i TO i COUNSELING

Chris Quaglino, LCSW, LCDC (512)775-5940

Child or Adolescent Client Intake Information Form

I want to assure you that I read every bit of the information you give me. Thank you for your time and information.

Child or Adolescent's Name:	Date of Birth:	Age:
Parents name if client is under the age of 18:	Date of Birth:	
BCBSTX PPO Member ID:	Group ID:	
The child or adolescents school:		Grade:
Home Address:		
Parent's Home Phone:		
Parent's Cell Phone:		
I need approval at the end of this form by BOTH parents/guardians prior to meeting with a person under the age of 18		
Mother's Name:		
If address and contact information is different from above, please complete area below		
Home Address:		
Parent's Home Phone:		
Parent's Cell Phone:		
Father's Name:		
If address and contact information is different from above, please complete area below		
Home Address:		
Parent's Home Phone:		
Parent's Cell Phone:		
Step Parent Name:		
Please supply the same information if you are the **Legal Guardian**.		
Home Address:		
Legal Guardian's Cell Phone:		
Relationship to child:		
If the Emergency Contact is other than parents or Legal Guardian both parents or legal guardians need to approve. Initial here >>		

Emergency Contacts			
Name:	Relationship to client:		
Best Phone Number (Daytime):	Best Phone Number (Nighttime):		
Address:	City:	State:	Zip:

Adult Client or Main Parental Contact Information and Permissions:

You are responsible if others access your electronic communication with me or if they look over your shoulder.

Also note that electronic communication can be subpoenaed and may become permanent record.

Home Phone:	Can I leave a message at home?		Yes		No
Personal Cell Phone:	Can I leave a message on your cell?		Yes		No
	Can I text message to this cell phone?		Yes		No
Email:	Can I send you emails?		Yes		No
Work Cell Phone: (**Work property use is not recommended**)	Can I leave a message on this work phone?		Yes		No
	Can I text message to this cell phone?		Yes		No
Work Desk Phone: (**I do not leave messages on desk phones**)	Companies can access personal desk phone messages				
Work Email: ---------------(**Do not use work email**) -------------	Email creates a permanent record of your personal business				

Employment						
Employed:		Yes		No	Occupation?	
Combined Household Income: **(optional)** ☐ Below $16,000/Year	☐	Between $16,000.00-$25,000.00/Year	☐	Between $25,000.00-$50,000.00/Year	☐	Between $50,000.00-$100,000.00/Year

i TO i COUNSELING

Chris Quaglino, LCSW, LCDC (512)775-5940

Family Information				
	Name(s)	Age(s)	Name(s)	Age(s)
(Ex)Spouse/Partner				
Children				
Siblings				
Parents				

Are there other family members in the home?		Yes		No	Explain:

Mental Health History

Name of your Doctor (PCP), Psychiatrist, Nurse Practitioner:			
Address:	City:	State:	Zip:
Date of last appointment:	Date of next appointment?		
Diagnosis (Past and Present):			
What medications are you currently taking?			
Name of Rx:	Dosage:	When started?	
Please note here (i.e. side effects, allergies, poor efficacy):			
Name of Rx:	Dosage:	When started?	
Please note here (i.e. side effects, allergies, poor efficacy):			
Name of Rx:	Dosage:	When started?	
Please note here (i.e. side effects, allergies, poor efficacy):			
List any other medical concerns I may need to know here (history of Rx, trauma, physical ailments):			
Child or adolescent's physical health □ Good □ Average □ Declining □ In Crisis			
Recent weight: _____Lost # lbs. _____Gained # lbs.	Date of last physical exam:		
How would you rate child or adolescent parents' marriage? ❑ Very Happy ❑ Happy ❑ Average ❑ In Conflict ❑ N/A			
Was a Release of Information form completed today? ☐ Yes ☐ No ☐ Declined	For Whom?		
Have you ever had previous psychological counseling or treatment?		Yes	No

