limited to:

- Therapy conducted online is technical in nature and problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the doctor, and the doctor makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, the doctor will call the patient back at the phone number provided on this form.
- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.
- The provider may not be able to provide treatment to the patient using interactive electronic equipment, or provide for or arrange for emergency care that the patient may require, in cases of connection failure.
- Delays in evaluation and treatment may occur due to deficiencies or failures of the equipment. • Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.
- A lack of access to all of the information that might be available in a face to face visit, but not in a TeleCounseling session, may result in errors in provider judgment.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to TeleCounseling.
- I understand that the technology used by the provider is encrypted to prevent the unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent to the use of TeleCounseling during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of TeleCounseling during the course of my care at any time.
- I understand that all the rules and regulations which apply to the practice of medicine in the state of California also apply to TeleCounseling.
- I understand that the provider will not record any of our TeleCounseling sessions without written consent.
- I understand that the provider will not allow any other individual to listen to, view, or record my TeleCounseling session without my express written permission.

My Responsibilities

- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- I understand that I am solely responsible for maintaining the strict confidentiality of my user ID and password and I will not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location, so that others cannot hear my conversation.
- I understand that the company that the doctor has chosen to conduct the online appointment (see Guidelines) is an independent company specializing in HIPAA compliant telemedicine. My doctor has no responsibility for that company's operations or security of my protected health information. In addition, the company might send me emails or communication, such as appointment reminders. I understand that the provider is not responsible for this communication. If I am receiving any unwanted communication from the company, I will call/contact the company directly and address my concerns with them.
- I will not record any TeleCounseling sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins. • I

have read and understand all of the clinic policies of The Maple Counseling Center, and that they apply to all telemedicine as well as all in-person visits.

- I consent to paying fees that are the same as an in-office visit for the type and length of service provided, through the billing department at The Maple Counseling Center.
- I understand that a TeleCounseling appointment is scheduled the same as an in-office appointment would be, and should I not be available for the appointment, or cancel it less than two full business days in advance, there will be a charge for a missed appointment for the time my practitioner has reserved for the scheduled appointment.

Patient Consent to the Use of TeleCounseling

- I have read and understand the information provided in the preceding pages regarding TeleCounseling. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleCounseling in my medical care and authorize the provider to use TeleCounseling in the course of my diagnosis and treatment.

Signature of Parent/Legal Guardian #1: _____ Date: _____

Signature of Parent/Legal Guardian #2: _____ Date: _____

Adolescent Counseling Information

(Please review with your teen)

What to expect from therapy?

You can expect that I will do my best to understand your concerns. I will listen non-judgmentally and provide an opportunity for you to learn more about yourself and hopefully together we will find better solutions to the challenges in your life.

You can expect that what we discuss will be kept private. **There are a few exceptions**, and here they are:

- You tell me that you plan to hurt yourself or someone else.
- You tell me that you are being abused physically, sexually, or emotionally, or that you have been abused in the past.
- You are involved in a court case and a request is made for information about your counseling or your therapy.
- You tell me that you are or have engaged in a sexual relationship with someone who is significantly older than you. In most cases I would be required by law to report this to Child Protective Services.

What to expect about my communications with your parent or guardian: Generally speaking I will keep the specifics of what you share with me private.

There are few exceptions, and here they are:

- If I do hear that you are involved in risk-taking behavior that becomes serious, then I will need to use my professional judgment to decide whether I must inform your parent/guardian, or we will discuss how to share this with your parent(s) together.
- Even though I am committed to keeping your information confidential, I may believe that it is important for your parent/guardian to know what is going on in your life. In these situations, we will work together to find the best way to discuss these things with your parent(s).
- When meeting with your parents I will discuss challenges and progress that you have made in counseling. Generally speaking, I will talk about themes rather than specifics. The purpose of meeting with your parent(s) is to support our work together and to facilitate improved family relationships.

What I expect from you:

- You agree to attend therapy sessions as scheduled and participate to the best of your ability.
- You agree to participate in goal setting and take an active role in making positive life changes.
- You agree to talk with me if you have thoughts or feelings about harming yourself or someone else.

What I expect from your Parent/Guardian:

- You agree to support your child's treatment by doing your best to arrange for regular attendance.
- You agree to make yourself available for parenting consultations and/or family meetings as requested by your child or his/her counselor.
- You agree to be supportive of the counseling process.