Dates of service (from? to ?)	Name of Provider or Hospital/Clinic

i TO i COUNSELING

Chris Quaglino, LCSW, LCDC (512)775-5940

Safety Issues/Concerns (Past and Present)					
Do you have a history of suicidal/homicidal ideation or attempt(s)? (include self-harming issues)		Yes		No	
Dates	Details				
Are there immediate suicidal/homicidal concerns?		Yes		No	
If yes, please explain:					

Drug, Substance, and Alcohol Use (include Rx abuse)					
Are there current or past issues and/or concerns with drugs and/or alcohol?		Yes		No	
If yes, please explain: (history, current use, substance, and anything else I may need to know that would be helpful to our sessions)					

Pre-Service Questionnaire
The process of therapy can be stressful and sometimes overwhelming. To help this process to be as productive as possible, an important therapeutic partnership must be established between you and your therapist in which good self-care routines are established. Please help me to understand more about you by providing the information listed below:
Please list the top areas of current concern for you that you would like or need to work on. And what has and has not worked in the past.:
Please tell me a little bit about your history (pertinent information concerning your family and relationships history):

i TO i COUNSELING

Chris Quaglino, LCSW, LCDC (512)775-5940

What do you hope to get out of our sessions?

Notice of Cancellation Policy

Your appointment time is held for you every week and will be confirmed after each session. If you need to make any changes to your appointment, please give at least 24-hour notice. Failure to provide 24-hour notice or no shows will result in a charge of full session rate. Please be on time for your appointments. Showing up more than 15 minutes late to the appointment may result in needing to reschedule the session. Showing up to sessions late will be charged the full cost of the session. Your session starts at the time scheduled and ends 50 minutes from that time. If you are late, please understand that I must end the session as scheduled so that I can complete administrative tasks and start on time for the next client. Payments are due at the end of each session or can be paid in advance. Payment for services is an important part of any professional relationship. It shows that you value your healing and personal development.

How did you hear about me? (please include name if appropriate)

☐ www.itoiaustin.com	☐ Conference/Seminar
☐ Friend/Family	☐ Yelp
☐ NetworkTherapist.com	☐ Psychology Today website
☐ Google search	☐ Yahoo search
☐ M.D./Counselor	☐ HelpPro website
☐ Other	

i TO i COUNSELING

Chris Quaglino, LCSW, LCDC
(512)775-5940

Complete a copy of this form for each person under the age of 18 who will be a client of Chris Quaglino and bring it, along with the copies of court orders, if any, to the first appointment. (Note: all information that is the same for each client please just write the word 'SAME' to note such. There is no reason to duplicate information).

You must supply me with written permission from the joint managing conservator prior to the time I see your child/children (i.e., both parents or guardians must sign this form). If you arrive without written permission, documentation, and both signatures, you will be charged for the session but I will not see the child/children or adolescent.

Name of Minor _____

1. Are both biological parents still living?	□ **Yes** □ **No**
2. Are biological parents: □ married □ separated □ divorced □ never married	
3. Is the child (or children) now, or has ever been, a named party to a legal proceeding or CPS case, including a divorce, child custody, adoption, termination of parental rights, guardianship, or other dispute?	□ **Yes** □ **No**
----------If you answered NO to question 3 you may skip to the bottom---------- **(Both parents must sign this form before I can work with the person under the age of 18)**	
If there is a court order involving your child or your divorce or separation, ----YOU MUST BRING A COPY OF THE COURT ORDER TO THE FIRST SESSION----	
Do you have a court order naming you a joint managing conservator of this/these child/children?	□ **Yes** □ **No**
Date and state, city and county where order was granted:	
Does the order grant you the right to seek mental health care for your child/children?	□ **Yes** □ **No**
Name of other joint managing conservator:	
Does the other joint managing conservator know that you are seeking mental health care for this/these child/children? If not, do you agree to inform that person within 24 hours? Initial here: □	□ **Yes** □ **No**
How will you inform that person? □ Phone □ In person	
Have the parental rights of either parent been terminated by a court order?	□ **Yes** □ **No**
If you answered "yes" to the question above, when were the rights terminated and in what state, county and city.	
If you are not the biological parent, are you the legal guardian with the legal right to seek mental health care for this/these child / children?	□ **Yes** □ **No**
If so, under what authority are you the legal guardian? □ Court order □ Appointment of guardianship Other:	

Please understand that I DO NOT conduct evaluations for divorce, custody, parental rights, visitation, sexual or emotional or physical abuse, CPS complaint or investigation, or any other legal or quasi legal proceeding. If I am subpoenaed to give testimony, my fee is $250 per hour, payable in cash in advance for the number of estimated hours for preparation, attendance, travel time, sitting at the proceeding site, all expenses, and actual testimony time. There is an additional charge of $25 for copying records, payable in advance.

If you believe that you may now or in the future need or want the child/children evaluated for any legal or quasi legal proceeding, please inform me immediately so that I can refer you to another mental health provider who performs this type of legal service.

Signature: _____ Print name: _____ Date:_____

Signature: _____ Print name: _____ Date:_____

Confidentiality and Notice of Privacy Practices

Overview

As a clinician, I am committed to providing services that enhance the well-being of my clients. I recognize that the people I serve must provide personal information in order for my services to be effective and that I have an obligation to protect my clients' privacy and use this information ethically and appropriately at all times. As such, personal information about my clients shall be obtained and used only when necessary. I believe that individuals have a fundamental right to privacy and that it is my obligation to ensure information is protected whether it exists in hard copy form, in electronic form or is communicated to other professional staff.

i TO i COUNSELING

Chris Quaglino, LCSW, LCDC
(512)775-5940

Informed Consent

I understand that all statements made by me or my child or adolescent to my counselor are of a confidential nature and generally, except as noted below, may not be disclosed by my counselor without my consent. I further understand and accept as a condition of receiving counseling, that certain statements made by me, by my child or adolescent or certain situations may require my counselor to take action or make disclosure when my counselor believes it is necessary for the protection of life or when my counselor may be required by law to disclose or report threats or past instances of harm to myself or threatened harm or past instances of harm to a third person. These disclosures will be made at the sole discretion of the Counselor I am seeing. I hereby acknowledge that I have read and understand the following six items concerning confidentiality of service provided. I understand that if I have any questions regarding privacy rights, I can contact Chris Quaglino, LCSW, LCDC.

1. I sign a Release of Information form authorizing Chris Quaglino to share specified information with only persons identified in said authorization. Also, this authorization is time limited to a maximum of 6 months from the time of signature.
2. If there is a Court order, from a judge, to disclose your information. (a fee of $225/hr. will be charged for court testimony).
3. If you are threatening eminent/plausible physical harm to yourself or to others.
4. If you tell me of neglect, physical or sexual abuse of a child, disabled or elderly person. I am required to report such to the Texas Protection Services.
5. If you tell me of physical or sexual misconduct by a therapist, minister or a person of authority, I am required to report it to the proper board or state entity.
6. If you are utilizing your insurance or are asking for reimbursement for your services, a diagnosis and pertinent therapeutic information may need to be disclosed to the insurance company for you to be reimbursed.

If you have any questions or concerns, please share them with me.

Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of these offices Notice of Privacy Practices (HIPAA). I understand that if I have any questions regarding this Notice or my privacy rights, I can contact Chris Quaglino at the above address.

Notice of Privacy Practices

I am required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is presently effective and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. The HIPPA Notice of Privacy Practices is posted at www.itoiaustin.com under the Forms page. You may request a written copy of a revised Notice of Privacy Practices from this office if you do not have internet access. In the event of any change to my privacy practices, I will provide you with an updated version in a timely fashion.

You have recourse if you feel that your privacy protections have been violated. Please notify me as soon as possible with any concerns. You have the right to file a formal, written complaint with us at the address below and your concerns will be immediately addressed. Or, with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

For more information about HIPAA or to file a complaint, please contact the following:

Chris Quaglino, LCSW, LCDC
1507 North Street Unit 1
Austin, Texas 78756
(512) 775-5940

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257

Signature Parent or Guardian 1:	**Date:**
Signature Parent or Guardian 2:	**Date:**