Minor's Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____

Client Name: _____
Client ID#: _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

In the course of providing services to you, we may create, receive, and store individually identifiable information, including information that relates to health care and payment for health care ("Personal Information"). It is often necessary to use and disclose this Personal Information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practices that describes these uses and disclosures. As described in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment purposes not only includes care and services provided here, but also disclosures of your Personal Information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your Personal Information for purposes of payment may include, for example, the submission of this information to a billing agent for processing claims or obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your Personal Information to treat you, to obtain payment for our services, and to operate The Maple Counseling Center. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You also acknowledge, by your signature below, that you have received a copy of our HIPAA Notice of Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Parent/Guardian/Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____

_____

Print Name: _____

Client Name: _____
Client ID#: _____

Divorced/Separated Family Agreement Form

We, at Maple Counseling understand the impact that family changes can have the entire family. Many parents and families may experience increased stress during a separation or divorce and want to support their child to effectively cope with these family changes.

I am bringing my child _____ to Maple Counseling for psychological services. I understand that my child is the client and the focus of support. Therefore, I agree to following:

- To provide my custody agreement information and the contact information of the other parent
- If parents share legal custody, both parents MUST sign our Consent to Treatment form prior to the first session with the child. If therapy is court-ordered, we will require a copy of the court order for our records.
- If one parent has sole legal custody, we will not require consent from the other parent; however, we will need a copy of the custody order for our records
- Both parents will be offered "equal time" in face-to-face or phone contacts as much as realistically possible, unless this is contraindicated or there are other factors limiting contact with one or both parents.
- Therapist will not communicate with attorneys for either parent or guardian.
- Therapist WILL NOT provide custody evaluations or visitation recommendations to the court, mediator, or psychologist conducting a family psychological evaluation as this is outside the therapist's legal and ethical scope of practice.
- I understand that the therapist will not provide custody evaluations or visitation recommendations.

I have read and agree to the above policies.

Parent/Guardian Signature: _____ Print Name:_____

Relationship to child: _____ Date: _____

Parent/Guardian Signature: _____ Print Name: _____

Relationship to child: _____ Date: _____

Client Name: _____
Client ID#: _____

Intake Financial Agreement

Personal Information

	Case #:
Client #1 Name:	
Client #2 Name:	
Home Address:	
Phone #1: ( )	Cell#: ( )
Phone #2: ( )	Cell#: ( )
Email Address:	
Email Address:	
Number of Dependents:	

Financial Information

Income		**Expenses**	
Annual Gross Salary	$	Rent or Mortgage	$
Monthly salary	$	Food	$
Spouse Monthly Salary	$	Medical Insurance	$
Unemployment Benefit	$	Child Support	$
Disability	$	Utilities	$
SSI Benefit	$	Education Expenses	$
Public Benefit	$	**Total Expenses**	$
Other Income	$		
Total Household Gross Income	$		

Signature: Client #1: _____ Date: _____

Signature: Client #2: _____ Date: _____

The center base fee is $100 per session. However, as a nonprofit community mental health agency, fees are assigned using a sliding scale, based on the ability to pay.

Based on my ability to pay, it is my understanding that my fee is $_____.

Client has made a verbal agreement. _____ Date: _____

Finance department officer signature _____ Date: _____

Attach to this application; two of the following proof of income and expenses.

• Tax return	• Copy of EDD check	• Rent or mortgage receipt
• 2 Month Pay stub	• Bank statement	• Copy of utility bill
• Copy of SSI check	• Proof for public help benefit	• Other

For office use only:

Client Name: _____
Client ID#: _____

As part of a programmatic partnership between The Maple Counseling Center and **The Jewish Federation of Greater Los Angeles,** we ask you to please fill in the following information:

Do you or any member of your family who will be receiving counseling services at TMCC identify as
Jewish?

☐ YES
☐ NO
☐ PREFER NOT TO ANSWER

Were you referred to us for services by a Jewish organization?

☐ YES; *If so, which organization?*
☐ NO
☐ PREFER NOT TO ANSWER

Thank you!

The Jewish FEDERATION OF GREATER LOS ANGELES
www.JewishLA.org